Supreme Court

New South Wales

Case Name:	SMF v South Western Sydney Local Health District
Medium Neutral Citation:	[2018] NSWSC 303
Hearing Date(s):	9 March 2018, together with written submissions
Date of Orders:	14 March 2018
Decision Date:	14 March 2018
Jurisdiction:	Equity - Protective List
Before:	Lindsay J
Decision:	Appeal Dismissed
Catchwords:	MENTAL HEALTH – Mental Health Review Tribunal – Appeal – Community Treatment Order – Forced medication by depot injection – Mental Health Act 2007 NSW, sections 51, 53, 163, 164
Legislation Cited:	Civil and Administrative Tribunal Act 2013 NSW Civil Procedure Act 2005 NSW Guardianship Act 1987 NSW Health Services Act 1997 NSW Mental Health Act 2007 NSW NSW Trustee and Guardian Act 2009 NSW Uniform Civil Procedure Rules 2005
Cases Cited:	A Duty List Plaintiff v A Local Mental Health Service [2018] NSWSC 96. B v St Vincent's Hospital Sydney Ltd [2016] NSWSC 392 Commissioner of Police (NSW) v Eaton (2013) 252 CLR at 28 M v Mental Health Review Tribunal [2015] NSWSC 1876 Mental Health Act: Z v Mental Health Review Tribunal [2015] NSWCA 373

	S v South Eastern Sydney & Illawarra Area Health Service [2010] NSWSC 178 Sarah White v The Local Health Authority [2015] NSWSC 417 Z v Mental Health Review Tribunal [2015] NSWCA 373 Z v Mental Health Review Tribunal [2015] NSWSC 1943
Texts Cited:	-
Category:	Principal judgment
Parties:	Plaintiff: SMF, a natural person Defendant: South Western Sydney Local Health District
Representation:	Counsel: Plaintiff: M Fraser (instructed under NSW Bar Association Pro Bono Scheme) Defendant: JS Emmett Solicitors: Plaintiff: Self Represented Defendant: NSW Crown Solicitor
File Number(s):	2019/00007252

JUDGMENT

INTRODUCTION

1 By a summons filed on 8 January 2018, the plaintiff (a person who has been diagnosed as suffering from schizophrenia) appeals from a community treatment order made against her by the Mental Health Review Tribunal (pursuant to section 51, in Part 3 of Chapter 3, of the *Mental Health Act* 2007 NSW) on 12 October 2017.

2 The respondent to the appeal (the defendant) is a local health district constituted as a body corporate by section 17 of the *Health Services Act* 1997 NSW in respect of an area which (by operation of section 18 of the Act) includes Campbelltown in the western suburbs of Sydney.

3 The defendant is responsible for management of the Campbelltown Community Mental Health Service, which is a “declared mental health facility” for the purpose of the *Mental Health Act* 2007, section 109.

4 The application made under section 51 of the *Mental Health Act* for a community treatment order in respect of the plaintiff was made by an authorised medical officer of the Campbelltown Mental Health Service.

5 Extracted in a Schedule to these Reasons for Judgment is an extract of the principal provisions of the *Mental Health Act* to which reference is made in the judgment, together with other, contextual provisions.

THE COMMUNITY TREATMENT ORDER UNDER APPEAL

6 The determination of the Tribunal to make a community treatment order on the defendant's application provides for an order which is expressed (in conformity with section 56 of the *Mental Health Act*) to expire on 11 April 2018.

7 The community treatment order made by the Tribunal incorporates a treatment plan (of the character described in section 54 of the *Mental Health Act*) dated 11 October 2017.

8 That plan imposes on the plaintiff an obligation (made explicit by section 57(1) of the *Mental Health Act*) to submit to a regime of medical treatment, required to be implemented by the defendant, involving:

(a) medication prescribed by a named treating doctor/psychiatrist (Dr HS), or delegate, described on 11 October 2017 as "currently" in the form of a 50 mg dose of Risperdal Consta (generically, risperidone), every two weeks;

(b) attendance at a review by a treating doctor or psychiatrist at least once every four weeks; and

(c) a meeting with a counsellor at least weekly.

9 The community treatment order, incorporating the treatment plan, authorises medication of the plaintiff by administration of a depot injection (that is, an "IMI" or intra-muscular injection).

THE NATURE OF THE APPEAL

10 There are two avenues for an appeal from a community treatment order. Section 67 of the *Mental Health Act* provides, *inter alia*, for an appeal "on any question of law or fact arising from the order or its making". Section 163 (read with section 164) provides for an appeal by way of a new hearing. The latter form of appeal is generally regarded as providing a broader right of appeal than the former: *S v South Eastern Sydney & Illawarra Area Health Service* [2010]

NSWSC 178 at [22]; *M v Mental Health Review Tribunal* [2015] NSWSC 1876 at [21]; *B v St Vincent's Hospital Sydney Ltd* [2016] NSWSC 392 at [8]-[9].

11 It is agreed between the parties that the present proceedings are to be regarded as an appeal governed by sections 163-164 of the *Mental Health Act*.

12 That carries the consequence that the plaintiff's contradictor, the defendant, accepts that:

(a) the Court has, for the purposes of hearing and disposing of the appeal, all the functions and discretions of the Tribunal in respect of the subject-matter of the appeal: *Mental Health Act*, section 164(1).

(b) the Court must consider afresh whether a community treatment order should be made affecting the plaintiff: *Z v Mental Health Review Tribunal* [2015] NSWCA 373 at [7], [173]-[174] and [181].

(c) the plaintiff does not need to establish error on the part of the Tribunal in order to succeed on her appeal: *Z v Mental Health Review Tribunal* [2015] NSWSC 1943 at [19].

(d) the Court must be satisfied as to each of the statutory preconditions for the making of a community treatment order, set out in section 53 of the *Mental Health Act*: *Z v Mental Health Review Tribunal* [2015] NSWCA 373 at [7]; *B v St Vincent's Hospital Sydney Ltd* [2016] NSWSC 392 at [14].

(e) the defendant bears an onus of establishing that a community treatment order should be made/continued: *M v Mental Health Review Tribunal* [2015] NSWSC 1876 at [21]-[22].

(f) forced medical treatment is an exceptional form of treatment (not to be approached lightly) insofar as it is a departure from the Common Law's norm that a prerequisite for the medical treatment of an individual is a need for the individual's consent to that treatment: *M v Mental Health Review Tribunal* [2015] NSWSC 1876 at [69].

13 On the hearing of a section 163 appeal, the Court may be assisted by assessors: sections 164(5)-(6). Neither party to the proceedings invites the Court to seek that assistance. Nor is it necessary, or desirable, for a proper disposition of the appeal that assistance be sought from assessors. Accordingly, the appeal is to be determined by the Court constituted by a judge sitting alone.

14 In character, proceedings under Part 3 of Chapter 3 of the *Mental Health Act* are essentially proceedings protective of the plaintiff.

15 In determination of the appeal the Court is bound to have regard, not only to the particular criteria for which section 53 of the *Mental Health Act* provides, but also to:

(a) the objects of the *Mental Health Act*, as enumerated in section 3 of the Act;

(b) the principles for care and management set out in section 68 of the Act; and

(c) the objectives of the NSW public health system identified in section 105 of the Act.

THE PLAINTIFF IS A PERSON UNDER LEGAL INCAPACITY, BUT NO TUTOR REQUIRED

16 In the current proceedings, the fact that the plaintiff is a person in need of protection is confirmed by the subsistence of orders made by the Guardianship Division of the Civil and Administrative Tribunal of NSW (NCAT), under the *Guardianship Act* 1987 NSW, appointing:

(a) the Public Guardian, and the plaintiff's father, as the plaintiff's guardians; and

(b) the NSW Trustee as her financial manager.

17 NCAT's guardianship order was made on 15 November 2017, upon an application by an officer of a mental health unit of Campbelltown Hospital. It was made, as a continuing guardianship order, for a period of 12 months from that date.

18 NCAT's financial management order was made, on 13 December 2017, upon an application by the plaintiff's father. As is customary, it was made for an unspecified, indefinite duration.

19 The guardianship order limits the respective functions of the plaintiff's father and the Public Guardian as follows:

(a) the plaintiff's father has authority to make decisions about her health care, including decisions about her medical or dental treatment where she is not capable of giving a valid consent.

(b) the Public Guardian has authority (described colloquially as emanating from a "coercive accommodation order") to make decisions about where the plaintiff may reside, the services to be provided to her and engagement of the NSW police and ambulance services in regulating her movements.

(c) in exercising their respective powers, the plaintiff's guardians are (in terms of a standard form of order) expressly required to "take all reasonable steps to bring [the plaintiff] to an understanding of the issues and to obtain and consider their [sic] views before making significant decisions".

20 I read the consultation order as one that requires the plaintiff's guardians to obtain and consider *her* views before making significant decisions. As a matter of practice, an antecedent requirement of any significant decision by either guardian might reasonably be expected, so far as may be practicable, to involve collaboration between the guardians and the plaintiff personally.

21 The plaintiff's appeal was the subject of a pre-trial directions hearing before me on 5 March 2018. The appeal was heard by me on a final basis on 9 March 2018, allowing for supplementary written submissions subsequently to be filed.

22 A representative of the Public Guardian attended the pre-trial directions hearing, but not the final hearing. At the final hearing, the defendant read an affidavit which deposed to a conversation between a solicitor having carriage of the proceedings on behalf of the defendant and a senior officer of the Public Guardian in which the Public Guardian authorised the solicitor to communicate to the Court the following statement about the practice of the Public Guardian in a case such as the present one:

> "….[T]he Public Guardian has no view in relation to the proceedings. The reason is that [the community treatment order under appeal] is made under the *Mental Health Act* whereas the guardianship order is made under the *Guardianship Act*. Even if the Public Guardian had functions with respect to health care and medical and dental care (which it does not in this case) the Public Guardian would take the view that it need not take part in the appeal.
>
> … [The] *Guardianship Act* and the *Mental Health Act* sit side-by-side but the *Mental Health Act* prevails if a person is subject to an involuntary treatment order or [a community treatment order]. If the Public Guardian had functions with respect to health care, and the person [affected by a community treatment order] did not want to be subject to a CTO, all the Public Guardian would do is have a discussion with the person's doctors to assist in presenting the person's views to the doctors. The situation is different for non-mental health matters, eg. if the person needed an appendix removed, in which case the guardian with respect to health care would need to approve the procedure."

23 This statement was proffered as a statement of *practice*, not a statement of *law*. As a matter of statutory construction, one of the questions for determination in the proceedings is the relationship between a community treatment order and a guardianship order involving a healthcare function.

24 Neither party to the appeal contended that the nature of the appeal required the Public Guardian to be a party to the proceedings or otherwise to be represented on the hearing of the appeal. Nor was there any suggestion that the NSW Trustee was a necessary or proper party, or that it should be consulted on the hearing of the appeal.

25 Under the legislation governing them, each of a financial manager (by virtue of section 71 of the *NSW Trustee and Guardian Act* 2009 NSW) and a guardian (by virtue of sections 21, 21A and 21C of the Guardianship Act) has a degree of power that supplants that of the person under protection. The power of a protected person to deal with his or her estate is suspended in respect of so much of that estate as is the subject of a financial management order. Subject to any conditions specified in a guardianship order, the guardian of a person under guardianship has power, "to the exclusion of any other person", to make decisions, take actions and give consents that could be made, taken or given by the person under guardianship if he or she had the requisite legal capacity.

26 Although a financial manager and a guardian have overlapping areas of concern that require them each to be mindful of the other's field of operation, a financial manager's primary concern is with the *estate* (property) of a person in need of protection whilst that of a guardian is the person's *person*.

27 In proceedings such as the present, in which an appellant seeks relief essentially protective in nature and the appellant's contradictor is a body corporate charged with protective functions, a concern of the Court is to ensure that the proceedings are constituted, and conducted, in a manner consistent with the jurisdiction to be exercised. That requires an appreciation of the legal, and administrative, framework within which the proceedings are located.

28 In this case, each of the NSW Trustee and the Public Guardian is available to provide assistance to the Court, and to the parties, if assistance be required. However, neither is a necessary party to the appeal. The defendant serves as the plaintiff's contradictor and, represented by the NSW Crown Solicitor's Office, it possesses the requisite capacity for performance of executive functions necessary to aid the plaintiff in prosecution of her appeal, reinforced

by the onus borne by the defendant to demonstrate why a community treatment order should continue to operate.

29 The plaintiff's father attended both the pre-trial directions hearing on 5 March 2018 and the final hearing on 9 March 2018. He was allowed an opportunity to participate in the proceedings on both occasions, and he did so without cutting across either the plaintiff (who appeared without representation at the directions hearing and with *pro bono* counsel at the final hearing) or her counsel. On both occasions he quietly interacted with the plaintiff, in a manner consistent with his roles as her father and principal carer, as she wandered in and out of the court room, constantly restless and apparently in a world of her own. For the final hearing he also provided an affidavit (sworn on 7 March 2018) in which he helpfully explained his daughter's personal circumstances.

30 The formal status of the guardianship order affecting the plaintiff is open to debate. That is because in separate proceedings (numbered 2018/00010914) the plaintiff, by a summons filed by her as a litigant-in-person on 11 January 2018, appears to have appealed against NCAT's guardianship order.

31 I say "appears" because the summons is open to being read, not as an appeal against NCAT's guardianship order, but merely as an "appeal" against a decision taken by the Public Guardian (at about the time the summons was filed) to move the plaintiff's place of residence from her family home (where she lived with her father and a younger brother) to a "group home" designed, *inter alia*, to provide her father with respite. Aged 64 years and living in retirement, he has borne the burden of caring for the plaintiff (now aged 34 years) since the death of his wife, her mother, in 2005. He is conscientiously attentive to the needs of his daughter, but he is in ill health and exhausted.

32 The NCAT appeal was not listed for hearing with the present proceedings. Having taken instructions from her at my invitation, the plaintiff's counsel announced that she had no instructions to appear for the plaintiff in the NCAT appeal. That appeal presently stands listed for directions on 26 March 2018.

33 If (as it can be) the NCAT appeal is construed as an appeal against the guardianship order made by NCAT, and not merely a challenge to an accommodation decision made by the Public Guardian, pendency of the

appeal operates (subject to any interlocutory order made by the Court) as a stay of the decision under appeal: *Civil and Administrative Tribunal Act* 2013 NSW, schedule 6, clause 14(5). No interlocutory order having been made to remove the stay, the guardianship order is at least arguably the subject of a stay.

34 As a practical matter, nothing of real consequence turns on this. That is because:

(a) the financial management order made by NCAT is not the subject of an appeal and, so, the plaintiff remains a "protected person" within the meaning of the *NSW Trustee and Guardian Act* 2009 NSW, section 38, if not also a "person under guardianship" within the meaning of the *Guardianship Act*, section 3(1) and, accordingly, a legally incapacitated person for the purpose of these proceedings in any event;

(b) the plaintiff's father and the Public Guardian have liaised with one another, and with the plaintiff, in arranging her group home accommodation;

(c) the father's evidence is that, although the plaintiff found it hard to adjust to living in a group home when she moved there in mid-January 2018, she now tells him that she is enjoying life at the group home; and

(d) whether or not there is a formal impediment to current operation of the guardianship order, there is general agreement that it is highly desirable that, as both the plaintiff's parent and her principal carer, the father be actively involved in the proceedings.

35 By virtue of her status as a "protected person", the plaintiff is a "person under a legal incapacity" within the meaning of section 3(1) of the *Civil Procedure Act* 2005 NSW.

36 As a "person under legal incapacity", the plaintiff cannot commence or carry on proceedings except by a tutor (*Uniform Civil Procedure Rules* 2005 NSW, rule 7.14) unless (pursuant to section 14 of the *Civil Procedure Act* 2005) the Court dispenses with the requirement for a tutor.

37 The practice of the Court in a case such as the present one, followed on this occasion, is to dispense with any requirement for a tutor lest the efficacy of the appeal be undermined by a need to find a person willing and able to act as a tutor or deflected by collateral inquiries about the appellant's capacity for self-

management: *M v Mental Health Review Tribunal* [2015] NSWSC 1876 at [12]; *B v St Vincent's Hospital Sydney Ltd* [2016] NSWSC 392 at [11].

38 Counsel who appeared for the plaintiff on the hearing of the appeal, and who had opportunities to take instructions from both the plaintiff and the plaintiff's father, informed the Court that she was comfortably satisfied about the ability of the plaintiff to communicate instructions required for the conduct of the proceedings.

39 Counsel appeared for the plaintiff, as part of the NSW Bar Association's Pro Bono Scheme, in response to an order made by Slattery J, as Duty Judge, on 12 February 2018 pursuant to the *Uniform Civil Procedure Rules* 2005, rule 7.36. His Honour was satisfied, in the terms of that rule, that it was in the interests of the administration of justice that the plaintiff be referred to the Registrar for referral to a barrister or solicitor on the Pro bono Panel for legal assistance: *A Duty List Plaintiff v A Local Mental Health Service* [2018] NSWSC 96. I acknowledge, with gratitude, the assistance of counsel in determination of the proceedings.

THE ISSUES IDENTIFIED FOR DETERMINATION

40 On the hearing of the appeal, counsel for the plaintiff invited the Court to address each of the following issues:

(a) **The first issue:** Is the plaintiff "mentally ill" within the meaning of the *Mental Health Act* and, therefore, a person for whom a community treatment order should be made?

(b) **The second issue:** Is the treatment plan before the Mental Health Review Tribunal on 12 October 2017 an appropriate treatment plan that will benefit the plaintiff?

(c) **The third issue:** Does a community treatment order have effect, or is it necessary, where a guardian has been appointed with health care and medical consent functions?

41 **The first issue.** In her supplementary written submissions counsel for the plaintiff expressly withdrew her submission that it was necessary for the Tribunal, and in turn the Court, to determine that the plaintiff is a "mentally ill person" (within the meaning of section 14 of the *Mental Health* Act) as a pre-requisite to making the community treatment order under appeal. The plaintiff accepts that the order under appeal was not made at a "mental health inquiry"

(as defined in section 4 of the *Mental Health* Act) so that section 53(4) of the Act was not engaged. Whether the plaintiff suffers a "mental illness" within the meaning of section 4 remains relevant to an exercise of the discretion to make a community treatment order, but a finding that the plaintiff was a "mentally ill person" is not a pre-condition to an order being made. Accordingly, the first of the three specified issues can be taken to have been qualified, if not withdrawn. Counsel concedes that the plaintiff has been correctly diagnosed as suffering from schizophrenia, plainly a form of mental illness.

42 In fact, she has been diagnosed as suffering from "treatment resistant schizophrenia", a diagnosis adopted when two or more antipsychotic medications for adequate dose and adequate duration have been tried without an adequate response. In earlier days, she was treated with Clozapine (an oral medication) but that treatment was discontinued as she was non-compliant with tablets, which she would not take, and the medication does not come in injection forms. A necessity for administration by depot injection governed a switch to risperidone.

43 **The second issue.** The key question that arises under the rubric of the second issue is whether the dosage of risperidone currently being administered to the plaintiff under the treatment plan is too high to be of benefit to her. The treatment plan provides for 50 mg to be administered every two weeks.

44 The evidence of the plaintiff's father (not medically qualified) is that, although he has always thought it was a good idea that the plaintiff be on a community treatment order (because otherwise, in his assessment, she would not take any medication), he believes her to be at her best when the medication administered to her is limited to 25 mg of risperidone; his personal view, based on his experience of the plaintiff, is that any higher dosage subjects the plaintiff to side-effects that make her "unbearable to live with".

45 **The third issue.** A determination of the third issue requires an assumption (not unreasonable notwithstanding uncertainty about the status of the plaintiff's NCAT appeal) that both NCAT's guardianship order and the Mental Health Review Tribunal's community treatment order are currently operative.

NO INTERLOCUTORY STAY OF THE COMMUNITY TREATMENT ORDER UNDER APPEAL

46 The only controversial aspect of the plaintiff's current treatment plan is the dosage of risperidone to be administered. No objection is taken to the requirement that the plaintiff attend for a review of her case at least once every four weeks or the requirement that she meet with a counsellor at least weekly.

47 There is no dispute that the plaintiff has a history of subjection to community treatment orders over several years.

48 Athough the current proceedings have been the subject of several directions hearings (before Black J as Duty Judge on 8 and 11 January 2018 and before Slattery J, as Duty Judge, on 12 and 22 February 2018 before the directions hearing before me on 5 March 2018) at no time has an interlocutory injunction been made to restrain the defendant from implementation, or purported implementation, of the community treatment order under appeal. Under her father's paternal supervision, the plaintiff has, in substance, complied with the terms of the community treatment order.

49 Her next injection of risperidone is imminent. The psychiatrist entrusted by the defendant with treatment of the plaintiff (Dr HS) anticipates that a 50 mg dose of risperidone will be administered on that occasion; but, in consultation with the plaintiff and her father, he has during the currency of the community treatment order under appeal, administered doses of 37.5 mg and 25 mg as to him, upon a proper exercise of medical judgement, seemed appropriate to the plaintiff's then circumstances.

THE EVIDENCE ADDUCED ON APPEAL

50 On the hearing of the appeal, counsel for the plaintiff read a formal affidavit affirmed by the plaintiff on 4 January 2018 (in which she simply asserted that she is "not in need" of the community treatment order under appeal) and the affidavit of the plaintiff's father sworn on 7 March 2018. Both deponents were available for cross examination. In light of the evidence given by the defendant's principal witnesses, and cross examination of them on behalf of the plaintiff, neither was cross examined on behalf of the defendant.

51 Accepting responsibility for carriage of the appeal, the defendant read two affidavits affirmed by Dr HS (the first on 21 February 2018, the second on 8 March 2018); an affidavit (affirmed on 21 February 2018) by an occupational therapist working as the plaintiff's case coordinator for the defendant; and the solicitor's affidavit (earlier extracted) deposing to contact with the Public Guardian. Dr HS and the plaintiff's case coordinator were both cross examined (the former at length), by counsel for the plaintiff, by telephone.

52 Various documents (principally medical records) were admitted into evidence as exhibits, and were the subject of cross examination of the defendant's witnesses.

53 No objections were taken to any of the evidence adduced on the hearing of the appeal. In particular, the expertise of Dr HS was not challenged.

54 No submission was made impugning the credit of any person who gave evidence in the appeal.

55 There was little factual dispute between the parties bearing upon the nature of the plaintiff's medical condition or the history of her treatment.

56 I adopt as factually correct, and as expressing soundly-based medical opinions, the following evidence of Dr HS (with editorial adaptation):

> "Schizophrenia can have symptoms such as hallucinations, persecutory delusions, paranoid delusions. [The plaintiff] did not have these symptoms when I saw her in November 2017 but, based on my review of her case notes, she has had these symptoms historically. She has had multiple admissions [to hospital] in the past due to active psychotic symptoms and aggression. She has had delusional belief of being possessed by a demon in [the] past. She has presented with poor sleep, poor feeding, mood lability (ie, quick or exaggerated changes in mood), responding to voices, persecutory delusions and religious preoccupation. She has claimed that 'Satan' was tormenting her and trying to kill her. She has taken her clothes off, yelling and screaming, spitting and hitting herself. Many of her symptoms are under control at present. In my view, this is due to the ongoing treatment, even though she is often non-compliant.
>
> The risks of untreated schizophrenia vary from person to person. There is a risk of aggression, risk of violence, risk of harm to self and others, risk of vulnerability and risk of suicide. In my face-to-face appointments, [the plaintiff] has appeared as if she was responding to stimuli, muttering to herself while I was in conversation with her father. But she denies having a hallucination"…
>
> Based on my experience with [the plaintiff] and my review of her clinical notes, I think it is highly unlikely that [she] would take her medication regularly without

a CTO. This has been well documented in her past presentations which led to multiple hospital admissions and prolonged in-patient stay.…

If [the plaintiff] continues treatment under a CTO then there are high chances of improvement. If she improves then she may gain insight and become compliant with treatment. At this stage it is difficult to say about her prospects of receiving treatment voluntarily but historically she has been poor at compliance. Even currently with the CTO in place it is difficult for [her] treating team to administer treatment as she refuses it".

57 From his perspective as her carer, the plaintiff's father (without medical expertise) tells much the same story, but accentuates the positive. His affidavit includes the following passages (with editorial adaptation):

"[21] [The plaintiff] has been on many community treatment orders. Since she ceased clozapine, she has complied with them. She attends [a clinic] and has an injection once a fortnight. She attends late and sometimes on the wrong day, but to the best of my knowledge, she has always accepted, eventually, the depot medication.

[22] It has been many years since [the plaintiff] has not had medication. In 2015, she went for about two months without medication. This is when she was on clozapine. She had a relapse. She started hearing voices and talking to herself.

[23] [The plaintiff] is at her best when she is on a low dose of Risperdal. To my observation, she is at her best on 25mg each fortnight. Inceased dosage does not improve her mental state. It worsens it. In addition, she has [side-effects such as production of a lot of saliva, coupled with an inability to swallow it; a fixated daze for prolonged periods; a deterioration in personal hygiene; and a rocking from foot to foot].

[24] On 16 November 2017 [sic], I was appointed a guardian for [the plaintiff] and given the function of healthcare and medical and dental consent.…

[25] On 22 November 2017, I met with [Dr HS]. This was [Dr HS's] first involvement with [the plaintiff]. I asked him to reduce the medication [from 50mg] to 37.5mg. He said, she should be on 50mg. I explained to him the side-effects that [she] suffered and how they made her unbearable to live with. After that interview, [the plaintiff] was given 37.5mg.

[26] Following that, very gradually, the hyper-salivation improved. The fixation of gaze reduced, and the movement of the legs reduced. [The plaintiff's] mental state did not change. She has not demonstrated any delusions, voices, or hallucinations for about 18 months.

[27] In early January 2018, I asked [Dr HS] to reduce the dose to 25mg. He did that. The side-effects have diminished very markedly. [The plaintiff's] mental state has also improved.

[28] I have always thought it was a good idea that [the plaintiff] be on a Community Treatment Order, because otherwise, I think she would not take any medication.

[29] [The plaintiff] likes going to the Emergency Department [of a hospital]. I do not know why. She does not watch television. She spends hours on

> youtube. She particularly likes religious and gospel music. She used to love reading but now does not read.…
>
> [36] I agree that [the plaintiff] has become verbally more aggressive. She has never shown physical aggression. If someone touches her, she may push them away, but she does not initiate aggression."

58 In his dealings with the plaintiff and her father, Dr HS has manifested a preparedness to review and adapt the plaintiff's treatment. In the second of his affidavits, he explained his approach thus:

> "[3] When deciding the dosage of medication to be given to a patient, one needs to do a risk/benefit analysis. The benefits of a medication should outweigh the risks in the form of side-effects. The goal is to start with least effective dose and titrate it depending on improvements and any side-effects. If the patient is having good benefits and minimal side-effects, I will stick with the dose. If the benefits are minimal, I may decide to increase the dose. If the side-effects are troubling, I may decide to decrease the dose or change in to a different medication.
>
> [4] In a medical review a patient's mental state and progress is assessed by asking questions to the patient and conducting a mental state examination. I also take into account collateral information from family and caseworkers, the patient's past treatment record and the patient's past response to medication.
>
> [5] A community treatment order allows for the type and dosage of medication to be changed because the treating doctor has to optimise the medication regime depending on response and side-effects. The decision is always taken in the best interest of the patient.

59 This approach is consistent with the statutory obligations of a medical practitioner governed by the *Mental Health Act*. Section 85 of the Act provides, for example, that "[a] medical practitioner must not, in relation to any mental illness or mental condition or suspected mental illness or mental condition, administer, or cause to be administered to a person a drug or drugs in a dosage that, having regard to professional standards, is excessive or inappropriate.

DETERMINATION OF ISSUES

The first issue : Is the plaintiff mentally ill?

60 In light of the evidence I have described, and in response to the first of the issues identified for the Court's determination, I find that the plaintiff *is* "mentally ill" within the meaning of the *Mental Health Act* and that she is a person for whom a community treatment order *should* be made. To the extent that some of the symptoms of schizophrenia are under control, I attribute that

to her ongoing treatment, a lapse of which has historically been associated with a relapse in the plaintiff's mental condition.

The second issue : Is the current treatment plan appropriate and beneficial?

61 In response to the second issue identified for determination, I find, subject to one point of clarification, that the treatment plan dated 11 October 2017 (which was before the Tribunal on 12 October 2017) is an appropriate treatment plan that will benefit the plaintiff.

62 The point of clarification is that, in my opinion, under that treatment plan, it is open to Dr HS as the nominated treating doctor/psychiatrist (or delegate) to titrate the dosage of risperidone administered to the plaintiff (in order to maximise the benefits to her, and to minimise side-effects) in accordance with standard medical practice, paying due regard to the statutory obligations (including the obligation for which section 85 provides) of a medical practitioner governed by the *Mental Health Act.*

63 The plan does not confer on any officer of the defendant, let alone the treating doctor/psychiatrist, an unconfined discretion in the prescription and administration of medication affecting the plaintiff. The treating doctor/psychiatrist must work, within the administrative structure of a declared mental health facility, in pursuit of stated goals, using medication of the nature and form of administration described in the plan.

64 The "Goals of Treatment" set out in the plan are as follows (with editorial amendment):

> "The goal of the treatment plan is to assist in the managing the symptoms of [the plaintiff's] mental illness using medication, counselling, education and promoting improved mental health in the least restrictive environment that is consistent with safe and effective care.
>
> This will enable [the plaintiff] to have increased independence with taking prescribed medication with a view to discharge from the Community Treatment Order".

65 In broader perspective, the plan must be read with medical reports which, in common with the plan, were placed before the Tribunal and the Court in aid of the community treatment order made on the basis of the plan. The whole of that material must be (and, in this case, is) such that, should a substantial or material change in circumstances occur or should fresh information become

available, there is an objective evidentiary foundation for the community treatment order to be varied or revoked pursuant to section 65 or section 66 of the *Mental Health Act*.

66 The plan accommodates a need for an independent exercise of judgement by a medical practitioner qualified to make it in the best interests of the affected person based on facts then known. Although the plan records that, as at 11 October 2017, the plaintiff's "current" dosage of risperidone was 50 mg it was, and it remains, open to the plaintiff's treating doctor/psychiatrist to vary the dosage in a manner calculated to serve her best interests at the time the medication is administered.

The third issue : Does a Guardianship Order trump a Community Treatment Order?

67 In response to the third issue identified for determination, I find that, on the proper construction of the *Mental Health Act* and the *Guardianship Act*, a community treatment order (to the extent of any inconsistency) overrides a decision made by the guardian of a person under guardianship (within the meaning of both the *Guardianship Act* and the *Mental Health Act*). In my opinion, a guardian is not entitled, in law, to override or countermand a community treatment order. That is not to say that a guardian should not ordinarily be consulted in the treatment of the person under guardianship, but that a guardian has no right of *veto* in law.

68 In contending for a contrary conclusion, counsel for the plaintiff relies upon sections 3C and 21-21C of the *Guardianship Act*, which (with emphasis added) are in the following terms:

> "**3C. RELATIONSHIP WITH MENTAL HEALTH ACT 2007**
>
> (1) A guardianship order may be made in respect of a patient within the meaning of the Mental Health Act 2007 .
>
> (2) The fact that a person under guardianship becomes a patient within the meaning of the Mental Health Act 2007 does not operate to suspend or revoke the guardianship.
>
> (3) However:
>
> (a) a guardianship order made, or
>
> (b) an instrument appointing an enduring guardian,

in respect of a person who is, or becomes, a patient within the meaning of the Mental Health Act 2007 is effective only to the extent that the terms of the order or instrument are consistent with any determination or order made under the Mental Health Act 2007 in respect of the patient.

21. RELATIONSHIP OF GUARDIANS TO PERSONS UNDER GUARDIANSHIP

(1) Subject to any conditions specified in the order, the guardian of a person the subject of a *plenary* guardianship order:

(a) has *custody* of the person *to the exclusion of any other person*, and

(b) has all the *functions* of a guardian of that person that a guardian has at law or in equity.

(2) Subject to any conditions specified in the order, the guardian of a person the subject of a *limited* guardianship order:

(a) has *custody* of the person, *to the exclusion of any other person*, to such extent (if any) as the order provides, and

(b) has such of the *functions* of a guardian of that person's person, *to the exclusion of any other person*, as the order provides.

(2A) Subject to any conditions specified in the order, the guardian of a person the subject of a guardianship order (whether plenary or limited) has the *power, to the exclusion of any other person,* to make the decisions, take the actions and give the consents (in relation to the functions specified in the order) that could be made, taken or given by the person under guardianship if he or she had the requisite legal capacity.

(3) Section 49 of the Minors (Property and Contracts) Act 1970 does not apply to a person the subject of a plenary guardianship order

21A. POWER TO ENFORCE GUARDIANSHIP ORDERS

(1) Without limiting section 16, a guardianship order may specify that:

(a) the person appointed as guardian, or

(b) another specified person or a person of a specified class of persons, or

(c) a person authorised by the guardian (the "authorised person"),

is *empowered to* take such measures or actions as are specified in the order so as to ensure that the person under guardianship complies with any decision of the guardian in the exercise of the guardian's functions.

(2) If a person referred to in subsection (1) (a), (b) or (c) takes any measure or action specified in the order in the reasonable belief that:

(a) he or she is empowered by the guardianship order to take the measure or action, and

(b) the measure or action is in the best interest of the person under guardianship, and

(c) it is necessary or desirable to take that measure or action in the circumstances,

> the person concerned is not liable to any action, liability, claim or demand arising out of the taking of that measure or action.
>
> **21B. ANCILLARY POWERS OF GUARDIAN**
>
> A guardian may, on behalf of a person under guardianship, sign and do all such things as are necessary to give effect to any function of the guardian.
>
> **21C. ACTS OF GUARDIAN TAKE EFFECT AS ACTS OF PERSON UNDER GUARDIANSHIP**
>
> A decision made, an action taken and a consent given by a guardian under a guardianship order have *effect* as if:
>
> (a) the decision had been made, the action taken and the consent given by the person under guardianship, and
>
> (b) that person had the legal capacity to do so (if the person would have had that legal capacity but for his or her disability).

69 It is common ground that at no material time, *vis a vis* the community treatment order under appeal, was the plaintiff a "patient" within the meaning of the *Mental Health Act.* Accordingly, section 3C of the *Guardianship Act* does not, in terms, apply.

70 In these circumstances, the plaintiff contends that section 3C was necessary because, without such a provision, a guardianship order (whether in plenary or limited form) which confers upon a guardian authority to make decisions about health care overrides a community treatment order.

71 Counsel for the plaintiff formulated her submission in the following terms:

(a) The general rule is that a guardianship order will override a community treatment order to the extent of any inconsistencies.

(b) Section 3C of the *Guardianship Act* derogates from the general rule. That section was inserted in the *Guardianship Act* in 1997 and amended to its present form in 2007.

(c) The Court should apply to the current problem the observations made by Slattery J in *Sarah White v The Local Health Authority* [2015] NSWSC 417 at [73] (here edited) when his Honour considered whether a guardian could override the wishes of a person seeking admission of the person to a hospital, or objecting to admission or requesting discharge under section 7 of the *Mental Health Act*:

> "It is not surprising that the *Mental Health Act* is silent on this question, because the issue is comprehensively dealt with under the regime of the *Guardianship Act*, sections 21-21C. In my view the combined effect of these provisions allows the guardian, in this case the Public Guardian, to override the wishes of the person under guardianship…. The guardian of a

> person the subject of a limited guardianship order [such as the plaintiff then before the Court] '*has the custody of the person to the exclusion of any other person, to such extent as the order provides*': *Guardianship Act*, section 21(2)(a)".

(d) Nothing in either the *Mental Health Act* or the *Guardianship Act* derogates from the exclusive custody of the guardian except in the case of a patient in hospital, or absent from hospital with or without leave: *Guardianship Act*, section 3C.

(e) It follows that a community treatment order can only be effective to the extent that it is consistent with the terms of a guardianship order. In the present case, there is a direct inconsistency. The defendant seeks an order allowing the administration of 50 mg risperidone each fortnight, whereas the guardian invested with decision-making responsibility for health care and medical consent, will only agree to 25 mg. There is no utility in making a community treatment order unless it is consistent with the guardian's decision.

(f) There is no inconsistency of purpose between the *Guardianship Act* (which recites protective principles in section 4) and the *Mental Health Act* (which incorporates statements of protective principle and, in section 53(3)(a), gives content to those statements of principle in the context of a community treatment order).

72 The *Mental Health Act* and the *Guardianship Act* share a field of operation. Each has cross references to the other. Ordinary principles of construction require that the legislation be construed in a way which best achieves a harmonious result: *Commissioner of Police (NSW) v Eaton* (2013) 252 CLR at 28 [78].

73 The plaintiff's contentions are predicated upon a bare statement of conclusion rather than an analysis of the legislation.

74 There is no reasonable foundation for the plaintiff's contention that there is a "general rule" that "a guardianship order will override a community treatment order to the extent of any inconsistencies". Such a general rule, if embraced, would deny a community treatment order substantial regulatory effect, particularly if (as occurs in section 3C(3) of the *Guardianship Act*) "an instrument appointing an enduring guardian" is treated as having the same effect as a guardianship order. If such a general rule were to be adopted it would elevate a guardianship order, if not also an enduring guardianship appointment, into a mechanism to avoid the operation of Part 3 of Chapter 3 of

the *Mental Health Act* (entitled “Involuntary Treatment in the Community”) and, so, frustrate the protective purpose of those provisions.

75 Section 3C of the *Guardianship Act* is not directed specifically to a community treatment order. This appears in section 3C(3)’s concluding reference to “any determination or order made under the *Mental Health Act”* in respect of a patient, and in section 56(3) of the *Mental Health Act*, which provides that “[a] community treatment order has no effect while an affected person is detained in a mental health facility [otherwise than under Part 3 of Chapter 3 of the *Mental Health Act*] or is a voluntary patient”. Upon its proper construction, section 3C is not predicated upon, or indicative of, a “general rule” such as that for which the plaintiff contends.

76 There is no necessary, or precise, correlation between “a person in need of a guardian” (within the meaning of sections 3(1) and 14 of the *Guardianship Act*) and a person who suffers from a “mental illness” (within the meaning of section 4 of the *Mental Health Act*). The *Guardianship Act* has a broader field of operation, the *Mental Health Act* a more specific one.

77 The expression “person in need of a guardian” is defined by the *Guardianship Act* to mean “a person who, because of a disability, is totally or partially incapable of managing his or her person”. Section 3(2) of the *Guardianship Act* provides that “a reference to a person who has a disability is a reference to a person: (a) who is intellectually, physically, psychologically or sensorally disabled; (b) who is of advanced age; (c) who is a mentally ill person within the meaning of the *Mental Health Act*; or (d) who is otherwise disabled, and who, by virtue of that fact, is restricted in one or more major life activities to such an extent that he or she requires supervision or social habilitation”.

78 These extracted definitions are sufficient to demonstrate that the *Guardianship Act* has a broader field of operation than the *Mental Health Act*. The concept of an incapacity for self-management of one’s person upon which the making of a guardianship order turns is broader than the concepts of “mental illness” and “mentally ill person” defined by the *Mental Health Act.*

79 Section 4 of the *Mental Health Act* defines “mental illness” to mean “a condition that seriously impairs, either temporarily or permanently, the mental functioning

of a person and is characterised by the presence in the person of any one or more of the following symptoms: (a) delusions; (b) hallucinations; (c) serious disorder of thought form; (d) a severe disturbance of mood; [or] (e) sustained or repeated irrational behaviour indicating the presence of any one or more [of those symptoms]." Section 14(1) of the *Mental Health Act* provides that "[a] person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary: (a) for the person's own protection from serious harm; or (b) for the protection of others from serious harm".

80 The fact (recognised by Slattery J in *Sarah White v The Local Health Authority* [2015] NSWSC 417 at [73]) that a guardian may be empowered to override the wishes of a person under guardianship says nothing about whether a guardian can override the Mental Health Review Tribunal's exercise of jurisdiction under the *Mental Health Act* in making a community treatment order. His Honour's judgment, in fact, ultimately dealt with a different factual scenario – one in which section 3C of the *Guardianship Act* applied in terms – and he decided (at [92]) that an order made by the Mental Health Review Tribunal that a patient under guardianship be discharged from a mental health facility overrode the guardian's inconsistent decision to keep the patient in the facility.

81 Sections 21 and 21A of the *Guardianship Act* describe the office of a guardian by reference to considerations of "custody" , "functions" and "power" directed towards attribution (in section 21C of the Act) of an "effect" that deems an act of a guardian to be an act of the person under guardianship. Those provisions do not place a person affected by a community treatment order who is a person under guardianship in a higher position than an affected person without the benefit of a guardianship order. Section 57(1) of the *Mental Health Act* provides that an affected person "must comply" with a community treatment order affecting him or her.

82 In the several places in which section 21 of the *Guardianship Act* uses the expression "to the exclusion of any other person" it does not comprehend the Mental Health Review Tribunal as such a "person". Nor does it refer to a

person acting pursuant to, and under the authority of, a community treatment order duly made by the Tribunal.

83 Neither does the concept of a community treatment order fall within the field of operation naturally thought of in the context of "guardianship'. It is an *order* made for the purpose of *authorising* (as the heading to Part 3 of Chapter 3 of the *Mental Health Act* records) "*involuntary* treatment in the community".

84 For these reasons, I reject the plaintiff's contention that, as her guardian entrusted with health care functions, her father is empowered, as a matter of law, to limit the nature and scope of a community treatment order otherwise duly made. He is not *entitled*, as a guardian, to *insist* that no more than a particular dosage of medication be administered under a community treatment order affecting the plaintiff.

85 That is not to say that, in implementation of a community treatment order affecting the plaintiff, the defendant should not pay heed to what the father says. Plainly, he is an important source of information material to the proper treatment of the plaintiff. His views, and those of the plaintiff personally, should be taken into account so far as is reasonably practicable.

STATUTORY CRITERIA : MENTAL HEALTH ACT, SECTION 53

86 The evidence adduced by the defendant (reinforced in material respects by the affidavit of the plaintiff's father) provides an evidentiary foundation for the continuing operation of the community treatment order under appeal. In particular:

(a) The Court has before it an application for a community treatment order (originally made to the Mental Health Review Tribunal pursuant to section 51(5)(c) of the *Mental Health Act*) giving rise to the question (identified in section 53(1) of the Act) whether the plaintiff is a person who should be subject to the order.

(b) The Court has before it for consideration, and has considered, *inter alia*:

(i) a treatment plan: *Mental Health Act*, section 53(2)(a).

(ii) a report by the plaintiff's psychiatric case manager, supplemented by hospital records and other medical evidence: section 53(2)(b).

(iii) reports as to the efficacy of previous community treatment orders: section 53(2)(c).

(c) The Court also has evidence demonstrating that attempts to administer oral medication to the plaintiff have failed; that she is in need of medication to address health and behavioural issues arising from her schizophrenia; and that some form of community treatment order is likely to be both necessary and beneficial for her. The treatment plan incorporated in the community treatment order under appeal satisfies the test of the least restrictive kind of care (consistent with safe and effective care) appropriate and reasonably available to the plaintiff and it does so nonetheless for allowing to the plaintiff's treating doctor/psychiatrist an element of discretion, consistent with standard medical practice, in selection of the dosage of risperidone to be administered to the plaintiff: *Mental Health Act*, section 53(3)(a).

(d) There is a declared mental health facility, with an appropriate treatment plan for the plaintiff (namely, that incorporated in the community treatment plan under appeal) and with capacity to implement that plan: *Mental Health Act*, section 53(3)(b).

(e) The evidence demonstrates that the plaintiff is likely to continue in, or at least to relapse into, an active phase of mental illness if a community treatment order is not granted: *Mental Health Act,* section 53(3A).

87 It is agreed between counsel that, in the context of the present proceedings, there is no necessity to address the requirements of sections 53(3)(c), 53(4) or 53(5) – although, in fact, as I find, the plaintiff has a "previous history of refusing to accept appropriate treatment" within the meaning of each of the sub-paragraphs of section 53(5).

88 If (as I find) the plaintiff's appeal should be dismissed, the community treatment order under appeal will continue in operation until (but not beyond) 11 April 2018, a period which conforms with the *Mental Health Act*, section 53(6).

89 In determining that the appeal be dismissed, I take into account the ongoing relationship between the plaintiff and the defendant, and the Tribunal's assessment that a community treatment order of six months duration was appropriate (in the context of section 53(7) of the *Mental Health Act*) to stabilise the condition of the plaintiff and to establish, re-establish or maintain a therapeutic relationship between the plaintiff and her psychiatric case manager.

CONCLUSION

90 In all the circumstances of the case, including the continuing engagement between the plaintiff, her father and the defendant, the appropriate order is simply an order that the plaintiff's appeal be dismissed.

91 If a community treatment order is to operate after 11 April 2018, the plaintiff's case will have to be considered afresh by the Tribunal.

SCHEDULE

(Extracted Provisions of the *Mental Health Act* 2007 NSW)

LONG TITLE

An Act to make provision with respect to the care, treatment and control of mentally ill and mentally disordered persons and other matters relating to mental health; and for other purposes.

3 OBJECTS OF ACT

The objects of this Act are:

(a) to provide for the care and treatment of, and to promote the recovery of, persons who are mentally ill or mentally disordered, and

(b) to facilitate the care and treatment of those persons through community care facilities, and

(c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and

(d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care and, where necessary, to provide for treatment for their own protection or the protection of others, and

(e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment.

Note : See also section 68 which contains principles for care and treatment and section 105 which sets out objectives for the New South Wales public health system.

CHAPTER 3 – INVOLUNTARY ADMISSION AND TREATMENT IN AND OUTSIDE FACILITIES

PART 3 - INVOLUNTARY TREATMENT IN THE COMMUNITY

DIVISION 1 - APPLICATIONS FOR AND MAKING OF COMMUNITY TREATMENT ORDERS

50 DEFINITIONS

In this Part:

"affected person" means a person for whom a community treatment order has been applied for or made.

"breach notice" --see section 58 (3).

"breach order" --see section 58 (4).

"director of community treatment" of a mental health facility means a person appointed under section 113 as the director of community treatment of the mental health facility.

"psychiatric case manager" means a person employed at a declared mental health facility who is appointed under section 114 as the psychiatric case manager of an affected person.

"treatment plan" --see section 54.

51 COMMUNITY TREATMENT ORDERS

(1) A community treatment order authorising the compulsory treatment in the community of a person may be made by the Tribunal.

Note : Section 56 sets out the matters to be included in community treatment orders.

(2) The following persons may apply for a community treatment order for the treatment of a person:

(a) the authorised medical officer of a mental health facility in which the affected person is detained or is a patient under this Act,

(b) a medical practitioner who is familiar with the clinical history of the affected person,

(c) any other person prescribed by the regulations.

(3) An application may be made about a person who is detained in or a patient in a mental health facility or a person who is not in a mental health facility.

(4) An application may be made about a person who is subject to a current community treatment order.

(5) A community treatment order may be made in the following circumstances and may replace an existing order:

(a) following a mental health inquiry,

(b) on a review of a patient by the Tribunal,

(c) on an application otherwise being made to the Tribunal.

(6) Without limiting subsection (5) (c), an application for a community treatment order may be made, and determined by the Tribunal, in the same proceedings as an appeal under section 44.

52 NOTICE OF APPLICATIONS

(1) The applicant for a community treatment order must notify the affected person in writing of the application.

(2) The notice of the application is to include a copy of the proposed treatment plan for the affected person.

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

(4) Subsection (3) does not apply:

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

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

53 DETERMINATION OF APPLICATIONS FOR COMMUNITY TREATMENT ORDERS

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

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

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

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

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

(d) any other information placed before the Tribunal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

54 REQUIREMENTS FOR TREATMENT PLANS UNDER COMMUNITY TREATMENT ORDERS

A treatment plan for an affected person is to consist of the following:

(a) in general terms, an outline of the proposed treatment, counselling, management, rehabilitation or other services to be provided to implement the community treatment order,

(b) in specific terms, the method by which, the frequency with which, and the place at which, the services would be provided for that purpose.

55 COMMUNITY TREATMENT ORDER MAY BE MADE IN ABSENCE OF AFFECTED PERSON

The Tribunal may make a community treatment order in the absence of the affected person, if the person has been given notice of the application under this Part.

56 FORM AND DURATION OF COMMUNITY TREATMENT ORDERS

(1) A community treatment order is to:

(a) nominate the declared mental health facility that is to implement the treatment plan for the affected person, and

(b) require the affected person to be present, at the reasonable times and places specified in the order to receive the medication and therapy, counselling, management, rehabilitation and other services provided in accordance with the treatment plan.

(2) A community treatment order ceases to have effect at the end of the period specified in the order or, if no period is specified, 12 months after the order is made.

Note : Section 53 (6) specifies that the maximum period for an order is to be 12 months.

(3) A community treatment order has no effect while an affected person is detained in a mental health facility (otherwise than under this Part), or is a voluntary patient.

(4) The fact that an affected person is the subject of proceedings before the Tribunal does not, unless the Tribunal otherwise orders, affect the operation or duration of the community treatment order.

(5) The time for which a community treatment order is in force does not cease to run during any period in which this section provides that it has no effect.

Note : The Tribunal may vary or revoke a community treatment order in accordance with section 65.

DIVISION 2 - OPERATION OF COMMUNITY TREATMENT ORDERS

57 DUTIES AND FUNCTIONS OF AFFECTED PERSON AND MENTAL HEALTH FACILITY

(1) The affected person must comply with the community treatment order.

(2) The director of community treatment of the declared mental health facility implementing a treatment plan under a community treatment order may take all reasonable steps to have medication administered, and services provided, in accordance with the order.

(3) Medication may be administered to an affected person for the purposes of a community treatment order without the person's consent if it is administered without the use of more force than would be required if the person had consented to its administration.

(4) The director of community treatment of a declared mental health facility implementing a treatment plan under a community treatment order must provide to the affected person particulars of the kind and dosages of medication that are being administered, or have recently been administered, to the person, if requested to do so by:

(a) the affected person, or

(b) any designated carer or the principal care provider of the affected person, or

(c) if the affected person consents, another person who would be entitled to apply for a community treatment order in relation to the person.

(5) A person implementing a treatment plan under a community treatment order may enter the land (but not the dwelling) on which an affected person's residence is situated without the person's consent for the purpose of implementing the community treatment order.

58 BREACH OF COMMUNITY TREATMENT ORDER

(1) The director of community treatment of a declared mental health facility implementing a community treatment order must take the steps set out in this section if the affected person in any way refuses or fails to comply with the community treatment order and the director is of the opinion that:

(a) the mental health facility has taken all reasonable steps to implement the order, and

(b) there is a significant risk of deterioration in the mental or physical condition of the affected person.

(2) The director must:

(a) make a written record of the opinions, the facts on which they are based and the reasons for forming them, and

(b) cause the affected person to be informed that any further refusal to comply with the order will result in the person being taken to the declared mental health facility or another appropriate mental health facility and treated there.

(3) On a further refusal or failure by the affected person to comply with the community treatment order, the director may cause the person to be given a written notice (a "breach notice"):

(a) requiring the person to accompany a member of staff of the NSW Health Service employed at the declared mental health facility for treatment in accordance with the order or to a specified mental health facility, and

(b) warning the person that the assistance of a police officer may be obtained in order to ensure compliance with the order.

(4) On the refusal or failure by the affected person to comply with a breach notice, the director may, in writing, make an order (a "breach order") that the affected person be taken to a specified declared mental health facility.

(5) For the purposes of subsection (3), the director causes a person to be given a breach notice if the director ensures that:

(a) the notice is handed directly to the person, or

(b) if it is not reasonably practicable to hand the notice directly to the person, the notice is posted to the last known address of the person.

59 POLICE ASSISTANCE

(1) A police officer to whose notice a breach order is brought must, if practicable:

(a) apprehend and take or assist in taking the person the subject of the order to the mental health facility, or

(b) cause or make arrangements for some other police officer to do so.

(2) A police officer may enter premises to apprehend a person under this section, and may apprehend any such person, without a warrant and may exercise any powers conferred by section 81 on a person who is authorised under that section to take a person to a mental health facility or another health facility.

Note : Section 81 sets out the persons who may take a person to a mental health facility and their powers when doing so.

60 PROCEDURES AT FACILITY AFTER BREACH NOTICE OR BREACH ORDER

(1) An affected person who is at a mental health facility as a result of the giving of a breach notice or a breach order:

(a) may be given treatment in accordance with the community treatment order, and

(b) may be assessed by a medical practitioner for involuntary admission to a mental health facility.

(2) A person who is at a mental health facility as a result of a breach notice or breach order may be released after treatment if treatment is accepted or may be dealt with at the mental health facility or taken to another declared mental health facility if treatment is refused.

61 REVIEW OF AFFECTED PERSON AT MENTAL HEALTH FACILITY AFTER BREACH ORDER

((1) This section applies to an affected person who is taken to or is at a declared mental health facility after refusing treatment at a mental health facility consequent on a breach order.

(2) An authorised medical officer must, not later than 12 hours after the person is taken to the declared mental health facility, review the affected person's mental condition and determine whether the person is a mentally ill person or a mentally disordered person.

(3) The authorised medical officer may cause the person to be given treatment in accordance with the community treatment order.

(4) If the authorised medical officer determines that the affected person is a mentally ill person or a mentally disordered person for whom no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate or reasonably available, the person is to be detained in the declared mental health facility for further observation or treatment, or both.

(5) The affected person may be detained until one of the following events occurs:

(a) in the case of a mentally ill person, the term of the community treatment order ends or the person is discharged from the declared mental health facility under this Act,

(b) in the case of a mentally disordered person, the maximum period for which a person may be held as such a person under Part 2 ends, the term of the community treatment order ends or the person is discharged from the declared mental health facility under this Act.

61A MEDICAL EXAMINATION OF DETAINED AFFECTED PERSONS

(1) An authorised medical officer must medically examine each affected person detained in a mental health facility to determine whether the person's continued detention in the facility is necessary.

(2) The medical examinations are to be carried out at intervals of not more than 3 months.

62 DISCHARGE AND DETENTION OF AFFECTED PERSONS

(1) An affected person detained in a declared mental health facility under this Division must be discharged from the facility:

(a) if the authorised medical officer determines that the person is not a mentally ill person or a mentally disordered person or is of the opinion that other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person, or

(b) if the authorised medical officer decides at any time that it is appropriate to do so.

(2) An authorised medical officer may do all necessary things to cause a person to be detained in a mental health facility under Part 2 at the end of the term of a community treatment order if the officer considers the person to be a mentally ill person.

(3) Any such person is taken to be detained in the mental health facility under section 19 when the authorised medical officer takes action to detain the person.

63 REVIEW BY TRIBUNAL OF DETAINED AFFECTED PERSONS

(1) An authorised medical officer must cause a person detained in a declared mental health facility under this Division to be brought before the Tribunal not later than 3 months after the person is detained, and at least every 3 months while the person is detained.

(2) The authorised medical officer must ensure that, as far as practicable, a person brought before the Tribunal is dressed in street clothes.

(3) This section does not apply if the affected person's community treatment order will end less than 3 months after the person is detained under this Division.

64 PURPOSE AND FINDINGS OF REVIEWS

(1) The Tribunal is, on a review of an affected person, to determine whether the person is a mentally ill person for whom no other care (other than care in a mental health facility) is appropriate and reasonably available.

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

(a) consider any information before it,

(b) inquire about the administration of any medication to the person and take account of its effect on the person's ability to communicate.

(3) If the Tribunal determines that the affected person is a mentally ill person or a mentally disordered person for whom no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate or reasonably available, the Tribunal must determine whether the person should be detained in the declared mental health facility until the end of the community treatment order or should be detained in the facility as an involuntary patient.

(4) If the Tribunal does not determine that the person is a mentally ill person or is of the opinion that other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate or reasonably available:

(a) it must make an order that the person be discharged from the declared mental health facility in which the person is detained, and

(b) it may make any community treatment order that it could make on a review of an involuntary patient.

(5) The Tribunal may defer the operation of an order for the discharge of an affected person for a period of up to 14 days, if the Tribunal thinks it is in the best interests of the affected person to do so.

(6) An order made by the Tribunal under this section is to be in the form approved by the President.

DIVISION 3 - REVOCATION, VARIATION AND REVIEW OF COMMUNITY TREATMENT ORDERS

65 VARIATION OR REVOCATION OF ORDERS BY TRIBUNAL

(1) The Tribunal may vary or revoke a community treatment order, on application being made under this section or at any time on its own motion.

(2) An application may be made by any of the following:

(a) the affected person,

(b) the psychiatric case manager of the affected person,

(c) any person who could have applied for the order.

(3) An application may be made only if:

(a) there has been a substantial or material change in the circumstances surrounding the making of the order, or

(b) relevant information that was not available when the order was made has become available.

(4) An order may be varied only if the order, as varied, could be made in relation to the affected person.

(5) The regulations may make provision for or with respect to applications under this section and the orders that may be made by the Tribunal.

66 REVOCATION BY DIRECTOR OF COMMUNITY TREATMENT

(1) The director of community treatment of a declared mental health facility implementing a treatment plan under a community treatment order may revoke a community treatment order if of the opinion that the affected person is not likely to benefit from a continuation of the order.

(2) Before revoking a community treatment order, the director must consult the affected person and, if it is reasonably practicable to do so, any designated carer and the principal care provider of the affected person (if the principal care provider is not a designated carer).

(3) The director must notify the Tribunal in writing if the director revokes a community treatment order or decides not to apply to the Tribunal for a further order.

66A NOTIFICATIONS

The director of community treatment of the declared mental health facility implementing a community treatment order must take all reasonably practicable steps to notify any designated carer and the principal care provider of the affected person (if the principal care provider is not a designated carer) of the order and if any of the following events occur:

(a) the order is varied or revoked by the Tribunal or director,

(b) an application is made for a further order or the director decides not to apply for a further order.

67 APPEALS

(1) The affected person under a community treatment order made by the Tribunal may at any time appeal to the Court:

(a) if the term of the order exceeds 6 months or no term is specified in the order, against the duration of the order, or

(b) on any question of law or fact arising from the order or its making.

(2) The affected person under a community treatment order made by a Magistrate may at any time appeal to the Tribunal:

(a) if the term of the order exceeds 6 months or no term is specified in the order, against the duration of the order, or

(b) on any question of law or fact arising from the order or its making.

(3) The regulations may make provision for or with respect to appeals to the Tribunal under this section and the orders that may be made by the Tribunal in respect of any such appeal.

CHAPTER 4 - CARE AND TREATMENT

PART 1 - RIGHTS OF PATIENTS OR DETAINED PERSONS, DESIGNATED CARERS AND PRINCIPAL CARE PROVIDERS

DIVISION 1 – GENERAL

68 PRINCIPLES FOR CARE AND TREATMENT

It is the intention of Parliament that the following principles are, as far as practicable, to be given effect to with respect to the care and treatment of people with a mental illness or mental disorder:

(a) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,

(b) people with a mental illness or mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards,

(c) the provision of care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community,

(d) the prescription of medicine to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others,

(e) people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment and be supported to pursue their own recovery,

(f) any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances,

(g) any special needs of people with a mental illness or mental disorder should be recognised, including needs related to age, gender, religion, culture, language, disability or sexuality,

(g1) people under the age of 18 years with a mental illness or mental disorder should receive developmentally appropriate services,

(g2) the cultural and spiritual beliefs and practices of people with a mental illness or mental disorder who are Aboriginal persons or Torres Strait Islanders should be recognised,

(h) every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and recovery plans and to consider their views and expressed wishes in that development,

(h1) every effort that is reasonably practicable should be made to obtain the consent of people with a mental illness or mental disorder when developing

treatment plans and recovery plans for their care, to monitor their capacity to consent and to support people who lack that capacity to understand treatment plans and recovery plans,

(i) people with a mental illness or mental disorder should be informed of their legal rights and other entitlements under this Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand,

(j) the role of carers for people with a mental illness or mental disorder and their rights under this Act to be kept informed, to be involved and to have information provided by them considered, should be given effect.

CHAPTER 5 - ADMINISTRATION

PART 1 - ADMINISTRATIVE OBJECTIVES AND FUNCTIONS

105 OBJECTIVES OF NEW SOUTH WALES PUBLIC HEALTH SYSTEM

The objectives of the New South Wales public health system under this Act in relation to mental health services are to establish, develop, promote, assist and encourage mental health services that:

(a) ensure that provision is made for the care, treatment, control and rehabilitation of persons who are mentally ill or mentally disordered, and

(b) promote the establishment of community mental health services for the purpose of enabling the treatment in the community wherever possible of persons who are mentally ill or suffering from the effects of mental illness or who are mentally disordered, and

(c) develop, as far as practicable, standards and conditions of care and treatment for persons who are mentally ill or mentally disordered that are in all possible respects at least as beneficial as those provided for persons suffering from other forms of illness, and

(d) take into account the various religious, cultural and language needs of those persons, and

(e) are comprehensive and accessible, and

(f) permit appropriate intervention at an early stage of mental illness, and

(g) assist patients to live in the community through the provision of direct support and provide for liaison with carers and providers of community services.

CHAPTER 6 – MENTAL HEALTH REVIEW TRIBUNAL

PART 2 - PROCEDURES OF THE TRIBUNAL

…

151 PROCEDURE AT MEETINGS OF TRIBUNAL TO BE INFORMAL

(1) Meetings of the Tribunal are to be conducted with as little formality and technicality, and with as much expedition, as the requirements of this Act, the Mental Health (Forensic Provisions) Act 1990, the regulations and as the proper consideration of the matters before the Tribunal permit.

(2) In determining any matter relating to a forensic patient, correctional patient or other patient or a person detained in a mental health facility, or any matter relating to a community treatment order, the Tribunal is not bound by the rules of evidence but may inform itself of any matter in such manner as it thinks appropriate and as the proper consideration of the matter before the Tribunal permits.

(3) The proceedings of the Tribunal are to be open to the public.

(4) However, if the Tribunal is satisfied that it is desirable to do so for the welfare of a person who has a matter before the Tribunal or for any other reason, it may (of its own motion or on the application of the person or another person appearing at the proceedings) make any one or more of the following orders:

(a) an order that the hearing be conducted wholly or partly in private,

(b) an order prohibiting or restricting the publication or broadcasting of any report of proceedings before the Tribunal,

(c) an order prohibiting or restricting the publication of evidence given before the Tribunal, whether in public or in private, or of matters contained in

documents lodged with the Tribunal or received in evidence before the Tribunal,

(d) an order prohibiting or restricting the disclosure to some or all of the parties to the proceedings of evidence given before the Tribunal, or of the contents of a document lodged with the Tribunal or received in evidence by the Tribunal, in relation to the proceedings.

Note : Section 162 prohibits the publication or broadcasting of the name of a person involved in Tribunal proceedings or other material that may identify any such person, except with the consent of the Tribunal.

(5) The President or a Deputy President or the chairperson of a meeting of the Tribunal may administer an oath to any person giving evidence before the Tribunal.

(6) The President or a Deputy President of the Tribunal has, in the exercise of his or her functions as a member, the same protections and immunity as a Judge of the Supreme Court has in the performance of his or her duties as a Judge.

CHAPTER 7 - JURISDICTION OF SUPREME COURT

163 APPEALS TO THE COURT

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

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

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

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

164 POWER OF THE COURT ON APPEALS

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

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

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

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

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

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

165 PANEL OF ASSESSORS

(1) The Minister must, from time to time, nominate in writing to the Chief Justice a panel of persons who, in the opinion of the Minister, have appropriate qualifications and sufficient experience to act as assessors in the hearing of appeals by the Court under this Chapter or the Mental Health (Forensic Provisions) Act 1990.

(2) A nomination made under this section is to be accompanied by an oath taken by the person nominated, in the form prescribed by the regulations.

(3) Sections 11, 11A and 12 of the Oaths Act 1900 apply to and in respect of an oath required to be taken under this section as if the oath were an oath required to be taken under Part 2 of that Act.

…

167 OTHER JURISDICTION OF THE COURT NOT AFFECTED

Nothing in this Chapter derogates from or otherwise affects the jurisdiction of the Court under any Act or other law.

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I certify that this and the preceding 44 pages

are a true copy of the reasons for judgment herein

of his Honour Justice Lindsay.

Associate

Date: 14 March 2018

Amendments

15 March 2018 - Paragraph 6, first line, deletion of "that" and insertion of "the defendant's".

Paragraph 22, quotation, "in voluntary" amended to "involuntary".

Paragraph 40(c), third line, deletion of the quotation mark and insertion of a question mark.

Paragraph 74, fifth line, "Mental Health Act" amended to "Guardianship Act".

Paragraph 75, first line, "3(c) amended to "3C".

Paragraph 80, "Mental Health Act" amended to "Guardianship Act"

15 March 2018 - Paragraph 75, first line, "Mental Health Act" amended to "Guardianship Act".