ORDER PROHIBITING PUBLICATION OF NAME, ADDRESS, OR OTHER INFORMATION IDENTIFYING 'H' (APPELLANT IN CA293/00 and THIRD RESPONDENT in CA290/00)

IN THE COURT OF APPEAL OF NEW ZEALAND

CA290/00
CA293/00

BETWEEN	WAITEMATA HEALTH Appellant
AND	HER MAJESTY'S ATTORNEY-GENERAL First Respondent
AND	MENTAL HEALTH REVIEW TRIBUNAL NORTHERN REGION Second Respondent
AND	H Third Respondent

Hearing:	6 and 7 June 2001
Coram:	Elias CJ Richardson P Gault J Thomas J Tipping J
Appearances:	M R Heron and M A McDowell for Waitemata Health (Appellant in CA290/00) D S Niven and I C Bassett for H (Appellant in CA293/00 and Third Respondent in CA290/00) W G Liddell and J S McHerron for Attorney-General (First Respondent in CA290/00 and CA293/00) D B Collins QC (*Amicus Curiae*) R Dobson QC for Mental Health Review Tribunal (Second Respondent)
Judgment:	3 October 2001

JUDGMENTS OF THE COURT

Judgments

	Para Nos
Elias CJ, Richardson P, Gault and Thomas JJ	**[1] – [109]**
Tipping J	**[110] – [123]**

ELIAS CJ, RICHARDSON P, GAULT AND THOMAS JJ (DELIVERED BY ELIAS CJ)

Table of Contents

[1] The appeal raises two points of importance in the application of the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ("the Act").

[2] The first is whether a person subject to a compulsory treatment order under the Act must be released if found to be not "mentally disordered" within the meaning of the Act. It turns on the definition in s2 of when such a person is "fit to be released":

> "Fit to be released from compulsory status", in relation to a patient, means no longer mentally disordered and fit to be released from the requirement of assessment or treatment under this Act.

"Mental disorder" is itself defined:

> "Mental disorder", in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it –
>
> (a) Poses a serious danger to the health or safety of that person or of others; or
>
> (b) Seriously diminishes the capacity of that person to take care of himself or herself; -

> and "mentally disordered", in relation to any such person, has a corresponding meaning.

[3] The second question raised by the appeal is whether the Director of Mental Health was entitled to be heard on an application for review of the condition of a patient subject to a compulsory treatment order in circumstances where the Review Tribunal knew that the Director was considering an application to the District Court for an order declaring the patient to be a "restricted patient". An effect of such an order is that a restricted patient may not be released from compulsory status without opportunity for the Director to participate in the decision.

[4] Both questions were raised by the Director of Mental Health on application to the High Court for judicial review of a decision of a Review Tribunal set up under s101 of the Act. The decision of the Mental Health Tribunal had been delivered on 25 May 2000 on an application for review of his condition by H, a patient subject to a compulsory treatment order. The Review Tribunal concluded that H is no longer mentally disordered and ordered his release from the compulsory treatment order.

[5] The judgment of the High Court on the application for judicial review was delivered on 29 November 2000. Justice Rodney Hansen held first that the Review Tribunal had misconstrued the definition of "fit to be released" in s2 of the Act. It had failed to consider distinctly whether H, even if not mentally disordered within the meaning of the Act (as the Review Tribunal had held), was in addition fit to be released from compulsory status. Secondly, the Judge held that the Review Tribunal had acted in breach of natural justice in not notifying the Director about the review of H's condition and giving her an opportunity to be heard on it. On these two bases, the Judge declared the decision of the Review Tribunal to be invalid, quashed it, and directed that the Review Tribunal rehear the application for review of his condition by H.

[6] From the judgment of the High Court, appeals are brought by both H and Waitemata Health.

[7] H appeals the decision of the High Court both as to the interpretation of the definition "fit to be released from compulsory status" and as to breach of natural

justice. H contends that the language of the definition and the scheme and purpose of the Act require those who are not mentally disordered to be released from compulsory treatment. He further contends that there can be no breach of natural justice when the Act does not expressly or by implication confer upon the Director a right to be heard on a review of a patient's condition. Alternatively, he claims that there was no right to be heard in circumstances where the Director had not made application for restricted patient status for him or given notice of an intention to make or consider making such application to the Review Tribunal.

[8] Waitemata Health is the Hospital and Health Service responsible for the operation of the Auckland Regional Forensic Psychiatry Services and the Mason Clinic in which H is a patient. It had appeared in the High Court to abide the decision of the Court. It appeals to this Court on the interpretation determination only. Waitemata Health is concerned that the two-step cumulative test accepted by the Judge as a matter of interpretation would preclude the discharge of patients who remain mentally disordered but who are clinically assessed as being able to be treated or managed without a compulsory treatment order remaining in place. Such result is contrary to its existing practice and is contrary to guidelines issued by the Director-General under s130 of the Act which provide:

> There are two circumstances in which a patient may be considered 'fit to be released from compulsory status':
>
> - the patient is no longer 'mentally disordered'; *or*
>
> - the patient continues to meet the criteria for 'mental disorder', but compulsion is no longer necessary where the patient agrees to continue with the necessary treatment on an informal basis and is not a danger to self or to the public, and this agreement is informed and genuine.

[9] The Review Tribunal appeared in support of the submissions advanced by Waitemata Health on appeal as to the interpretation of "fit to be released". Properly, it did not seek to be heard on the question of breach of natural justice.

[10] The Attorney-General, on behalf of the Director of Mental Health, made submissions in opposition to the appeal by H on the natural justice determination in the High Court. Despite having taken a different stance in the High Court, the

Attorney-General did not in this Court support the interpretation adopted by the Judge of "fit to be released from compulsory status". Although formally the Director of Mental Health did not seek to be heard on the interpretation point, her counsel in oral argument indicated support for the position taken by Waitemata Health.

[11] Because no party appearing supported the interpretation of "fit to be released from compulsory status" adopted in the High Court, Mr Collins QC was appointed as amicus curiae to ensure that all arguments were put.

The history of the compulsory orders made in relation to H

[12] H is a patient in respect of whom inpatient compulsory treatment orders under the Act have been continuously in effect since 1998. Such orders are made by a District Court Judge after preliminary assessment during which the patient may be compulsorily assessed and treated. After completion of the preliminary processes, which are subject to tight time frames, the Court must determine "whether or not the patient is mentally disordered" (s27(1)). If the Court considers that the patient is not mentally disordered it is required to release the patient from compulsory status "forthwith" (s27(2)). If the Court considers that the patient is mentally disordered:

> …it shall determine whether or not, having regard to all the circumstances of the case, it is necessary to make a compulsory treatment order.

[13] H has had a lengthy history of criminal offending characterised by serious assaults upon women and has spent much of his adult life in hospitals or prisons.

[14] In 1998 when the first compulsory treatment order was made, H was serving sentences for sexual violation and threatening to kill. Upon the making of a compulsory inpatient treatment order in 1998, H was transferred from prison to the Mason Clinic, in which he continues to be detained. Because H was a sentenced prisoner, an outpatient community treatment order was not an option (s45(4)(g)). The inpatient compulsory treatment order became one of indefinite duration by reason of s34(4) of the Act in May 1999. It continued in effect after H completed his

sentence of imprisonment in 1999 and ceased to be a "special patient" subject to the additional requirements of the Act for serving prisoners.

[15] Under s30 of the Act, the responsible clinician must keep under review whether the patient can be adequately treated as an outpatient. If so, the clinician must direct the discharge of the patient from hospital and direct the patient "to attend at the patient's place of residence, or at some other place nominated in the notice, for the purposes of treatment". In such a case the inpatient order has effect as a community treatment order. No responsible clinician has directed that H be released as an outpatient after he completed his sentence of imprisonment in 1999 and became eligible for treatment under a community treatment order.

[16] A patient subject to a compulsory treatment order, unless declared by the Court to be a "restricted patient" under s55 of the Act, must be released from compulsory status if the responsible clinician considers the patient "fit to be released from compulsory status" (s76(5)). H has never been declared to be a restricted patient.

[17] Clinical reviews of the condition of every patient subject to a compulsory treatment order must be conducted at intervals no longer than 6 months (s76). At the end of each review the clinician in charge of the treatment of the patient must certify whether or not in his or her opinion the patient is fit to be released from compulsory status (s76(3)). No responsible clinician has ever certified that H is fit to be released from compulsory status.

[18] On a six monthly review in January 2000 the responsible clinician, Dr Skipworth, certified that H was not fit to be released. The reason provided by the clinician was his opinion that H was a "serious danger to health and safety of another person". In explanation, Dr Skipworth recorded:

> Mr [H] has a cluster B personality disorder, and it has been accepted that he has been delusional in the past, at the time he threatened to kill a woman therapist with whom he developed a pathological attachment.
>
> He recently went AWOL from the Mason Clinic for 4 days, and was attempting to leave the country.

> He will require long term psychotherapy in a secure setting in order for there to be progress in future risk mitigation.

[19] The incident referred to by the clinician in which H had been absent without leave from the hospital occurred in late December 1999. It prompted a request to the Director of Mental Health from Dr Chaplow, the Director of Regional Forensic Psychiatry Services, that the Director of Mental Health apply to the District Court for an order under s55 of the Act declaring H to be a "restricted patient". Such order can only be applied for and made if the Director considers, and if the Court is satisfied, that the patient "presents special difficulties because of the danger he or she poses to others". Dr Chaplow's letter was supported by reports from Dr Skipworth, who later signed the 19 January 2000 clinical review certificate as the responsible clinician for H, and Dr Morris, the responsible clinician in the more secure unit to which it was proposed to transfer H.

[20] Restricted patients are subject to particular control in relation to leave and change of compulsory treatment status. In the case of such patients, leave can only be granted at the direction of the Minister of Health (s56, applying ss50-53 to restricted patients), compulsory status cannot expire after 3 months' absence (s56, providing that s32(3) does not apply), and compulsory status cannot be lifted by certificate of a responsible clinician alone but requires the direction of the Director of Mental Health. Certificates of clinical review of a restricted patient must be sent to the Director of Mental Health (s78(4)). On receiving such certificate, the Director may apply to a Review Tribunal set up under s101 of the Act for review of the patient's condition (s81(1)). If the Director of Mental Health is not prepared to direct release on the certificate of the responsible clinician that a restricted patient is fit to be released from compulsory status, the Director must apply to the Review Tribunal for a review of the patient's condition (s78(5)). Where the patient is not fit to be released from compulsory treatment but the responsible clinician is of the opinion that it is no longer necessary for restricted patient status to apply, revocation of restricted status can only be made by the Minister of Health, after consultation with the Attorney-General (s78(6)).

[21] The effect of the provisions of the Act dealing with restricted patients is that the Director of Mental Health is given special supervisory powers in relation to such

patients. The lifting of compulsory status for a restricted patient is ultimately achieved in one of three ways: by the acceptance of the Director of Mental Health of the certificate of the responsible clinician that the patient is fit to be released; by the direction of the Review Tribunal, if the Director is not prepared to act on the certificate of the responsible clinician; or by a determination of the Review Tribunal that, notwithstanding the absence of a certificate by the responsible clinician, the patient is fit to be released. This last determination may be made on the application of the Director of Mental Health, or the application of those persons named in s76(7) of the Act, including the patient.

[22] Application for restricted patient status is a serious matter. In an affidavit in the proceedings, the Director of Mental Health advised that only five applications for restricted patient status had previously been applied for. Upon receiving Dr Chaplow's request in late January 2000, the Director took steps to consider whether such application should be made. An opinion was sought from Crown Law as to whether sufficient grounds existed. In the meantime, H continued to be subject to the inpatient compulsory treatment order alone. Following the expiry of his sentence of imprisonment, he was no longer a special patient.

[23] Any patient who is dissatisfied with the outcome of a clinical review can apply to the Review Tribunal for a review of the patient's condition (s79). On 4 February 2000 H applied to the Review Tribunal for review of his status, having received the certificate dated 19 January (referred to in paragraph [18]) that Dr Skipworth as his responsible clinician considered he was not fit to be released. No notice of the application was given to the Director, who continued to seek advice as to whether to apply to the court for an order declaring H to be a restricted patient.

[24] On 12 April 2000 the Director obtained an opinion from Crown Law. It advised that it was unlikely that a court would grant a restricted patient application on the basis of H's absence without leave alone. It had happened in part because of a breakdown in supervision and no issues of physical safety for others had arisen. More information was sought by counsel as to the danger posed by H. This request was apparently overtaken by the review application.

[25] The application for review of his condition by H was heard by the Review Tribunal on 20 April 2000. It was the third review of H's condition the Tribunal had conducted since H became subject to the compulsory treatment provisions of the Act in 1998. The inquiry for the Review Tribunal was whether H was "fit to be released from compulsory status" within the meaning defined by s2 of the Act (fully set out above at paragraph [2]): "no longer mentally disordered and fit to be released from the requirement of assessment or treatment under this Act".

[26] In the first review conducted by the Review Tribunal in 1998, whether H was mentally disordered within the meaning of the Act had been squarely in issue. The psychiatric experts agreed that as a result of his severe personality disorder H was a serious danger to others. That view was borne out by H's repeated violent offending towards women with whom he became unreasonably infatuated. But expert psychiatric opinion was divided on whether H was mentally disordered.

[27] In 1998, Dr Simpson, Dr Chaplow, and other clinicians treating H took the view that H was not mentally disordered. Two outside consultant professors of psychiatry, Professor Mullen and Professor Kydd, took a different view. Professor Mullen considered that H suffered from "delusional" disorders of erotomanic type. Professor Kydd described both an intermittent disorder of mood and "an abnormality of belief, and of reason, and hence of cognition, of a degree and type to pose a serious threat to the health and safety of others". Both Professor Mullen and Professor Kydd considered the abnormalities of mind they recognised to be of such a degree as to cause a serious danger to the safety of others.

[28] Upon this conflicting evidence, the Review Tribunal found in February 1999 that H was mentally disordered and not fit to be released. It relied in particular on the independent assessment of his condition obtained by the Tribunal itself from Professor Mullen. In reliance upon Professor Mullen's opinion the Review Tribunal found that H was mentally disordered because he had "an abnormal state of mind characterised by delusions of such a degree that it poses serious danger to the safety of others".

[29] In July 1999, the responsible clinician again certified that H was not fit to be released from compulsory status. H applied to the Review Tribunal for review again. In the second review in September 1999, H accepted for the purposes of the review hearing that he was mentally disordered but contended that he was nevertheless fit to be released. The Review Tribunal which considered the clinical review in September 1999 concluded that H was not fit to be released from compulsory status.

[30] In the third Review Tribunal hearing conducted in April 2000 in respect of the January 2000 clinical review (the conclusions of which are set out at paragraph [18] above), the issue whether or not H was mentally disordered was again the central inquiry.

[31] Before the hearing, the Review Tribunal issued a detailed Minute on 27 March 2000 about the procedure to be followed. It anticipated "extensive evidence and submissions" at the hearing. It directed all evidence and submissions to be provided to the Tribunal by Thursday 13 April 2000 and noted that both the applicant and the Auckland Regional Forensic Psychiatry Services would be represented by counsel:

> Given the background to this case, the tribunal is not prepared to countenance a situation in which it commences a hearing without advance knowledge of the evidence and submissions.

[32] The Review Tribunal in the Minute asked the psychiatrists who supplied the reports to concentrate on changes in the circumstances and opinions since the Tribunal had previously considered H's condition. In particular, the clinicians were asked whether they agreed or disagreed with the assessment made in 1998 by Professor Mullen at the time of the Tribunal's first review of H's condition and whether they now considered H to be mentally disordered.

[33] Written reports were received by the Review Tribunal from Dr Simpson, a consultant psychiatrist with the Regional Forensic Psychiatry Services, and Dr Morris (the responsible clinician at the time of the hearing who was not however able to attend it). In addition the Review Tribunal received the reports prepared in

support of Dr Chaplow's letter requesting restricted patient status for H, and a report from H's psychologist. Through these reports, the Review Tribunal was made aware of the request by Dr Chaplow to the Director of Mental Health for application to the court for an order to have H declared a restricted patient.

[34] In addition, the written submissions provided to the Review Tribunal by counsel for Waitemata Health identified the changes of circumstances since the Tribunal's previous hearings as including H's absence without leave and that "an application has been made to have H made a restricted patient". That advice was wrong, since the Director was still considering whether to apply.

[35] Other clinicians from the Mason Clinic attended the hearing. The expert member of the Tribunal interviewed H, who was subsequently interviewed in addition by the whole panel. The Review Tribunal had submissions from counsel for H and the Auckland Regional Forensic Psychiatry Services.

[36] The Director of Mental Health was not notified about the hearing. She accordingly did not appear or take any position. The evidence of the Director in the High Court was that, if notified, she would have sought to have the Tribunal obtain independent opinion evidence from psychiatrists not directly involved in H's treatment, particularly Professor Mullen.

[37] All clinicians and counsel for the Auckland Regional Forensic Psychiatry Services accepted that H posed a danger to the public if released. They agreed that he required ongoing psychotherapy and "focal use of medication" for a severe cluster B personality disorder. But the reports received by the Review Tribunal maintained the view expressed by the clinicians treating H that, contrary to the opinion of Professor Mullen, H had probably never been deluded. Dr Morris, Dr Skipworth and Dr Simpson had not observed any delusional thinking in H. When transferred to the more secure unit after being absent without leave, H was described as a "model patient".

[38] Dr Morris reported that H continues to believe that the victims of his vengeance in the past deserved his treatment of them. He did not deny that H could

develop "negative intent" towards others in the future, but denied any such existing intent. In interview H was "cognitively intact, with good judgment". Dr Morris reported that H does not believe he has either a mental illness or a personality disorder. There is no present manifestation of H's history of major depressive disorders. Dr Morris's conclusion was that H "has a Personality Disorder with multiple features": "From my point of view he has features of antisocial, narcissistic, paranoid and sadistic personality traits".

[39] Dr Skipworth in a January 2000 report concluded that, in the period since October 1999, "I have seen no evidence of the pathological (delusional or overvalued ideas) erotomanic attachment to his previous therapists or other women". He noted however that H had been "far from honest in terms of discussing openly his feelings, thoughts and plans, either with his clinical team or psychotherapist", in apparent reference to the well-planned attempt to escape the jurisdiction which prompted Dr Skipworth's earlier support for Dr Chaplow's recommendation that restricted patient status be sought for H.

[40] Dr Simpson's view was that H is not "mentally ill" although he acknowledged that whether he was "mentally disordered" within the terms of the Act is a different question:

> In general, there are no major shifts in viewpoint since the previous hearings. As will be discussed in more detail below, diagnostic consensus at the Mason Clinic is that Mr [H] is not, and probably has never been, deluded. A general belief is that he has been treated for a severe cluster B personality disorder which has resulted in major danger to others and depression and self harm in himself. His treatment plan is aimed at containing and diminishing that risk through a mixture of supported structured programme within the Mason Clinic and individual psychotherapy. Medication is now being used on a focal basis only.
>
> *Which aspects of the 1998 report provided by Professor Mullen are currently agreed or disagreed with and the reasons why?*
>
> I will address this question in relation to the paragraphs of Professor Mullen's opinion. In the first paragraph Professor Mullen states that he has a profound personality disorder. This is agreed with. Secondly, that he has depressive mood swings, a diagnostic conclusion also agreed with. Paragraph 4 describes the development of his infatuations with IS. That pattern is also agreed with. That

such an infatuation is a recurring pattern that grows out from his abnormal personality is also the diagnostic formulation that we share. That has been a recurring theme throughout his life and has been related to his prior extreme acts of violence against women.

…I fully agree that Mr [H's] infatuations grow out from his severe personality disturbance. That this is a recurrent pattern that has continued over many years in his life. He at times becomes intensely preoccupied and his consciousness dominated by such thoughts which have a sense of calm and power associated with them. That would fit the category of overvalued ideas, but would not fit with a definition of delusion as I understand the term.

It has been contended that this type of difficulty is particularly difficult to treat. It does not mean that it is untreatable. Certainly I agree with some of what Professor Mullen says in paragraph 11, that the combination of supportive psychotherapeutic interventions and focal use of medication might well allow him to gain distance from his ideas and improve his interpersonal relationships to a point where he does not imperil others in future. This is, I believe, the primary focus of the interventions that have occurred since that time and that I have advised. There is evidence that this degree of impulsivity and degree of threatening behaviour towards others has progressively reduced and his ability to engage therapeutically has been attested by his work with [the psychologist] (see attached report).

In summary, therefore, there is diagnostic agreement with Professor Mullen that Mr [H] suffers a severe personality disorder and out of that can develop infatuations with others that can imperil the well being of others. It is not our belief that such circumstances amount to delusional ideas. Having seen this man over a long period of time and in various phases of this process, and having carefully read Professor Mullen's report, I would still respectfully disagree with the diagnosis he comes to.

As I have argued extensively previously, I believe that the issue is whether a severe personality disorder of the type suffered by Mr [H] is a mental disorder in terms of the Act. I would refer the Tribunal to the arguments that I have set out in my report to the Tribunal in 1998, for full arguments in relation to these issues. It is my position, and that of my colleagues here, that whether personality disorder of this nature constitutes mental disorder in terms of the Mental Health Act or [not] is a legal not a clinical decision. Mr [H] is not mentally ill. He may be mentally disordered if an objective interpretation of abnormal state of mind is made, and if his pattern of thinking, feeling and behaving is deemed a disorder of volition, cognition and mood in relation to the second part of Section 2. He presents, in our view, a continuing risk to others, albeit somewhat lessened over his previous degree of immediate risk to IS and BW, but nonetheless with the same propensity to enter relationships that would imperil others, resulting in his being a serious risk to the health and well being of

> others. I would also note that suicidality is an ongoing issue for him and may be a risk at his time of desperation.

[41] In addressing the question whether H was fit to be released, Dr Simpson concluded:

> I do not believe the applicant is fit to be released, if the condition of his detention is that he is mentally disordered on the basis of his personality disorder. I understand that that question will not of itself be addressed in detail. His recent AWOL, his suicidal feelings, and the magnitude of his threatening behaviour towards others, with the lack of remorse in relation to that all give us sources of significant concern in relation to his future risk.

[42] In its decision of 24 May 2000, the Review Tribunal held that H was fit to be released on the basis that it found him not mentally disordered. It accepted that H is a serious danger to himself or to others and that the second limb of the test of mental disorder was satisfied. It accepted that he had a severe personality disorder. But it concluded that such personality disorder was insufficient to constitute mental disorder. The Tribunal found no evidence that H is presently deluded. "Undoubtedly" there are "overvalued ideas" but the Tribunal considered that they do not constitute delusions. All clinicians were agreed that H was not currently suffering from a disorder of mood. He was not considered depressed and had been free of mood stabilisation medication for a year. No psychiatrist had suggested any disorder of perception on the part of H. Hallucinations, the classic disorder of perception, had not been present:

> In the context of the mental disorder definition, the term perception should not be extended to the likes of "view of the world" in the sense of attitude, outlook and belief. That would be to attribute a dangerously broad definition to the term.

[43] There was no disorder of volition because "disorders of volition are concerned with irresistible impulses involving loss of free will":

> By contrast, the Applicant's behaviour is characterised by careful, considered and planned actions, albeit often anti-social ones. He freely chooses to do what he does, even though what he does is, by dint of his distorted personality, socially unacceptable.

[44] In terms of cognition, the Review Tribunal found there to be no formal thought disorder on the part of H:

> His thinking is lucid. Again, it would be dangerous to extend the term cognition such that it might embrace the notion of how a patient thinks about the world and life in the broad sense. It should not be said that the Applicant has a disorder of cognition because he has thoughts about the nature and role of women for example which differ from the consensus of the population at large. It would be wrong to attribute to the term cognition a meaning such that any person who thinks thoughts society regards as unpalatable (eg criminal or bigoted) must ipso facto have a disorder of cognition.

In coming to its conclusion that there was no evidence of disorder of cognition on the part of H, the Review Tribunal did not consider, and may have overlooked, the earlier assessment of Professor Kydd. It placed some emphasis upon there having been no psychiatric opinion at the September 1998 hearing of any disorder of mood, perception, volition or cognition. This misstatement was relied upon as indicating mistake of fact which was advanced as a ground for judicial review in the High Court. The Judge however considered any mischaracterisation of the evidence at the 1998 hearing to be immaterial to the Tribunal's decision. The matter is not in issue on the appeal.

[45] The Tribunal, while finding no present disorder, considered whether H had an intermittent disorder. It found no evidence of intermittent disorder. Indeed it considered that "it is the very abiding features of his personality which are of concern". Although H might present with delusional or other disorder of mood, volition or cognition in the future, there was no identified continuing link:

> To speak of an abnormal state of mind of an intermittent nature requires the identification of a causative factor which links the intermittent episodes of abnormality. No one has identified such a causative factor in this case, save for the Applicant's personality. But that is most accurately described as a predisposing variable.
>
> A disordered personality per se does not constitute an abnormal state of mind. The abnormal state of mind referred to in the mental disorder definition must be one characterised by delusions or disorders of mood, perception, volition or cognition.

[46] The conclusion that the applicant was not mentally disordered was determinative. The Tribunal accepted that H had a recognised personality disorder and that there was a "powerful" argument the public safety interest would be served by H's continued compulsory treatment and a "gradual release" from constraint. Indeed, because of public safety issues the Tribunal delayed the issue of a certificate that H was fit to be released for one month, "so that all who should be notified of the Applicant's pending release are so notified". During that period H was to remain an inpatient under secure care. The Director of Mental Health was to be notified forthwith so that notification to others could be arranged and the Director could "take any other appropriate steps", including notifying the Minister.

[47] The Tribunal commented that, although the result might seem inconsistent with public safety,

> The Applicant however, has the right to have his case determined in accordance with the law. Parliament has not enacted legislation as has occurred in other jurisdictions directed at those persons who might be so dangerous that they require incarceration but who would otherwise fall between the criminal justice and mental health systems. The Applicant is entitled to have his case determined in accordance with what the law is, not what it could or might be.

The application to the High Court for judicial review

[48] Before the month allowed for by the Review Tribunal expired, the Director of Mental Health applied for judicial review of its decision of 26 May 2000 and sought interim orders to prevent the Tribunal issuing the certificate which would require H's release, pending determination of the substantive claim.

[49] The claim named the Review Tribunal as first respondent, H as second respondent, and Waitemata Health as third respondent. The Director claimed that, in the circumstances of the pending restricted patient application, the principles of natural justice required the Review Tribunal to notify her of H's application and give her the opportunity to be heard before making the decision that H was fit to be released. Further causes of action claimed errors of law in interpretation of the statutory test and mistake of fact (a claim that the Review Tribunal had overlooked

Professor Kydd's view that H has a disorder of cognition) but are no longer live issues in the present appeal.

[50] In the course of a judgment granting interim relief until the substantive hearing, Rodney Hansen J indicated that he would need persuading that the Tribunal was correct in its interpretation of the definition of "fit to be released from compulsory status". In particular, he questioned whether the Tribunal was right in assuming that a finding of absence of mental disorder was determinative. He suggested that there was an argument that, in addition to absence of mental disorder, the test required separate assessment of fitness for release.

[51] No doubt in response to this intimation, the statement of claim was amended before the hearing of the substantive application. The amendments included a claim that the Tribunal had erred in law by concluding that once H had been determined not to be mentally disordered "then ipso facto he was fit to be released from compulsory status under the Act". The Director contended that the Tribunal should have separately considered whether H was fit to be released.

[52] The substantive hearing was held before Rodney Hansen J on 14 and 15 September 2000. Waitemata Health (named in the pleadings as the Regional Forensic Psychiatry Services) abided the decision of the Court. The argument for the respondents was carried by counsel for H and, unusually, counsel for the Review Tribunal.

[53] By the judgment of 29 November 2000 it was held that, on the special facts of the case, the Director should have been given an opportunity to be heard. The Tribunal's failure to give her notice of the application and an opportunity to appear was a breach of natural justice. In reaching this conclusion, the Judge acknowledged that there is no express provision in the Act requiring notice to be given to the Director. The Court would supplement the express provisions of the statute where necessary to achieve justice. The Director's statutory obligations and duties in the scheme of the Act in relation to restricted patients were sufficient to found a right to be heard on matters affecting the status of such patients. The Judge considered that there was "no reason in principle why, in appropriate cases, that right should not

extend to reviews which take place when an application for restricted patient status is being actively considered or pursued":

> A restricted patient order can be made only in respect of a patient who is subject to a compulsory treatment order. A decision on review that the patient is fit to be released would therefore stop an application in its tracks. That would cut across the discharge by the Director of her statutory duty. In my view, a relevant interest comes into existence.

[54] Justice Hansen also accepted the claim that the Tribunal had erred in its interpretation of the definition of "fit to be released from the requirement of assessment or treatment under this Act". The Tribunal had treated its finding that H was not mentally disordered as determinative of the question that he was fit to be released. The Judge considered that the Tribunal had failed to "consider the second limb of the definition, merely noting that the fact that H may not be fit to be released in the clinical sense is beside the point". Justice Hansen was not persuaded that application of the words of the definition "as it is written" would be contrary to the scheme of the Act:

> [63] …That is not, however, what the words of the legislation say, and compelling reasons are necessary before they can be ignored.
>
> [64] I can find no reason to disregard the words of the definition in their plain and ordinary meaning or to interpret the definition to mean what it does not say. There is no ambiguity in the use of the word "and". There is no hiatus or absurdity produced if it is given its ordinary meaning, nor inconsistency with the scheme and purpose of the Act. I see no reason why the words of the definition should not be taken to have expressed what the Legislature intended, no more and no less. In some circumstances "and" may have to be read as "or" in order to give meaning to legislation e.g. *R v Oakes* [1959] 2 QB 350, but this is not one of them.
>
> [65] In my opinion the definition of "fit to be released from compulsory status" establishes a two-part test. The patient must have ceased to be mentally disordered and must also be fit to be released from the requirement of assessment or treatment under the Act. The Legislature must have contemplated that a patient who is no longer mentally disordered may nevertheless require continuing treatment, and that sometimes the nature of the treatment and the particular needs of the patient may necessitate a continuation of the compulsory treatment order. The treatment necessarily would be for a mental disorder; the use of the word "requirement" in the definition makes clear that further assessment or treatment would have to be for that purpose. So, I conclude that when a patient ceases to be mentally

> disordered the legislation requires that, in the interests of the patient and the community, the judgment be made as to whether the need for ongoing treatment nevertheless renders the patient unfit to be released.

[55] The Judge also held that the Tribunal erred in law in deferring its certificate until one month after the decision. He recognised the public safety concerns which had motivated the Tribunal. But the approach taken was inconsistent with s79(8) of the Act which requires immediate release and confers no power to defer or to attach conditions to the right of release. A staged approach could have been adopted on the interpretation of "fit to be released" accepted by the Judge if the Tribunal determined that, although no longer mentally disordered, the patient was not "fit to be released" until further arrangements to manage the transition from compulsory status to release had been put in place. As an alternative the Judge suggested that the Tribunal could adjourn the hearing under s79(6) to allow any necessary arrangements to be put in place. This determination is not the subject of appeal. Nor are the Judge's conclusions dismissing other grounds of review for error of law. It is therefore not necessary for this Court to express any view on the correctness of the determinations on these matters or the correctness of the Tribunal's interpretation of "mental disorder" (a matter we touch upon briefly to express some reservations at paragraphs [71-73] below).

[56] On the basis of the breach of natural justice and his finding that the Tribunal had misinterpreted the definition of "fit to be released" the Judge granted a declaration that the Tribunal's decision of 26 May is invalid, an order setting aside the decision, and an order that the Tribunal rehear H's application "in accordance with law and the principles of natural justice".

"No longer mentally disordered and fit to be released from the requirement of assessment or treatment under this Act"

[57] Notwithstanding the careful argument presented by Mr Collins in support of the judgment under appeal, we are unable to accept that it is correct. The Judge may well have been wrong-footed by the manner in which the argument proceeded in the High Court. It seems to have posed a stark choice between a conjunctive and a

disjunctive approach to the definition (perhaps as a result of Waitemata's concern to maintain the meaning upon which it has acted and which is reflected in the guidelines of the Director-General referred to above at paragraph [8]). That left the Judge to chose between what he thought to be the only "plain and ordinary meaning" of the word "and", and a reconstruction of the statutory language in a context in which he did not consider there to be any ambiguity or absurdity in the application of the ordinary meaning.

[58] But the "plain and ordinary meaning" of "and", used as a conjunction to connect clauses or sentences or to coordinate words in the same clause, is not simply additive. The *New Shorter Oxford English Dictionary* (1993) at p75 identifies nine uses of "and" in its coordinating sense. They include its use in "introducing a consequence", and "introducing an explanation, amplification, or parenthesis".

[59] This sense was applied in construction of legislation in *Roper v Roper* [1972] 1 WLR 1314. There the Court had to consider a ground of divorce provided by s2 of the Divorce Reform Act 1969 (UK). It provided that a court hearing a petition for divorce could not hold a marriage to be broken down irretrievably unless the petitioner satisfied the court of one of a number of facts including:

> That the respondent has committed adultery and the petitioner finds it intolerable to live with the respondent.

It was submitted on behalf of the wife that it was sufficient if the wife had formed the view that the husband was intolerable to live with before his adultery. Justice Faulks would have none of that (at 1317):

> I think that commonsense tells you that where the finding that has got to be made is that the respondent has committed adultery and the petitioner finds it intolerable to live with the respondent, it means "*and in consequence*" of the adultery the petitioner finds it intolerable to live with the respondent.

[60] Similarly, in *Re British Columbia Civil Liberties Association v Attorney-General for British Columbia* (1988) 49 DLR (4th) 493 (SCC), McEarchern CJ, in considering a clause in a regulation which linked two concepts, referred to the consequential sense of "and" (at 498-499):

> The connection of these two clauses in s. 4.04 by the conjunction "and" is capable of suggesting a flow of thought from one element to the other. In fact, the original meaning of "and" was "thereupon, then, next" and it can be used as a "consequence or result" as in "he told her *and* she cried": Webster's New World Dictionary, p51.

[61] Here, the Judge rejected the argument that a compulsory treatment order must end when a patient is found not to be mentally disordered because of his view that such a conclusion would entail disregarding the plain and ordinary meaning of the words of the legislation. We consider that view to have been mistaken and to have overlooked the consequential sense in which the second clause of the definition of "fit to be released from compulsory status" may be read and which is available as a matter of ordinary usage. On that basis, a major plank in the Judge's reasoning is removed.

[62] In considering whether the additive or the consequential use of "and" is the proper meaning to be given to it in the definition, the statutory scheme is critical.

[63] Mr Collins supported the judgment by arguing that the scheme of the legislation does not set up exact equivalence between attachment of compulsory status to a patient under Parts I and II of the Act and release from compulsory status under Part VII. Release, he suggests, is governed by wider questions of public interest which provide content for the test of whether a patient no longer mentally disordered is fit to be released. On this basis, while "mental disorder" is required for the making of a compulsory treatment order, whether the patient is "fit to be discharged" requires an additional assessment.

[64] The Tribunal (or the clinician on earlier clinical review under s78) could, on this view, conclude that a patient no longer mentally disordered is nevertheless not fit to be released because of danger to the public, even if that danger arises out of characteristics not within the definition of "mental disorder". If accepted, the Review Tribunal would need to consider whether a patient no longer mentally disordered is nevertheless unfit to be released. Examples of cases in which the patient might be considered not fit for release could include those where the patient is too institutionalised to be able to be released safely into the community or where the patient has behavioural disorders which make him a danger to the community.

Mr Collins submits that such interpretation is not inconsistent with the protections of the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993 (as to unlawful discrimination, arbitrary detention and double jeopardy) or international human rights standards because it is imposed by the legislation for reasons of protection of the public. The criteria for detention for reasons of unfitness can be developed by the Court and are likely to be confined to exceptional cases.

[65] We are unable to accept the argument. It is contrary to the meaning of the Act.

[66] The Mental Health (Compulsory Assessment and Treatment) Act is major reforming legislation which was a considerable time in the making. As its long title provides, it is:

> An Act to redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.

[67] The Act is not a general mental health Act. It applies only to those whom it is necessary to assess or treat compulsorily and then only if their condition reaches a sufficient state of seriousness. Other statutes such as the Protection of Personal and Property Rights Act 1988 deal with the care of those with diminished ability to look after themselves in the community.

[68] The Act avoids reference to mental or psychiatric illness. The words used in the definition of mental disorder are words in ordinary use, although their application is heavily dependent upon the assessment of clinicians. If at any time the responsible clinician or a Judge is of the opinion that the patient is fit to be released from compulsory status, he or she must direct the patient's release from that status.

[69] A finding of mental disorder requires:

- an abnormal state of mind

- (whether of continuous or intermittent nature)

- characterised by delusions, disorders of mood or perception or volition or cognition

- of the degree of seriousness described in the definition.

[70] By s4 of the Act, the procedures for compulsory assessment and treatment in Parts I and II may not be invoked in respect of any person by reason only of beliefs, sexual preference, criminal or delinquent behaviour, substance abuse or intellectual disability.

[71] It is unfortunate that some of the expert opinions in the present case continue to refer to a distinction between mental illness and behavioural disorders which may not sufficiently mirror the definition of mental disorder and which perpetuates the former arid debate about the difference between the "mad" and the "bad". The language of the Act attempts to avoid that simplistic division. A recognised and severe personality disorder which has the phenomenological consequences identified in the definition of mental disorder (delusions, disorders of mood, perception or volition or cognition) of the severity indicated in the definition ("serious danger", "seriously diminish[ed] capacity") would in normal speech be "an abnormal state of mind". It is disturbing therefore that the clinicians whose opinions are referred to above at paragraphs [39-41] seem to decline to apply the definition directly, seeing it as a legal matter which must be determined by the Tribunal, rather than a clinical decision. That view has the capacity to undermine their responsibilities under the Act.

[72] So too, there is room for concern that the Tribunal, although allowing that a severe personality disorder might amount to an abnormal state of mind for the purposes of the definition, seems to have taken a narrow view of what constitutes disorders of perception or cognition. Section 4 makes it clear that someone is not to be subjected to compulsory assessment or treatment "by reason only" of criminal or delinquent behaviour. But if the behaviour is caused by disordered thinking or perceptions arising out of an abnormal state of mind of such a degree as to pose

serious danger, there is no obvious statutory impediment to a finding of mental disorder. The suggestion that the definition cannot have been intended to apply to a "view of the world" arising from such cause and of such severity (see paragraphs [42-44] above) is not immediately attractive. It is difficult to see how H's personality disorder can be causative of the danger he is recognised to pose (as the Tribunal accepts) except through disordered thinking or perception. A sense of unease is reinforced by the reasoning that H cannot be said to have an intermittent abnormal state of mind because his personality disorder "is most accurately described as a predisposing variable" and is, moreover, not "intermittent" but an "abiding feature" (see paragraph [45] above).

[73] The impression remains that both Tribunal and clinicians are reluctant to recognise in H's severe personality disorder (which makes him a danger to others and in need of ongoing psychotherapy and focal use of medication) an abnormal state of mind. The matter is not currently before us. It may be that there are strong arguments which would dispel the sense of unease about the application of the definition of mental disorder. But it should not be assumed that the reasoning of the Tribunal is one which we accept.

[74] By s27(1) of the Act the Court is required to determine "whether or not the patient is mentally disordered". If the Court considers that the patient is not mentally disordered, it is required to order that the patient be released from compulsory status "forthwith". There is no additional requirement of fitness to be released once it is decided that the patient is not mentally disordered.

[75] Release from compulsory status is provided for in Part I of the Act in s35. If at any time the responsible clinician considers a patient subject to a compulsory treatment order is "fit to be released from compulsory status" the clinician must direct the patient's release from that status "forthwith" (s35(1)).

[76] If the responsible clinician considers that the patient is not fit to be released from compulsory status, the case can be referred for consideration of the Review Tribunal under s79 of the Act, contained in Part VII. Further appeal to the court is provided by s83. Under s84 the High Court can inquire into the legality of a

decision under the Act or whether the person is "fit to be discharged from the hospital". The second limb of the inquiry would seem directed at the need for the compulsory treatment order to continue as an inpatient order since the language of "discharge from the hospital" is common to s30(2)(a) and s84. The first limb would appear to be concerned with whether the basis for a compulsory treatment order exists.

[77] The approach suggested by Mr Collins would require different content to be given to the definition of "fit to be released from compulsory status" in Part VII and in Part II. Disparate tests for release according to which Part of the Act the release falls to be assessed under is contrary to the sense of the legislation. Patients not released from compulsory treatment orders continue to be treated in accordance with Part II of the Act, to which s4 applies. Under s35 their treatment is conditional upon their continued mental disorder. Section 35 is of general application. It requires release "at any time during the currency of a compulsory treatment order" if the responsible clinician considers that the patient "is fit to be released from compulsory status". There is no basis for different outcomes for patients according to whether their condition is considered under s35 or Part VII.

[78] Section 4 provides what its heading describes as "general rules relating to liability to assessment or treatment". It forbids the procedures in Parts I and II being invoked by any person by reason only of the matters identified. But the principle it applies is a general one and a significant pointer to the interpretation of the whole Act. Section 4 makes explicit what is clear from the long title and terms of the Act. It is concerned with the assessment and treatment of those suffering from mental disorder. It is not a vehicle for compulsory detention of those who are socially deviant or inadequate but not mentally disordered. Although it balances therapeutic and ethical concerns against public safety concerns, that is only in the case of those who are mentally disordered within its definition. It is not necessary to have recourse to the legislative history, but the debates in Parliament underscore that the Act is a humane and careful response to the need to provide for compulsory treatment for those suffering from mental illness (NZPD 8 December 1987, 1628; 12 March 1992, 6861).

[79] When the Court considers an application for compulsory treatment order, it is directed by s27(2) to order the patient's release from compulsory status forthwith if it considers that the patient is not mentally disordered. There is no good reason why the same result should not be achieved on review of the condition of a patient in respect of whom a court order has been made. Once no longer mentally disordered, the patient must be fit to be released from compulsory status. The definition makes it clear that the relevant "fitness" is fitness to be released from "the requirement of assessment or treatment under this Act". The only purpose of compulsory status is to achieve assessment or treatment. And that purpose cannot attach to someone who is not mentally disordered.

[80] The cumulative interpretation is inconsistent with an Act which establishes mental disorder as the necessary threshold for all intervention. As the long title to the Act makes clear, this is legislation to "reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder" as defined according to phenomenological characteristics and a scale of seriousness. The Act does not authorise assessment and treatment of those who are not mentally disordered as defined.

[81] Moreover, no standard against which an additional judgment of "fitness" is to be made is contained in the Act. Such wide power to detain for reasons of public interest is inconsistent with the careful scheme of the Act and its respect for the human rights of those subject to its provisions. And in application it would raise the risk of potential conflicts with the provisions of the New Zealand Bill of Rights Act, particularly the right recognised by s22 not to be arbitrarily detained.

[82] The consequential meaning of "and" is a natural and ordinary meaning which does not give rise to any inconsistency with the statutory structure. Although such emphasis is perhaps unusual in statutory expression, the definition is itself unusual and awkward in its repetition of the phrase defined. If the second phrase used is consequential, then it is not redundant but didactic. Because it is inconsistent with the legislative scheme, we are of the view that the cumulative interpretation adopted by the Judge is wrong. Subject to consideration of the argument put forward for Waitemata Health and H that the definition is to be construed disjunctively, we

would read it as imposing a unitary test: whether the patient is no longer mentally disordered and thereby fit to be released.

[83] Waitemata Health and H contend that the definition of "no longer mentally disordered" is to be disjunctively interpreted so that the word "and" in the definition of "fit to be released from compulsory status" should be read as "or". It is acknowledged that in its natural use, "and" does not mean "or". Counsel also accept that it would be proper to read "and" as "or" in a statute only to avoid an evident absurdity or where it is clear from the legislation read as a whole that such reading is necessary. They submit, however, that this is an exceptional case (such as was recognised in *R v Oakes* [1959] 2 QB 350) where the interpretation is required to give effect to the Act and to avoid absurdity. Support for the interpretation is to be found in decisions of the Mental Health Review Tribunal (for example, *Re I* (28 July 1993, NRT 191); *Re ER* (1 March 1995, NRT 304/95); *Re LB* (15 December 2000, NRT 848/2000)).

[84] A disjunctive interpretation would permit a patient to be released from compulsory status either when he is "no longer mentally disordered" or, while remaining mentally disordered, when he is nevertheless fit to be released because compulsion is no longer necessary. Waitemata Health, and other hospital services, have operated on the basis that patients who are mentally disordered may be released from compulsory status on clinical assessment that they are nevertheless "fit to be released". A change in that approach, it is submitted, would have financial and therapeutic implications: hospital services would require greater resources and the "therapeutic alliance" between clinicians and patients that is able to be achieved upon discharge from compulsion, would be undermined. It is suggested that compulsion would no longer be necessary where a patient agrees to continue with treatment on a voluntary basis or where for some other reason it is not necessary to continue compulsory status. The approach and the interpretation is supported by the Guidelines referred to in paragraph [8] above. It is followed generally by mental health services. It was submitted that a contrary interpretation would disrupt the operation of the Act, which has worked well for eight years.

[85] In support of the interpretation, the appellants submit that the "entry" and "exit" criteria in the Act are intended to be identical. If the Court considers that a patient is mentally disordered, it is not by reason of that circumstance alone entitled to make a compulsory treatment order. Under s27(3) the Court must first determine:

> Whether or not, having regard to all the circumstances of the case, it is *necessary* to make a compulsory treatment order. [*emphasis added*].

[86] The additional requirement that the order be "necessary" makes it clear that even the scale of seriousness built into the definition of "mental disorder" is not itself sufficient for an order. If, for example, the person has caregivers or family who can contain the danger or compensate for seriously diminished capacity, an order may not be thought by the Judge to be "necessary".

[87] Similarly, it is argued, a patient who is mentally disordered is fit to be discharged from compulsory status if a compulsory treatment order is no longer necessary. Otherwise, it is said, patients would be admitted to a compulsory treatment order "under the criteria of mental disorder and necessity", but would not be released where the conditions of necessity no longer apply. Such symmetry is said to follow as a matter of logic. It is also said to be consistent with the legislation of other jurisdictions which influenced the New Zealand Act, notably the Mental Health Act 1983 (UK).

[88] We are not persuaded that the appeal to symmetry is sound. A high threshold is in keeping with the substantial intrusion into personal liberty entailed in the making of a compulsory treatment order. That is underscored by the requirement of Court determination. Once that threshold is passed, however, it is not at all clear from the scheme of the Act that the clinicians upon whom, subject to review, the principal responsibility for discharge rests, are concerned with anything other than the question of continuing mental disorder. No other guidance is given by the statute as to the additional criteria to be applied. As an alternative test of sufficiency for continuation of a compulsory treatment order "fitness" raises the same problems of criteria discussed above at paragraph [81] in connection with the argument that it is a test additional to mental disorder.

[89] Some care is required in using the UK legislation. The definition of mental disorder in the Mental Health Act 1983 is wider than in the New Zealand Act. Unlike the New Zealand definition, the UK definition does not include a scale of seriousness based upon the safety of the patient or others. Instead, those public interest concerns are met (in the case of compulsory admissions to hospital) by the requirement that it "is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section". In the case of applications for guardianship, in addition to mental disorder it must be "necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received". In those circumstances, the criteria for discharge, unsurprisingly, require commensurate assessment of whether it remains necessary for the health, safety or welfare of the patient or the protection of others for the detention in hospital or the guardianship to continue.

[90] In the New Zealand Act, the considerations of serious danger to others or seriously diminished capacity (stronger thresholds than are required in the UK legislation) are built into the definition of "mental disorder" and must be considered at every stage. They must be judged at "entry" and at "exit" by responsible clinicians, the Review Tribunal, and the Court. The Court is required to consider whether an order is necessary in all the circumstances before making a compulsory treatment order. That is an additional protection for the patient. It requires caution of the Judge. But it is not evident from the requirement that the Judge consider the order necessary, that discharge from compulsory status should turn on any consideration other than whether the patient continues to suffer from mental disorder. The test for mental disorder achieves a balance between the rights of the individual and the public interest. There is no reason to assume that those who have the responsibility for discharge (principally the responsible clinicians) are given a power to achieve a re-balance in the individual case beyond application of the test for mental disorder. No standards against which such additional judgments are to be made are identified.

[91] Indeed, the structure of the Act seems to point the other way. Release provisions which do not turn on whether the patient is "fit to be discharged from

compulsory status" turn entirely on whether the patient is considered to be mentally disordered (ss10(3), 12(3), 27(2)). Section 14(3) directs release of a patient on final assessment if "fit to be released from compulsory status", but that does not mirror an "entrance" criteria of necessity such as is argued to be provided by s27(3). The "exit" criteria within the Act are not identical and they do not exactly correspond with the "entrance" criteria. The greater consistency is achieved if "fit to be released from compulsory status" is interpreted as "no longer mentally disordered and thereby fit to be released from compulsory status". That is the alternative meaning put forward by the appellants.

[92] Nor do we consider that this interpretation leads to results which are unworkable. The examples given in argument of a patient willing to take medication voluntarily and an anorexic for whom hospital treatment was not appropriate need to be considered in the context of the Act as a whole. It permits intervention only where mental disorder is of "such a degree that it… poses a serious danger to the health or safety of that person or of others… or seriously diminishes the capacity of that person to take care of himself or herself". If that degree of danger or diminished capacity is present, there is a public interest in the compulsory status provided for by the Act.

[93] The presumption in the Act is that community treatment orders will be made (s28(2)) and in-patient orders will be converted into community treatment orders (s30(2)) unless the responsible clinician considers that the patient cannot be adequately treated in the community. Community treatment orders, which permit supervision of the treatment of the patient in the community, cannot be said to lead to a result in the case of the examples given which is unworkable or absurd. A third way (discharge from compulsory status where the person remains mentally disordered but the clinician is of the view that the danger inherent in the mental disorder can be contained by a voluntary rather than compulsory regime) has not been provided explicitly in the statute. It would be overstepping legitimate interpretation to imply any such option from the language of the definition of "fit to be released from compulsory status".

[94] It may be, as has been urged upon us, that the approach adopted by Waitemata Health is therapeutically sound. Public safety is however engaged by reason of the definition of mental disorder. The scheme of the Act is that those disordered to such a degree remain subject to compulsory status but with a presumption of community treatment. That may be a wiser balance. But it is a matter for Parliament. The interpretation argued for by the appellants would require the definition to be construed in a way which is contrary to the normal meaning of the language employed. There is no occasion to do so.

[95] The sequential sense of the two limbs of the definition accords with the scheme of the Act. It does not require the reading in of additional words to achieve the meaning "no longer mentally disordered or, being still mentally disordered, is nevertheless fit to be released from compulsory status". That is a strained construction which may have consequences which the Court is not able to weigh. We are of the view that "and" is used in the definition of "fit to be released from compulsory status" in its natural sense of introducing a consequence. As a result, we would allow the appeal from the determination of the High Court on the point and accept the alternative interpretation contended for by the appellants.

Natural justice and notice to the Director

[96] The Review Tribunal is a body required to act in accordance with the standards of procedural fairness described as natural justice. Those standards require anyone whose rights or interests are affected to be given notice of its hearings and an opportunity to be heard, unless those rights or interests are speculative or insignificant. Prior notice is essential to an effective right to be heard and in its absence there is denial of the right. The question on the appeal is whether the Director was a person whose rights or interests were affected. If so, in the acknowledged absence of notice to her, the Tribunal has failed to comply with the requirements of natural justice.

[97] The argument for H is that the Act provides exclusive identification of the persons whose rights and interests are affected by the Tribunal's decision on review. Part VII of the Act sets out in detail provisions for notice and identification of those

entitled to apply to the Tribunal for review. In addition, the First Schedule to the Act provides the procedures to be followed by the Tribunal and identifies those who may attend its hearings and who are entitled to be heard and call evidence. The Director is not one of those identified in Part VII or the First Schedule. In those circumstances, Mr Bassett submits that there is no occasion for implication of a right for the Director to be heard. In addition, it is submitted that it would undermine the distinct treatment in the Act of applications for restricted patient status (which have to be made to the Court) if the Director could be heard by the Review Tribunal on the concerns which prompt consideration of restricted patient status. It is said the Director should have moved immediately to apply to the Court. Upon the making of an order for restricted patient status, she would have been entitled to be heard in the Tribunal. In the absence of an order, she had no standing to be heard and no entitlement to notice of the hearing.

[98] Failure to comply with the mandatory provisions of the statute as to notice and hearing will lead to remedy in the courts. But in addition, the common law will supplement the statute to achieve fair procedure unless the statutory procedure is clearly intended to be exhaustive (*Ronaki v Planning Board* [1977] 2 NZLR 174, 181 per Woodhouse and Cooke JJ; *R v Secretary for the Home Department, ex parte Doody* [1994] 1 AC 531 (HL); *Kioa v West* (1985) 159 CLR 550, 585).

[99] The rights and interests which may require hearing are broader than legal rights and interests. The interest may be that of a public body exercising responsibilities affected by the decision (*R v Secretary of State for Transport ex parte Greater London Council* [1986] QB 556).

[100] Under the Act, the Director has three main functions: the administration of the Act, including the setting of guidelines under s130 (s91(1)); powers of inspection and inquiry and supervision of district inspectors (ss 94A - 99), and powers and duties relating to special and restricted patients. The Director therefore is greatly concerned with matters of interpretation and operation of the Act generally, and exercises responsibility in relation to those who are a particular risk to public safety by reason of mental disorder. The responsibilities of the Director are acknowledged by the Review Tribunal's decision to delay implementation of the release of H

(contrary to the statutory direction) so that the Director could be notified in advance and could take any steps she considered necessary. This approach is based upon the reality that it is the Director who will be publicly accountable for failure to use the powers of the Act to ensure public protection.

[101] Whether the Director should have been given an opportunity to be heard is also affected by the function of the Tribunal under the legislation. It is required to apply a definition of mental disorder which seeks to achieve a balance between the rights of patients and the wider public interest. The powers of inquiry conferred upon the Review Tribunal (s104(3) and clauses 4-6 of the First Schedule to the Act) emphasise its freedom and responsibility to arrive at the correct answer in assessing whether a patient is fit to be released from compulsory status. The subject-matter of its responsibilities are significant not only for the patient but also for the wider community. In such circumstances, it would be strange if the Act prevented the Tribunal receiving such help as it needs by imposing any procedural straitjacket limiting those it must hear. It clearly does not. The mandatory requirements of notice are not exhaustive of the notice and hearing required in the particular case. There is nothing in the scheme or the detailed provisions of the Act which is inconsistent with the Director's right to be heard in the particular circumstances.

[102] We do not accept a submission by Mr Bassett that the Director should have accelerated the application in the District Court. The application for restricted patient status required careful consideration. Nor would it have been responsible to have pursued such application when there was a real question as to whether H remained mentally disordered. The appropriate place for that question to be addressed was in the Review Tribunal.

[103] Nor do we agree with the suggestion that, because the Director will not be heard on clinical review under s76 and that review may lead to summary discharge, there can be no right to be heard before the Review Tribunal. The two considerations are different. In the case of H, no clinician has certified that he is fit to be discharged. (Indeed, none has assessed him as able to be adequately treated under a community order.) Such certificate in the scheme of the Act is sufficient.

No question of responsibility of the Director arises because the clinician, to whom the decision is entrusted by the Act, has taken responsibility for the assessment.

[104] As the Judge rightly observed, the requirements of natural justice depend on the circumstances of the case. It is not necessary to decide whether, given the vexed history of the case with its background of clinical disagreement and disputes about the legal definitions, notice to the Director of a review of H's status should have been given in any event. In our view the Director is sufficiently affected in discharging her responsibilities under the Act to require notice and an opportunity to be heard in the circumstances of this case.

[105] The question whether H was mentally disordered fell to be determined by the Review Tribunal after hearing and submissions. It was known from the previous history of H's case that there were deep divisions between the psychiatric opinions and that there were issues with the legal definition of mental disorder and its application to those with severe personality disorders. That these differences about the application of the statutory criteria persisted would have been evident at least from the time evidence was filed in accordance with the Tribunal's direction. Indeed, they appear to have prompted its Minute. These were matters upon which the Tribunal could well have benefited from the participation of the Director and upon which the Director had a direct interest by reason of her responsibilities in administration of the Act. Given the fact that the responsible clinician had certified that H was not fit to be released from compulsory status, it was clear that the decision would be a particularly difficult one. It was notable, in the context of the previous hearings, that the evidence put forward was from clinicians who had dealt with H and that there was no outside assessment such as had been previously relied upon by the Tribunal.

[106] Against this contentious background, the Tribunal was made aware that the Director was considering an application to have H declared a restricted patient. We are of the view that the Judge was clearly right to hold that the failure of the Tribunal to give the Director notice of the hearing in the circumstances was a breach of natural justice. The Tribunal appears not to have turned its mind to the point. While some protocol, such as was discussed at the hearing, whereby the Director gives

notice of any interest in a review application would clearly seem to be a sensible precaution for the future, no such precaution was needed here as a matter of practicality because the Tribunal knew of the Director's interest. The sense of such a system for the future does not overcome the deficiency in procedure in the present case.

[107] The fact that the Tribunal knew that restricted patient status had been requested by Dr Chaplow and was being considered by the Director is sufficient to have made it incumbent on the Tribunal to give the Director notice of the review. The purpose of the review was to consider whether H was "fit to be released from compulsory status". A determination that he was fit to be released removed the opportunity to seek restricted patient status.

[108] The case was not one where the discretion could have been exercised against judicial review in the High Court. Whether H was "fit to be released from compulsory status" was, on any view of the matter, a difficult and contentious question, turning on legal definitions as well as expert opinion (as the evidence of Dr Simpson referred to above at paragraph [40] makes clear). It could not be assumed that the outcome would have been the same had the Director participated. In evidence in the High Court the Director indicated that she would have urged that the Tribunal obtain a further report from Professor Mullen or some other independent expert. She expressed concern that the question of intermittent disorder had not been sufficiently explored. And it may well have been that she would have made submissions on the test for mental disorder which would have been helpful to the Tribunal.

Conclusion

[109] The appeal in CA 290/00 is allowed. The appeal in CA 293/00 is allowed in part. For the reasons given, which differ in part from those in the High Court, the orders made in the High Court are confirmed.

TIPPING J

Introduction

[110] I am in general agreement with the judgment prepared by the Chief Justice but I see the two issues in this case through a somewhat narrower lens. The natural justice point turns on conventional principles of fairness. The meaning of the word "and" in the statutory definition of the expression "fit to be released from compulsory status" is a question of statutory construction in the light of the scheme and purpose of the relevant provisions of the Act.

Natural justice

[111] On the natural justice point, I agree with Rodney Hansen J that the Mental Health Review Tribunal (the Review Tribunal) should have given the Director of Mental Health (the Director) notice of the hearing of H's application for review of his condition, so as to allow the Director to be heard on it if she wished. The Review Tribunal is a body which must act in accordance with the principles of natural justice. There was rightly no dispute about that, no doubt because the proposition is self-evident from 27(1) of the New Zealand Bill of Rights Act 1990:

> **27 Right to justice**
>
> (1) Every person has the right to the observance of the principles of natural justice by any tribunal or other public authority which has the power to make a determination in respect of that person's rights, obligations, or interests protected or recognised by law.

[112] The Review Tribunal knew that the Director was considering making an application for H to be given restricted patient status. It must have been aware that if it found that H was fit to be released from compulsory status and made an order accordingly, the Director would no longer be able to pursue her contemplated restricted status application.

[113] Natural justice is not a concept confined to the immediate parties to an issue. If a Tribunal or other qualifying body is aware that an order it might make could

have a detrimental effect on the rights, interests or obligations of someone who is not an immediate party to the proceedings, it should ordinarily inquire whether the person wishes to be heard on the matter. If the possibility of detrimentally affecting the position of a third party emerges only at the hearing, the Tribunal should consider whether an adjournment is necessary to allow the third party to participate, and should take that course if an order detrimentally affecting the third party is a real possibility.

[114] The fact that a legislative scheme does not expressly provide for service on, or the participation of, the third party does not mean that third parties' interests can be ignored. That would be inconsistent with s27(2) of the Bill of Rights:

> (2) Every person whose rights, obligations, or interests protected or recognised by law have been affected by a determination of any tribunal or other public authority has the right to apply, in accordance with law, for judicial review of that determination.

[115] This provision is intended to supplement statutory and other schemes so as to afford natural justice to anyone whose rights, interests or obligations are affected by what the Tribunal decides to do. It is of course an elementary principle of natural justice that a person be given a right to be heard before a decision is made which detrimentally affects their interests. There can be no doubt that in the present instance the Director's interests and obligations were liable to be affected by the issue with which the Review Tribunal was concerned. That is so both specifically in relation to her potential restricted status application and generally in relation to her responsibilities in the administration of the Act.

[116] The point is underlined by the fact that the Review Tribunal thought it necessary to delay H's release, in a way not authorised by the Act, to allow the Director to be notified so she could take any steps she regarded as necessary in the public interest. To do that at the end of the process without engaging the Director in the substantive issue is, with respect to the Review Tribunal, and irrespective of legalities, a rather curious inversion of approach. The Review Tribunal appeared thereby to recognise the public interest role performed by the Director but only after the crucial decision had been made. The Judge was right to take the view that a breach of natural justice had occurred.

The definition issue

[117] The definition of the expression "fit to be released from compulsory status" is "no longer mentally disordered *and* fit to be released from the requirement of assessment or treatment under this Act". I have emphasised the word "and" because it is the word the meaning of which is in issue. The definition is unusual in that it incorporates the essence of what, and some of the very words which, it is defining. That immediately suggests that those words are present in a declaratory and consequential sense; otherwise there would be a very awkward element of circularity in the definition. With that opening observation, I set out the three possible meanings of the word "and" in its context. I will, for ease of reference, again emphasise the key words:

(1) no longer mentally disordered *and also* fit to be released.

(2) no longer mentally disordered *and therefore* fit to be released.

(3) no longer mentally disordered *or* fit to be released.

[118] For reasons which I can give quite shortly, I agree with the Chief Justice that the "and therefore" meaning is the correct one. The "and also" meaning and the "or" meaning have this in common. They both pre-suppose that "fit to be released…" is a criterion separate and distinct from "no longer mentally disordered". In the case of the "and also" meaning the separate criterion is additional to the "no longer mentally disordered" criterion; whereas in the case of the "or" meaning the separate criterion is an alternative one. In both cases the concept of fitness to be released must represent something distinct from that of no longer being mentally disordered. But what is the substance of that distinct concept? The separate concept is "fit to be released from the requirement of assessment or treatment under this Act". This is the practical and conceptual equivalent of "fit to be released from compulsory status" which is the phrase being defined. It is not, however, exactly the defined phrase. If it were treated as such, and the statutory definition was thus invoked, the process of interpreting the whole definition would be back to where it started. The only way to break the circle would be to stop at "no longer mentally disordered" which would

effectively lead us to the "and therefore" meaning which, as I noted at the start, is already implied as a matter of logic.

[119] If the concept of "fit to be released…" is treated as different from "fit to be released from compulsory status" there is then the same major difficulty that there are no statutory criteria for what is, ex hypothesi, an additional or alternative criterion, meaning something other than no longer mentally disordered. There was much debate at the hearing about entry criteria matching or not matching exit criteria in relation to patients coming into or leaving the system of compulsory assessment or treatment. I do not consider the legislation itself points one way or the other on this issue with any real clarity. But there is force in the view that it would be surprising if once the criterion for entry ceased to exist the person could nevertheless be held in compulsory status.

[120] It should be noted, as the Chief Justice has demonstrated, that the "and therefore" meaning represents a perfectly legitimate use of the word "and", albeit a use which is not the primary one of addition. In most of the dictionaries I have examined the "and therefore" meaning of the word "and" is noted early in the secondary meanings of the word. As already indicated, both the other meanings (and also – or) have the difficulty of introducing an additional or alternative criterion which is both somewhat circular and has no defined content if, as they must, they mean something different from no longer mentally disordered. If someone is no longer mentally disordered, on what basis, if the fitness for release criterion is additional, is that person to be kept under compulsory status? In any event continued compulsion, absent mental disorder, seems inconsistent with the whole structure and policy of the Act: see for example s27(2).

[121] It must also be borne in mind that to be mentally disordered it is necessary that the person pose a serious danger to the health or safety of self or others, or the person must have a seriously diminished capacity to take care of self. While there may be occasions when such a person could be released from compulsory status, I find it difficult to accept that Parliament would have left that potentially difficult decision, often involving public safety, to be made on a completely undefined basis. If, for the reasons discussed in argument, patients are to be released from

compulsory status into some sort of intermediate regime, there again Parliament could be expected to have set the metes and bounds in some appropriately structured way.

[122] A further point against the meaning of "and" being "or" is that although occasionally capable of bearing such a meaning, "and" does not normally mean "or". If those drafting the legislation had meant "or" they could easily have said so. The only sensible conclusion is that the intention behind the word "and" as the link between the concepts of "no longer mentally disordered" and "fit to be released…" is to convey the consequential meaning "and therefore". The effect of the definition is that a patient is fit to be released from compulsory status if, and only if, that patient is no longer mentally disordered.

[123] If that conclusion does not reflect the original Parliamentary intent or if it is thought to be unsatisfactory for the proper and safe transitional management back into the community of people who have suffered or are still suffering mental disorder, Parliament will have to amend the Act so as to introduce a different definition of the concept of fit to be released from compulsory status or to approach the issues raised by some of counsel's submissions in a different way. Thus, while I agree with Rodney Hansen J on the natural justice point, I find myself unable, for the reasons given, to agree with him on the meaning of the definition. I therefore agree with the orders proposed in the judgment prepared by the Chief Justice.

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