Geraldine Patricia Burnett

v.

Mental Health Tribunal

and

Director of Mental Health Services and Community Advocate and Australian Capital Territory

SUPREME COURT OF THE ACT
[1997] ACTSC 94
21 November 1997

CRISPIN J

This is an appeal a decision of the Mental Health Tribunal ordering that the appellant be detained in a Mental Health facility for a period of up to 28 days and authorizing the Director of Mental Health Services or his delegate to administer psychiatric treatment during that period. The Tribunal found that the appellant was suffering from a psychiatric illness and stated that it was satisfied of the following:

"she is a mentally dysfunctional person;

the order is necessary for her own protection;

that she is incapable of having the insight for weighing out for herself the considerations involved in making a decision whether to accept adequate treatment for that mental dysfunction; and

that the order imposed cannot be provided in a less restrictive or intrusive environment" (sic)

The preponderance of evidence suggests that the appellant has a mild psychotic disorder. She is now 38 years of age, divorced and lives alone. She had been a legal officer in the Public Service but retired in 1990 for what are described as 'psychiatric reasons'. In 1991 she began living in Hughes. There has since been a protracted series of disputes with neighbours. Police have attended from time to time and on occasion she has been taken into custody. However, the material before me does not include any comprehensive record of either the incidents in question or any proceedings initiated as a result of them. It does appear that prior to her most recent admission to the Psychiatry Unit of the Canberra Hospital on 11 October 1997 she had been admitted on five other occasions, all said to have been related to aggressive behaviour towards her neighbours.

It appears that the catalyst for bringing the application for the order now subject to appeal was an incident on 11 October 1997 in which she allegedly became aggressive towards a neighbour, physically assaulted him and caused damage to his property. I note however, that no attempt was made to produce any evidence to establish these allegations. Indeed, the President expressed the view that it was not the Tribunal's function to adjudicate on them and

that it did not intend to do so. Nonetheless, from comments made during the course of argument it seems clear that the Tribunal acted on the assumption that the allegations were well founded. As the President put it, the police reports which revealed the nature of the allegations were to enable the Tribunal to inform itself and provide the history upon which the illness was to be judged. It is not clear from the transcript how reports of the allegations could have provided relevant history or other information in the absence of any determination of their truth.

Regrettably, there were no reasons for judgment to indicate what findings were made or otherwise reveal the basis of the decision other than in the terms quoted above. Section 108 of the *Mental Health (Treatment and Care) Act* 1994 enables a person entitled to appeal against such a decision to request a statement of reasons, and if such a request is made within 28 days of the decision, the President is obliged to provide a written statement of those reasons as soon as practicable, but in any event, within a further 28 days from the date of request. In the present case this procedure was not followed, no doubt because the matter came before me as a matter of urgency for the hearing of an application to stay the order pending the appeal, and the hearing of the appeal itself was expedited. Whilst in the circumstances it was entirely understandable that there was no statement of reasons, that fact together with the inadequacy of the transcription of the evidence of Dr Gupta, who is the Director of Mental Health Services, did give rise to problems in the resolution of the appeal. Further problems arose from the paucity of evidence concerning the oft cited but largely unspecified history. Various aspects are recorded in the evidence of various medical witnesses, patient notes, a letter of complaint from a neighbour and even submissions to the Tribunal. It is unclear how much of these accounts were regarded as common ground or otherwise accepted by the Tribunal, though it does appear from the transcript that counsel for the appellant had accepted that some findings had been made against the appellant during earlier proceedings in the Magistrates Court.

The bulk of the evidence consisted of psychiatric reports from Drs Evans, Cullen, Rosenman and Eramudugolla and oral evidence from Drs Eramudugolla and Gupta.

Dr Mandy Evans provided a report dated 20 August 1997 concerning her assessment of the appellant as an in-patient of the psychiatric unit of the Canberra Hospital from 3 July to 4 August 1997. It appears that she was admitted as a voluntary patient though it had been a condition of bail granted to her on the previous day that she submit herself for assessment in that manner. The assessment was carried out by Dr Evans pursuant to an order under s16 of the Act. During that period she carried out her own examinations and interviews with the appellant and gathered information from numerous other sources. She concluded that the appellant's medical file and discussions with another psychiatrist, Dr Cullen, indicated "a uniformity of presentation between what has been observed during this prolonged hospitalization and past admissions or other contact". Whilst no positive symptoms of psychosis had been elicited or observed there had been a "consistency of opinion" that the history of disability and pattern of social difficulties probably indicated a mild psychotic illness. Dr Evans felt that the long term history which she noted was incomplete, was suggestive of the onset of a psychotic illness prior to her sickness related retirement from the public service. The applicant had told her that there were eleven charges pending against her including three of common assault, but maintained that she had not done all of the things of which she had been accused. She said that there had been constant arguments but that they were 'two sided' and that she had also been threatened and assaulted. Dr Evans described the nature of the complaints which had been made against the appellant and her own limited

account of the incidents as an almost "textbook" case of the condition of delusional disorder or paranoia.

She noted that that type of illness was most effectively treated with neuroleptic anti-psychotic medication. She said that the effectiveness of this medication against the delusional component of psychosis is 50-60% but that the literature indicated that it was less effective in those with delusional disorder of chronic delusions due to any other disorder. The medications also had a high incidence of unpleasant side effects although they could be ameliorated by the alteration of doses and the use of additional oral medications if there was the necessary level of co-operation between the patient and the doctor. She noted that the "alleged behaviour" arising from the appellant's "presumed" delusional beliefs regarding her neighbours had been "reported" to be extreme and distressing for others but that the illness could not be described as severe in a clinical sense. The appellant did not display disorganization of her emotions or thinking but appeared to adequately attend to the tasks of daily living. When assessed in this manner she did not clearly meet the "severity criteria" for treatment if based entirely upon her needs rather than what might be in the best interests of the community. Since she was unwilling to voluntarily accept medication the only alternative was injectable medication and Dr Evans observed that the doctor who ordered this and the nurse who delivered it would almost certainly have lost any opportunity for trust and therapeutic relationship with the appellant, particularly if she developed side affects of which there was a high likelihood and if it proved ineffective in the treatment of her illness, of which there was a 50% likelihood. She concluded "after weighing up all the considerations outlined above I would personally find it difficult to force a treatment upon Ms Burnett which is of disputable benefit to her and with a high likelihood of producing side effects".

Dr Cullen in a report dated 23 September 1997 referred to having read two reports, one from Dr Lawrence and the other from Dr Evans. I take it that the latter report was the one to which I have already referred, but the report from Dr Lawrence was not before me. Dr Cullen had seen the appellant on previous occasions particularly during a period of about 18 months between 1992 and 1994. He referred to the long history of friction with her neighbours but noted that although there had been hints of a delusional state at times, her ideas were not bizarre or totally incredible. During the period in which she saw him between 1992 and 1994 she had seemed to be coping well with her life and had not been expressing delusional ideas although the friction with her neighbours had been continuing. He had diagnosed her condition as one of a paranoid disorder on the basis of "presumption" that she must be misinterpreting her neighbour's actions and communications as being harmful to her, and despite her denial, that she was reacting in a hostile way to them. However he said that "she seems to manage to care for herself, manage her home, pets, garden, financial affairs very adequately." In relation to the proposed treatment order he said "she has never taken medication voluntarily, and I am in agreement with my colleagues that the potential benefits of a regime of enforced medication are outweighed by her distress and the potential side effects. The potential benefit of medication in illnesses which are as 'mild' and chronic as hers, where there is an absence of florid symptomtology and where the personality remains reasonably intact, is very doubtful." He added that when he had seen her on 16 September 1997 he had been impressed by the absence of any deterioration in her mental state over the three years since he had previously seen her and noted that she showed no evidence of delusional or a thinking disturbance. Her mood had been good, she made reasonably good rapport and there had been no gross disturbances of reasoning or judgment. The reference to his agreement with "my colleagues" might suggest that Dr Lawrence also thought that the

potential benefits of a regime of enforced medication were outweighed by the distress and potential side effects which such a course might induce.

In addition there was a report by Dr Stephen Rosenman dated 24 January 1996. Whilst his assessment of the appellant's mental state must be discounted by the effluxion of time since he had last seen her, his assessment was generally consistent with those of Dr Evans and Dr Cullen. He expressed the view that unwanted side effects of the enforced injection of medication were very likely and were hard to justify in the absence of acute symptoms and in view of the low probability of beneficial affect.

The application for the order was made by Dr Kamini Eramudugolla who is apparently a psychiatric registrar at the Canberra Hospital. Her report of 14 October 1997 adverted to the appellant's previous admissions to the Psychiatric Unit "all related to aggressive behaviour towards her neighbours" and stated that she had been re-admitted on 11 October 1997 on an emergency order "after she had attacked her neighbour with a stick and a piece of concrete and had also destroyed his letterbox and attempted to destroy his lawn mower with no provocation". She suggested that she had no insight into her illness and "denies ever having attacked anybody". During the proceedings before the Tribunal she said that the psychiatrist who had seen her when previously admitted had prescribed medication but she had consistently refused to accept it. She said that "the doctor (presumably Dr Gupta) has told me to say that he is prepared to medicate with any psychotic medication.....". During the course of cross examination about Dr Evans' report, she was asked whether either she or Doctor Gupta had conducted such an extensive assessment. Whilst she did not answer the question directly, the answer that the assessment had been done only two months earlier and that there would have been no change in her clinical assessment suggested that neither of them had in fact carried out such an intensive assessment. When it was then put to her that Dr Cullen had supported Dr Evans in not recommending involuntary medication, she replied "I can only say what Dr Gupta has told me to say....".

In these circumstances, it appears likely that the Tribunal acted largely upon the evidence given by Dr Gupta. Unfortunately that evidence was given by telephone and the transcription is so poor that important aspects of it may well have been omitted. Indeed, the only part of his evidence in chief which appears to have been recorded is his agreement with the proposition that "the allegations that are made are related to her mental condition and that is causing her to get into strife". However it did appear that he had been unable to successfully interview her. He said that he had had regard to Dr Evans report but also to "my own knowledge of this patient and the circumstances of the current admission". When asked whether he would say he had done his own assessment of the appellant, his answer appeared to indicate that he had relied upon his general awareness of the patient's illness, her past history and the circumstances leading to her admission to hospital. The answer is not wholly recorded and this summary may not do justice to what the doctor in fact said, but I am left with the impression that he had not carried out a full assessment of the kind attempted by Dr Evans or even had the benefit of a normal interview with the patient. This may have been due to lack of co-operation on the appellant's part but it does, nonetheless, mean that he may have lacked the opportunities for assessment that were enjoyed by Dr Evans or even Dr Cullen.

During the course of argument Mr Nash sought an adjournment to obtain updated reports from Drs Evans and Cullen who, he suggested, may have revised their opinion. He referred me to s141(5) of theMental Health (Treatment and Care) Act which provides that ss.214(3) and (4) of the Magistrates Court Act 1930 applies to appeals of this nature as if

they were appeals of the kind referred to ins214(1) of that Act. That section in turn provides as follows:

"Where evidence is tendered in an appeal to which this section applies the Supreme Court shall, unless it is satisfied that the evidence would not afford any ground for allowing the appeal, receive the evidence if -

(a) it appears to the Supreme Court that the evidence is credible and would have been admissible in the proceedings out of which the appeal arose on an issue relevant to the appeal;

(b) the Supreme Court is satisfied that the evidence was not adduced in those proceedings and there is a reasonable explanation for the failure to adduce it."

Despite the objections of Ms Tonkin who appeared for the appellant, I acceded to this application. When the matter resumed on 14 November, 1997 Mr Nash tendered a further report from Dr Evans. This report dated 10 November 1997 confirms that there had been evidence of deterioration and downward social drift since the appellant had been employed as a lawyer, that she probably suffers from a paranoid psychosis and that she had not benefited from psychotherapy during the time she saw Dr Cullen between 1992 and 1994 and lacked the qualities necessary for successful psychotherapy. Dr Evans also confirmed her opinion that any treatment other than pharmacological treatment was unlikely to be effective. So far as the mental health order is concerned she commented: "If it *can be accepted that the alleged events actually occurred* they represented an immediate and substantial danger to the neighbour and, in my opinion, involuntary detention of Mrs Burnett was justified." (emphasis added). Presumably on the same assumption, she concluded that "In the light of the recent allegations of threat and danger to her neighbours, despite clearly understanding the ramifications of such activities, I believe the balance of what is in Mrs Burnett's best interests has tipped towards a trial of antipsychotic medication, with the understanding that prospects for success are limited."

No attempt was made to tender any further report from Dr Cullen or to explain the failure to do so. I presume that no further evidence from him would have assisted the first respondent.

Ms Tonkin used the period of the adjournment to obtain a further report from Dr Rosenman. He confirmed that he had not seen the appellant since January 1996 and I accept Mr Nash's submission that one must approach his conclusions concerning the nature and extent of her illness with some caution due to the absence of any recent opportunity for personal assessment. However, he had read the recent reports of Drs Evans and Cullen and the notes of her recent hospitalisation and felt that the reports were sufficiently detailed for his purpose. He also diagnosed the appellant as suffering from mild paranoid psychosis and added that despite its mildness, it was adequate to cause severe social disruption without destroying the capacity to care for herself. In his view, enforced treatment might reduce that social disruption but would not improve her own well being and might even reduce it. It is evident that he regarded the involuntary medication of the appellant as contrary to her interests though possibly in the interests of others such as her neighbours.

The basic power to make mental health orders is found in 28 of the Mental Health (Treatment and Care) Act 1994 which is in the following terms:

"(1) This section applies in relation to -

(a) a person who is the subject of an application or referral under Division 1; or

(b) a mentally dysfunctional offender.

(2) If, having regard to an assessment under section 23 and after holding an inquiry under section 24, the Tribunal is satisfied -

(a) that a person is mentally dysfunctional; and

(b) that -

(i) the person's health or safety is, or is likely to be, sustantially at risk; or

(ii) the person is, or is likely to be, a danger to the community;

the Tribunal may, subject to subsection (3), make a mental health order in respect of the person.

(3) The Tribunal may not make an order of the kind described in paragraph 29 (a) in respect of a person unless satisfied that the person has a psychiatric illness."

Section 29(a) deals with orders for psychiatric treatment other than convulsive therapy or psychiatric surgery.

Section 23 provides that the Tribunal shall not make a mental health order without regard to an assessment of the person concerned conducted pursuant to an order under s16 or another assessment that the Tribunal considers appropriate. Section 16 provides the power to order such an assessment and, inter alia, sets out the nature of the order that must be made. It was pursuant to an order under that section that Dr Evans carried out her assessment.

Section 26 provides that, subject to s27, the Tribunal shall not make a mental health order without the person's consent. Section 27 is in the following terms:

"(1) The Tribunal may made a mental health order in respect of a person (other than a mentally dysfunctional offender) without the person's consent if the Tribunal is satisfied that -

(a) the person needs to undergo treatment, to undertake a program, to begin care or support, or to be subject to prohibitions or conditions;

(b) the order is necessary for the persons own protection or for the protections of the community;

(c) the person - (i) the person has refused to consent to the order or (ii) is incapable of weighing for him or herself the considerations involved in making a decision whether to consent to the order and; (d) the treatment, program, care, support, prohibitions or conditions cannot be provided or imposed adequately in a less restrictive or intrusive environment."

(2) Without limiting the kinds of mental health orders that may be made without consent under subsection (1), those orders include the following:

(a) an order requiring the person to remain in the custody of the person named or described in the order (in this Part called the "custodian") at such premises as the person so named or described specifies;

(b) an order requiring the person to attend, at the direction of the custodian, at such places and times as the custodian specifies for the purposes of complying with an order of the Tribunal;

(c) in the case of a person who has a psychiatric illness - an order authorising the Director to administer or cause to be administered such psychiatric treatment to the person as the Director thinks necessary, other than treatment that has, or is likely to have, the effect of subjecting the person to whom it is administered to undue distress or deprivation, having regard to the benefit likely to result from the administration of the treatment."

It was submitted by Mr Nash who appeared on behalf of the second and fourth respondent that the power to make involuntary orders was limited only by the terms of s27 and that s28 had no relevance to applications for orders of that kind. The scheme of the relevant portion of the statute was that s27 governed involuntary orders and s28 governed voluntary orders. I do not accept this construction. It seems to me that s28 is intended to lay down the basic conditions which must be satisfied before any mental health orders may be made and that s27 imposes further conditions which must be satisfied before involuntary orders may be made. That is clear from the absence of any words limiting the operation of s28 in the manner suggested. Furthermore, if that were not so then an involuntary order could be granted without proof that the person was mentally dysfunctional and without the need for an adequate assessment under s16. It would obviously be innappropriate to adopt a construction involving such an illogical consequence. If is true that s27(2)(c) provides that orders authorising the administration of psychiatric treatment may only be made in the case of a person who has a psychiatric illness, but that limitation does not apply to the other provisions of the section.

Ms Tonkin who appeared for the appellant, attacked the order on a number of grounds. She initially submitted that there was no evidence that the appellant was mentally dysfunctional within the meaning of the Act. During the course of argument amended grounds of appeal were provided, and this contention was apparently abandoned. In any event, it could not have been upheld.

The term "mental dysfunction" is defined by s.4 to mean "a disturbance or defect, to a substantially disabling degree of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion". This is a very broad definition in which the relevant test is dependent not upon the nature of any underlying psychiatric illness or disturbance, but its effect. Whilst the evidence as to this aspect of the case was again less than comprehensive, it is reasonably clear that the appellant was retired from the Public Service in 1990 as a result of her psychiatric condition and has been unable to practice her profession since. There is also evidence of a significant deterioration in cognitive function since she was so employed. Even if the recent allegations had been wholly ignored there was evidence which, in my view, was sufficient to support this finding.

Ms Tonkin also submitted that the evidence was insufficient to support the finding that the appellant was suffering from a psychiatric illness. The relevant portion of s4 provides that:

"psychiatric illness" means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms:

(a) delusions; (b) hallucinations; (c) serious disorder of thought form; (d) a severe disturbance of mood; (e) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c), or (d)"

Ms Tonkin pointed to evidence that the appellant is able to care for herself and her pets and generally manage her own affairs, including her financial affairs. She submitted that it could not be said that the mental functioning of a person had been seriously impaired by her condition if she were able to manage her life to that extent. The manner in which a person is coping with the normal demands of life is obviously relevant to the issue of whether he or she may be suffering from a psychiatric illness as defined, but in my view, that issue cannot be determined solely by reference to this factor. The test is not whether the person's mental functioning had dropped below the level necessary to manage his or her affairs but whether it had been sustantially impaired. In the present case, the evidence of a significant deterioration in cognitive function would fulfil this requirement.

However the condition must be one which is characterised by delusions, hallucinations, serious disorder of thought form, severe disturbance of mood or sustained or repeated irrational behaviour indicating the presence of such symptoms. The reports of Drs Evans and Cullen contain reference to the appellant harbouring delusional beliefs, but they seem to reflect diagnoses based largely upon presumption. Dr Evans' report of 20 August 1997 state that during her hospitalisation in June 1997 she was under direct observation for the majority of the time. Yet there was no observable behaviour which suggested that she might be developing odd ideas about people around her or the purpose of her hospitalisation and there was no observable evidence of hallucinosis. There had been a uniformity of presentation between what was observed and earlier admissions or other contact. She concluded that there had been no indisputable evidence from interviews or prolonged staff observations of active symptoms or signs indicative of mental illness. She acknowledged that the long term history available to her was incomplete but said that it was "very suggestive" of the onset of a psychotic illness prior to her retirement from the Public Service. It was her "belief" that the appellant "has or had" beliefs about her neighbours which had played a part in the earliest altercations. She said, however, that "the long history of acrimony now means that the original ideas or fears Ms Burnett held are only part of the problem and her anger about the responses of her neighbours now fuels the difficulties." In short, there was no actual evidence that the appellant was suffering from delusions, but Dr Evans deduced from what she understood to be part of the relevant history that she had beliefs based upon "persecutory ideation" either then or some time earlier. Her report of 10 November 1997 offered other reasons for her opinion that the appellant suffers from a "paranoid psychosis (delusional disorder)" but generally confirmed what she had said in the earlier reports. She added that the main difficulty with this diagnosis was that to her knowledge the appellant had never reported any delusional beliefs to Mental Health Services staff during her numerous encounters with them.

Dr Cullen said that although there were 'hints' of a delusional state at times, her ideas had not been bizarre or totally incredible. During her attendance at his rooms in Curtin between 1992 and 1994 she had not been expressing delusional ideas. He had diagnosed a paranoid disorder on the basis of a "presumption" that she must be misinterpreting her neighbours' actions and communications as harmful. When he had seen her on 16 September 1997 she had displayed no evidence of a delusional or thinking disturbance. Dr Roseman seems to have made a similar deduction in January 1996. He said that the history then available to him "suggested" a very mild psychotic illness.

In my view, this evidence does not establish that the appellant's condition was producing delusions, hallucinations or serious disorder of thought form as at the date of the hearing before the tribunal. Further difficulties arise in relation to any suggestion of severe disturbance of mood. Dr Roseman suggested in January 1996 that by then her reactions appeared to be due largely to the "quite common intransigence of people who have reached litigation." Dr Evans expressed a somewhat similar view in August 1997.

Whilst there is much to suggest that the appellant's behaviour may have been irrational on a number of occasions, the paucity of evidence makes it difficult to determine whether it should be regarded as "sustained or repeated" as required by the definition. Having regard to the nature of this legislation and the potential consequences of a finding of psychiatric illness, I think that this phrase should be construed as requiring more than mere evidence that irrational behaviour occurred on more than one occasion. In my view, the word 'repeated', used as an alternative to 'sustained', refers to a pattern of irrational behaviour or at least to behaviour of that kind which occurs with some measure of frequency. On the basis of the evidence before me it is difficult to determine whether the irrational behaviour has been repeated in that sense. It is even more difficult to determine whether such behaviour was indicative of the presence of delusions or any of the other sysmptoms referred to in the definition.

The Tribunal may have taken into account information obtained during previous applications or knowledge otherwise acquired but the medical reports to which I have referred and the other evidence contained in the transcript of the proceedings does not establish that the appellant was experiencing any such symptoms at the time of the order.

It may be argued that the phrase "is characterised by" means that the condition must be of such a character that it tends to produce symptoms of the kind described. In that event, all that would be required, apart from proof of serious impairment of mental functioning, would be evidence of the nature of the condition. There would be no need to establish that one or more of the relevant symptoms was continuing at the time of the order. Such a construction would no doubt be convenient but, in my view, it would be incorrect. The words of the definition require that the condition 'be characterised by*the presence in the person* of any of the symptoms (emphasis added). This suggests that it is not enought to show that the condition is of a kind which tends to produce such symptoms. They must actually be present in the person concerned. Furthemore, the use of the present tense suggests that the condition is so characterised only whilst one or more of the symptoms remains present in the person. No doubt this requirement of contemporaneity would need to be approached as a matter of practical reality. A person with a continuing pattern of delusions might perhaps be regarded as falling within this requirement even if there were short intervals between them. However, I do not accept that it is sufficient to point to the existence of a condition which tends to produce delusions and to presumptions that the person may have suffered from them at some

antecedent but unspecified time. Consequently, I am not satisfied that the evidence supports the finding that the appellant had a psychiatric illness at the time of the order.

Ms Tonkin also argued that there was insufficient evidence to justify the finding that the Order was necessary for her own protection. Section 27(1)(b) does not specify the nature of the risks which might justify an Order for "the persons own protection". However, since the section contemplates the deprivation of the liberty of a person not shown to be guilty of any criminal offence it is obvious that the grounds must be substantial. That is confirmed by the requirement that the Order be "necessary". One would expect that this provision would normally be invoked when it was necessary to protect the person from suicide, self mutilation or some other physical harm. It is true that there was an allegation made from the bar table to the affect that the appellant had threatened to commit suicide some six weeks or two months prior to the hearing and there was an implied admission from the appellant to the affect that that statement was made. However there is nothing in any of the psychiatric reports to suggest that there is a real risk that that threat might be implemented.

Mr Nash submitted that the risk of further assaults by the appellant gave rise to a corollary risk that she might suffer retaliation. This submission ignores the fact that the opinion is predicated upon the truth of unresolved allegations. In any event, in the absence of any evidence to suggest that it was a real possibility, I would not be prepared to assume that her neighbours would act violently towards a woman known to have a psychiatric illness. Nor would I be prepared to assume that there was an appreciable risk that it might be necessary to injure her in order to restrain her or otherwise in lawful self defence.

Alternatively, he submitted that she needed to be protected from the risk of criminal prosecution and the attendant shame and embarrassment. This submission is dependent to some extent upon inferences that might be drawn from the recent allegations of assault and property damage but those allegations have not been substantiated. There may be circumstances in which a person's psychiatric state is such that feelings of disgrace or humiliation occasioned by prosecution could be seen as involving a risk to a person's mental health but the evidence does not establish that such a risk exists in this case. The appellant is apparently aware of the implications of her behaviour and there is no impairment of her mental functions sufficient to absolve her of responsibility for her actions. I do not believe that the evidence discloses circumstances justifying the finding that the order was necessary for her own protection.

I have no doubt that this application has been brought by Dr Eramudugolla and supported by Dr Gupta in the best interests of the appellant. Similarly I have no doubt that the Community Advocate, Ms McGregor, has sought to maintain the present Order due to a genuine and heart felt concern for the appellant. I have given due consideration to her comprehensive written submission, and if I may say with due respect, reflected a very caring and responsible approach. I accept the overall impression urged upon me both by Mr Nash and Ms McGregor that it is in the appellant's own best interest that her disputes with her neighbours cease. Despite the paucity of evidence about such matters I am also inclined to accept that it is likely that unacceptable behaviour arising from her psychotic illness played some part in the creation and/or maintenance of those disputes. In these circumstances it is obviously desirable that she receive appropriate medical treatment. As Ms McGregor points out if she cannot be assisted to live in the community harmoniously the future for her may be very grim.

In these circumstances one can readily understand Mr Nash's submission that even if the prospects of successfully treating the condition are only 50-50, she should be given the benefit of that chance. However with due respect, the argument ignores the negative aspects of the proposal. The risk of side effects and the risk of further alienating the appellant and destroying any potential for obtaining her trust must be taken into account.

Furthermore, it was incumbent upon the Tribunal to have due regard for the provisions of s9 of the Act which is in the following terms:

"A person performing a function or exercising a power under this Act, or pursuant to an order of the Tribunal, in relation to a mentally dysfunctional person shall endeavour to ensure that any restrictions on that person's personal freedom and any derogation of that person's dignity and self-respect are kept to the minimum necessary for the proper care and protection of the person and the protection of the public."

It was also incumbent upon the Tribunal to take into account the matters referred to in s25 including the following:

"(a) the views and wishes of the person, so far as the can be ascertained;

(e) that the person's welfare and interests should be appropriately protected;

(f) that the person's rights should not be interfered with except for the least extent necessary;

(g) that the person should be encouraged to look after himself or herself;

(h) that, as far as possible, the person should live in the general community and join in community activities;

(j) that any restrictions placed on the person should be the minimum necessary for the safe and effective care of the person;

(k) the alternative treatments,. programs and other services available;

(n) the benefits likely to be derived by the person from those treatment, programs and services;

(p) the distress, discomforts, risk, side effects or other disadvantages associated with those treatments, programs and services."

Ultimately, it seems to me that this was an issue in which the Mental Health Tribunal should have been guided by the preponderance of psychiatric evidence. Indeed s.23 enjoins the Tribunal not to make a Mental Health Order without having regard to an assessment of the person conducted pursuant to an Order under s.16 or another assessment of the person that the Tribunal considers appropriate. The earlier report of Dr Evans reflected such an assessment. Of course, the Tribunal was not bound by it and was free to prefer the evidence of Dr Gupta. However the fact that the assessment by Dr Evans was supported by Dr Cullen, Dr Rosenman and, it seems Dr Lawrence, should have been seen by the Tribunal as establishing a formidable case against the making of such an Order.

Insofar as one may glean the mind of the Tribunal from the transcript, it appears that the opinions of Drs Evans, Cullen, Rosenman and perhaps, Lawrence, were discounted on the basis that they were proferred prior to and hence without knowledge of recent allegations, and conversely, the opinion of Dr Gupta, supported to some extent by that of Dr Eramundugolla, was preferred because it took those allegations into account. With due respect to the members of the Tribunal, this approach was obviously illogical unless the truth of the allegations could be assumed. Yet they were not admitted and the Tribunal declined to adjudicate upon their accuracy. Indeed, when the appellant protested, understandably enough, that the Tribunal seemed to be accepting that the allegations were correct without a hearing, she was told by the President that that was not the issue. When she persisted to say that she did not agree with what the neighbour had stated she was told that the Tribunal did not intend to have a five day hearing to decide the accuracy of the allegations.

It should be noted that whilst the Tribunal is required to observe the rules of natural justice it is not bound by the rules of evidence, but may inform itself on any matter relevant to such a proceeding in such a matter as it thinks fit. It is perhaps inevitable that the Tribunal will frequently be called upon to determine issues without direct evidence of the details of the person's relevant history. However, this was not an issue which the Tribunal determined, albeit by reference to hearsay or other evidence that would not have complied with the rules of evidence had they applied. It was an issue which the Tribunal did not determine at all. Furthermore, this issue was apparently decisive of the application. In this context, it was not open to the Tribunal to purport to leave the issue unresolved and then act on the assumption that the allegations were well founded. Nor was it a case in which the decision could be explained by reference to the mere fact that the allegations were made irrespective of their truth.

Mr Nash submitted that submissions which Ms Tonkin had made to the Tribunal suggested that the truth of the allegations was common ground. I do not accept that this was the case. It seems to me that Ms Tonkin was attempting to address the apprent gravity of the allegations in the face of an indication from the President that he did not wish to 're-canvass' the allegations and that they were only 'background history for the doctor's opinion.' I do not believe that statements of that kind would have alerted her to the risk that the Tribunal would blithely assume their truth and then use that assumption as the decisive factor in the case. It is plain that the appellant did not accept their truth and I have no doubt that Ms Tonkin would have vigorously asserted her client's right to have them properly resolved had she realised the implications of what was to occur. In any event, I do not accept that the Tribunal would have been entitled to act on the basis of allegations neither admitted nor otherwise substantiated merely because the appellant's counsel failed to protect or subsequently made submissions on the basis of the assumption which the Tribunal had embraced.

Mr Nash was ultimately driven to submit that the Tribunal was entitled to act upon the allegations even if unsubstantiated because they were of the same character as earlier allegations which had been sustantiated. I do not accept this submission. It is not clear what earlier allegations had been substanitated and the paucity of evidence made any realistic comparison of the present allegations with earlier incidents difficult. More importantly, the approach suggested would have involved an unacceptable abrogation of responsibility by the Tribunal and a grave infringement of the appellant's rights. Natural justice required that the appellant be made aware of any intention to act on the basis of the allegations and be given the opportunity to be heard in relation to their truth or falsity.

It cannot be said too emphatically that to deprive a person of his or her liberty on the basis of unsubstantiated allegations flies in the fact of the policy reflected in s9 of the Act and is contrary to the fundamental principles of freedom and justice which undergird a democratic society.

I am conscious of the specialist nature of the Mental Health Tribunal and the expertise which it is able to bring to cases of this nature. It's decisions are entitled to respect, especially when they are based upon assessments of competing psychiatric opinions. Nonetheless, I am driven to the conclusion that its decision was clearly wrong . The evidence of Dr Evans, based as it was on observations of the appellant in hospital over the course of a month, should have been given considerable weight. The fact that she, Dr Cullen and Dr Rosenman all expressed the opinion that the benefits of enforced medication were outweighed by the likely distress and potential side effects, should have been recognised as providing a strong if not compelling reason for refusing the application. As I have indicated, those opinions were apparently discounted and the contrary opinions of Drs Gupta and Eramudugolla preferred only because of disputed and unsubstantiated allegations. The evidence of Drs Evans, Cullen and Rosenman was not challenged in cross-examination and there is no reason to believe that their opinion would not have been accepted but for this approach.

An appeal of this nature is by way of re-hearing and it is open to the parties to urge this Court to make further or alternative findings. Mr Nash submitted that I should approach the matter afresh, particularly in view of the later report from Dr Evans. I have in fact made by own assessment of the evidence. It is true that Dr Evans has now expressed support for a trial of the 'antipsychotic' medication. However, her revised opinion is predicated upon the assumption that the truth of recent allegations can be established. They have not been. Furthermore, even on that assumption her support is based largely upon the perceived risk to the neighbours, but the Tribunal did not make any finding about the existence of such a risk.

Mr Nash submitted that I should make a fresh finding that the order was necessary for the protection of the community. I am not prepared to do so. It is a serious step to deprive a person of his or her liberty, especially if it is intended that the detention be used to facilitate involuntary psychiatric treatment such as enforced medication. In my view, such a step should be taken only when facts demonstrating the necessity for it have been established by clear and persuasive evidence and the person concerned has been given the opportunity to be heard. In the present case the submission that I should make such a finding was not foreshadowed by any notice of contention and was raised only after Ms Tonkin's submission in chief had been concluded. The evidence is largely hearsay and even that has not been tested in cross-examination. The appellant has not given evidence and was not in court when the submission was made. Furthermore, the conduct alleged is said to have occurred more than a month ago and she subsequently spent some ten days in the Psychiatry Unit at the Canberra Hospital during which she was apparently served with a further restraining order. Other options are available. Even if I had been satisfied that the appellant presently had a psychiatric illness as defined in s4, I would not have been satisfied that the mental health order appealed from was necessary for the protection of her neighbours or other members of the community.

Finally, I accept Ms Tonkin's submission that a mental health order of this nature should be regarded as a remedy of last resort. There was evidence that the appellant has some insight into her condition and is willing to address it by voluntarily attending for counselling. Dr Evans and others have expressed that view that psychotherapy alone is unlikely to prove

effective. That may well be so. However, it is but one of a number of available options. Even the course favoured by Dr Gupta had less than a 50:50 chance of successfully alleviating the appellant's symptoms. Furthermore as Drs Evans and Rosenman pointed out, those symptoms may provide at best a partial explanation for any ongoing hostility towards her neighbours. There has been a long history of acrimony which the appellant maintains is 'two-sided'. She believes that there is no hope of reconciliation. In these circumstances, it seems to me that any long term solution may need to involve some re-location so that the cycle of disputes may be broken. I have been informed that the appellant is intending to move to another area. Of course, it is possible that further problems may arise in her new location as Ms McGregor fears, but this should not be assumed. The applicant may need further assistance and it now appears that she acknowledges this. Psychotherapy in the context of a new start without the legacy of neighbourhood acrimony may offer some hope.

A further application may be made to the Tribunal at any time and its powers extend to making orders relating to a person's place of residence. Proof that a person is suffering from a psychiatric illness is not a condition precedent to the making of an order of that nature.

Of course, it is true that a change of location and some counselling may do little to arrest or reverse the deterioration in cognitive function apparently demonstrated. The evidence before me was insufficient to enable the nature and extent of that deterioration to be determined or any sensible view formed as to the best means of addressing it. The present order cannot be sustained on that ground.

The appeal must be upheld. Having regard to the intimation that the appellant intends to move to a new locations and is willing to attend for counselling and since it is open to the respondent to bring a fresh application, I propose to make no further orders.