



30 JUN 1995

### CATCHWORDS

MENTAL HEALTH - appeal against order of the Mental Health Tribunal of the Australian Capital Territory - order appealed against was that the appellant be detained in custody of Director of Mental Health Services pursuant to s27(2)(a) of the Mental Health (Treatment and Care) Act 1994 (ACT) - nature and extent of right to appeal from Mental Health Tribunal decision - requirement that an error of law or fact be demonstrated - rehearing *de novo* if considered necessary or desirable - power of Mental Health Tribunal to make a mental health order - requirement for and meaning of "mental dysfunction" - requirement for and meaning of "psychiatric illness" - were orders made within power - nature and extent of detention order - relevant factors when making detention order - need for "custodian" consent to making of detention order - nature and extent of treatment order - relevant factors when making treatment order.

### RETURN TO LIBRARY

Mental Health (Treatment and Care) Act 1994 (ACT), ss4, 5, 9, 14, 16, 23, 27, 28, 29, 36, 48, 103, 141, Part V (ss37-48)  
Magistrates Court Act 1930 (ACT), s214

*Campbell v Fortey* (1987) 85 FLR 462  
*Devries v Australian National Railways Commission* (1993) 177 CLR 472  
*M v R* (1994) 126 ALR 325  
*House v The King* (1936) 55 CLR 499  
*Humphries v TWT Ltd* (1993) 120 ALR 693.

**J v V**

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No. SCA 31 of 1995

Coram: Higgins J

Supreme Court of the ACT

30 June 1995

IN THE SUPREME COURT OF THE )  
 )  
AUSTRALIAN CAPITAL TERRITORY )

No. SCA 31 of 1995

BETWEEN: J

Appellant

AND: V

Respondent

### ORDER

Judge Making Order: Higgins J  
Where Made: Canberra  
Date of Order: 30 June 1995

#### THE COURT ORDERS THAT:

1. The appeal be upheld.
2. The respondent's application be remitted to the Mental Health Tribunal for rehearing according to law.

This is an appeal from a decision of the Mental Health Tribunal of the Australian Capital Territory dated 4 April 1995.

***The history of the matter***

On 12 March 1995, the appellant's mother applied, pursuant to the Mental Health (Treatment and Care) Act 1994 (ACT) (MH(T&C) Act) for an order from the Mental Health Tribunal (the Tribunal).

That application was based on the appellant's history of repeated attempts at suicide. In January 1994 she had attempted suicide by carbon monoxide poisoning. She survived but was hospitalised for five months. She suffered brain damage as a result of the effects of the carbon monoxide. This consequence has exacerbated the appellant's problems. She had previously abused both illicit drugs and alcohol. Since the suicide attempt in February 1994, that behaviour has continued. She has made numerous further attempts at suicide. There has been, in all probability, further brain damage from the excessive drug and alcohol consumption.

Dr Jeff Cubis, a psychiatrist and director of psychiatric services at Calvary Hospital, provided a report to the Tribunal dated 24 March 1995. He noted:

... a well established pattern by multiple suicide attempts (from overdose, self cutting, jumping from moving vehicles and apparent attempts jumping from MLC building and other carbon monoxide poisoning) she explained to me because she is aware of her brain damage she feels life holds for her no future...

He noted also "gross brain damage", in his opinion, due probably to carbon monoxide poisoning but contributed to by alcohol as well. It was considered that she was, as a result, unable to care for herself notwithstanding a superficially confident presentation.

she was, as a result, unable to care for herself notwithstanding a superficially confident presentation.

On 17 March 1995 an interim order was made committing the appellant to Calvary Hospital for one month. However, she left on 23 March 1995.

On 4 April 1995, evidence was given before the Tribunal by Dr Cubis. He indicated that his evidence was, in fact, based on observations made and opinions held by Dr Luby, another psychiatrist.

However, it was his personal opinion that the appellant's condition was not responsive to psychiatric treatment. The main problem he identified was the abuse of drugs and alcohol. The condition was not treatable by medication. As to that possibility, he said:

... when she's well, when she's not intoxicated from medication she's very pleasant, quite a lovely person and, you know, it probably would make her functioning worse and it would reduce her impulsivity. And because she has a significant deficit any drug that she were given probably would make her function worse rather than better. The problem is to really keep her abstinent and keep her in a controlled environment over a long period of time to try to reduce this sort of habitual behaviour of impulsively - intoxication followed by drug abuse followed by depression and this belief about being suicidal.

He was also asked to advise as to what long term solution, if any, there was to the obvious problem presented by the appellant. He offered the view that:

... she does need some time in a new environment over a long period of time, or new environment away from intoxication substances so she can actually just be - develop some stability in a life sort of routine which doesn't involve abuse - you know, drugs and alcohol.

It was his view, also, that the appellant was not "mentally ill". He said:

... there's that grey area between somebody with an intellectual handicap and somebody with psychiatric illness. But they overlap, and I think they overlap in Jane's case, but from my experience most of her problems relate to her intellectual - you know, cognitive to ... abuse rather than a psychiatric illness but I don't know - you know, I - that was from my - the most extensive contact I had with her while she was in inpatient in the ward for about a week.

There was, therefore, a grave dilemma which faced the Tribunal. The appellant was, on the evidence, a serious suicide risk. Naturally, this was a cause for anxiety to her family as well as to the Tribunal. However, she did not appear to have a "psychiatric illness" and, in any event, there was no short term cure. To keep her confined and supervised seven days a week, 365 days per year would have reduced the risk of suicide dramatically. It would, however, place an intolerable restriction upon the appellant's right to liberty.

The appellant herself expressed the view that the Tribunal was wasting its time.

She said:

No, no, I do not see any point in being here. There is nothing you can do. You cannot stop me from taking drugs and alcohol, you cannot stop me with my style of living. There is nothing you can do.

The Tribunal ordered that the appellant be detained, pursuant to s27(2)(a) of the MH(T&C) Act, for one month and that she remain in the custody of the Director of Mental Health Services (Dr Stephen Rosenman) at an ACT Mental Health Facility (Woden Valley Hospital, Psychiatric Unit). The Director was authorised, pursuant to s27(2)(c), to administer such "psychiatric treatment" as he considered necessary.

The Notice of Appeal, dated 11 April 1995, complained of the following alleged errors of law and fact by the Tribunal:

1. The finding that the appellant was suffering from a "psychiatric illness" within the meaning of s4 of the [MH(T&C)] Act.

2. The finding that the appellant was in need of treatment, of care and support or to be subject to prohibitions or conditions.
3. The finding that detention of the appellant was necessary.
4. The conclusion that the appellant lacked insight into her condition so that she was not capable of properly deciding for herself whether to agree to an order.
5. The conclusion that the appellant be detained despite the evidence of the examining doctor that the appellant is not mentally ill.
6. The finding that the appellant was "mentally dysfunctional", notwithstanding the provisions of s5(k) of the [MH(T&C)] Act.

On 13 April 1995 I made an interim order releasing the appellant subject to certain conditions following evidence from a psychiatrist, Dr Drew, that the appellant's mental state had improved sufficiently to render that course preferable to continued detention. Indeed, he saw a negative consequence from further detention at that time.

A further Notice of Appeal was filed on 20 April 1995 on behalf of the Director of Mental Health Services (the Director). That Notice complained of two errors, although five grounds were relied on. Those were, in summary, that:

1. The appellant was placed in the custody of the Director without his consent and without consultation with him contrary to ss103(1) and (2) of the [MH(T&C)] Act, and was to be detained at the Woden Valley Psychiatric Unit without confirmation by the Director that such detention could be there enforced.
2. The finding that the appellant was suffering from a "psychiatric illness" within the meaning of s4 of the [MH(T&C)] Act.

***Nature and Extent of the right to appeal***

The Tribunal itself has the power to vary or revoke any order it has made: see s36 MH(T&C) Act.

An appeal to this Court from a decision of the Tribunal is authorised by s141 MH(T&C) Act. It is an appeal as of right: see s141(2). The powers of this Court on appeal are expressed in s141(4), in the following terms:

The Supreme Court shall hear and determine the appeal and may make such orders as are just, including an order -

- (a) confirming the decision;
- (b) setting the decision aside and remitting the matter to the Tribunal with directions;  
or
- (c) substituting its own decision.

Section 141(5) MH(T&C) Act expressly equates such an appeal with an appeal to which s214(1) of the Magistrates Court Act 1930 (ACT) (MCA) applies. It expressly applies ss214(3) and (4) but not (2) MCA.

Section 214(2) MCA places a restriction on appeals to which s214(1) MCA applies.

It states:

In an appeal to which this section applies, the Supreme Court shall have regard to the evidence given in the proceedings out of which the appeal arose, and has power to draw inferences of fact.

Subsections 214(3) and (4) MCA permit the Supreme Court to receive further evidence. That discretion was considered in *Campbell v Fortey* (1987) 85 FLR 462

The nature of an appeal pursuant to s214(1) MCA has been held to be by way of rehearing: see *Campbell v Fortey* (supra).

Insofar as a decision of the Tribunal depends on the assessment by the Tribunal as to the acceptance of the credibility of a witness not seen or heard by this Court, the

principles affirmed by the High Court in *Devries v Australian National Railways Commission* (1993) 177 CLR 472 will apply.

With appropriate modification for the different standard of proof and different issues, it seems to me that the principles affirmed by the High Court in *M v R* (1994) 126 ALR 325 will also apply in the event that the result appealed from appears erroneous. It is also necessary to give due deference to the exercise of any discretionary judgment made by the Tribunal: see *House v The King* (1936) 55 CLR 499; *Humphries v TWT Ltd* (1993) 120 ALR 693.

It is, nevertheless, the duty of this Court to ensure that the orders appealed from are to be amended or revoked so as to achieve a result which is "just": see s141(4) MH(T&C) Act.

It is an important consideration that orders of the Tribunal may restrict the liberty of persons and subject them to compulsory medical treatment. Those restrictions would, ordinarily, infringe the rights of citizens and should, therefore, be imposed only so far as necessary and within statutory authority. It is not a sufficient reason for exercising such drastic powers that the subject of their exercise might benefit from that action.

That consideration is confirmed by the terms of s9 MH(T&C) Act. That section provides:

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.

Section 9, in my view, applies to this Court on the hearing of an appeal under s141 MH(T&C) Act.

It seems to me, therefore, that the powers of this Court on appeal are wide enough to embrace a rehearing *de novo*, if that is considered necessary or desirable. It is the duty of the Court to ensure that the result achieved is not only according to law but also just. It can have regard to further developments in relation to the appellant and act on them, as the Tribunal might pursuant to s36 MH(T&C) Act.

Further, it is not a necessary pre-condition to the exercise by this Court of its powers under s141 MH(T&C) Act that an error of fact or law on the part of the Tribunal be demonstrated. It is enough that the Court is satisfied that justice requires the exercise of its power to set aside or vary the Tribunal's orders or to cause the Tribunal so to do on a reference back to it. In the course of that process the Court will, of course, pay due regard to and give due respect to the findings and orders of the Tribunal. That regard and respect includes an appreciation of the specialist nature of the Tribunal and of the skill and experience of its membership.

***What is "mental dysfunction" and was the appellant a person suffering therefrom?***

The term "mental dysfunction" is defined by s4 MH(T&C) Act. It means:

... a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.

There are behaviours or attitudes of a person referred to in s5 MH(T&C) Act, the manifestation whereof are not to be considered as rendering that person "mentally dysfunctional".

Particular reference was made, in the circumstances of the present case, to s5(k) MH(T&C) Act, that is:

That the person takes or has taken alcohol or any other drug.

Thus, if a person is addicted to alcohol and/or other drugs and exhibits, as a result, any or all of the categories of disturbance or defect referred to in s4, that person is not to be regarded as mentally dysfunctional because of that behaviour. This will be so whether or not the addiction results in substantial disability.

However, that does not mean that a person who habitually consumes alcohol and other drugs so as to be substantially disabled will never be "mentally dysfunctional". It will depend on the reason for, or result of, that habitual use. Habitual use might lead to or evidence mental dysfunction. If, for example, brain damage or a psychiatric condition results from drug abuse, the person so affected might be regarded as mentally dysfunctional, not merely because of the drug and alcohol abuse, but because of that drug induced brain damage or psychiatric condition.

The definition of "mental dysfunction" focuses on the effect exhibited not the cause of that effect. Section 5 focuses on behaviour not on the cause of that behaviour.

The behaviour of the appellant, as summarised by Dr Cubis, is:

... drug and alcohol abuse, punctuated now in a well established pattern by multiple suicide attempts ...

... [name used] is unable to care for herself (ie she cannot manage money, she cannot manage to cook, she consistently loses her way in the hospital).

... she is a brain damaged alcoholic with evidence of earlier immature personality disorder in her life, who needs care but declines to have it.

It follows, therefore, that the first consideration is the behaviour of the person who is allegedly mentally dysfunctional. If, from that behaviour, active or passive, it is apparent that they suffer from one or more of the disturbances or defects referred to in the statutory definition, then the person is mentally dysfunctional if those disturbances or defects are present to "a substantially disabling degree".

It is clear from Dr Cubis' report and evidence and, indeed, from Dr Drew's affidavit of 12 April 1995, notwithstanding his inadmissible legal opinion, that the appellant suffers from impaired judgment and motivation as a result of which she engages in excessive and dangerous drug and alcohol consumption as well as self-destructive behaviour with a view to suicide.

The impaired judgment and/or impaired motivation, even if it leads to disabling behaviour, is not to be regarded as a mental dysfunction insofar as it merely results in any, or even all, of the behaviours enumerated in s5.

It must be stressed that the existence or not of a psychiatric condition causing the behaviours referred to in s5, or the disturbances or defects referred to in the definition of "mental dysfunction", is immaterial.

However, in this case, there are two other categories of behaviour causing concern. They are the multiple suicide attempts, usually associated with drug and alcohol abuse, and the lack of capacity, as described, for self-care. They are, in themselves, "substantially disabling" behaviours.

The phrase "disturbance or defect" implies some condition of a person that is continuing. A person might, for example, be overcome by grief. He or she might become unable to eat. That would, for the duration of that emotional disturbance, be "substantially disabling". However, for most persons, such an emotional disturbance and the disabling effect of it will be transitory. It is only if such disturbance and disability becomes entrenched that it can be regarded as a "disturbance or defect" sufficient to render the person "mentally dysfunctional". It is a question of degree as well as of duration.

The mere fact that behaviour evidencing a relevant disturbance or defect is spasmodic does not mean that, during the absence of such behaviour, the person has ceased to be mentally dysfunctional. The question is whether the disturbance or defect, as evidenced by the relevant behaviour is continuing at the relevant time or whether it is not. That is a question of fact for the Tribunal to determine.

It was, in this case, open to the Tribunal to conclude and I also conclude, that the appellant is, and then was, "mentally dysfunctional".

***Was there power to make a "Mental Health Order" and did the appellant suffer from a "psychiatric illness"?***

A finding of "mental dysfunction" is a necessary precondition to the making of a "mental health order". Mental health orders are orders of the kind referred to in s29 MH(T&C) Act.

The application in this case was made pursuant to s14 MH(T&C) Act. That section empowers a person to make application for a mental health order in respect of another person if the applicant:

... believes on reasonable grounds [that the person] -

(a) is unable, because of mental dysfunction -

(i) to make reasonable judgments about matters relating to his or her health or safety; or

(ii) to do anything necessary for his or her health or safety;

and, as a result, the person's health or safety is, or is likely to be, substantially at risk.

It may be noted that a person who is at risk of self-harm is not, by reason only of that fact, liable to be a respondent to an application for a mental health order. The "risk in question" must be believed, on reasonable grounds, to arise from the state of "mental dysfunction" of the respondent.

Pursuant to s23 MH(T&C) Act, the Tribunal may not make a mental health order unless there has been an "assessment" of the respondent. The Tribunal may order an assessment under s16 if "prima facie satisfied" that the respondent is "mentally dysfunctional" and "at risk" in the sense referred to in s14(1)(a).

Section 28(2) enables a "mental health order" to be made in respect of a person if 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 substantially at risk; or
  - (ii) the person is, or is likely to be, a danger to the community.

The types of mental health order which might be made are prescribed by s29 MH(T&C) Act.

There is a further precondition in respect of the order prescribed by s29(a), that is:

an order for a person to undergo psychiatric treatment, other than convulsive therapy or psychiatric surgery.

That precondition is specified by s28(3), that is:

The Tribunal shall 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.

The term "psychiatric illness" is defined in s4 as follows:

... 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 paragraphs (a), (b), (c) or (d).

Thus to have a "psychiatric illness" there must not only be "serious" impairment of mental functioning but also one or more of the symptoms in (a) to (d) inclusive. Irrational behaviour, even if accompanied by such serious impairment will not suffice

unless it is indicative of the presence of one or more of the symptoms in (a) to (d) inclusive.

I have agreed with the finding of the Tribunal as to "mental dysfunction". There is some hope that whilst the underlying brain deficit is permanent, there can be some recovery over time if alcohol and drug abuse is eliminated. That development, in turn, would reduce the risk of self-destructive behaviour and enable more productive behaviour patterns to become entrenched. Capacity for self-care, although not likely to be completely restored, is likely then to become improved.

That mental dysfunction clearly has placed, and, at the present time, continues to place, the appellant's health and safety "substantially at risk". She was similarly "at risk" when the Tribunal made its decision.

It seems to me, therefore, that the Tribunal was, pursuant to s28(2) MH(T&C) Act, empowered to make a "mental health order".

***Was it open to the Tribunal to make the "mental health orders" which it did?***

The appellant was clearly in need of care and support. Given the appellant's refusal to consent to any order, and the need to give her protection from the consequences of her current state of mental dysfunction, it was open to the Tribunal to make an involuntary order pursuant to s27 MH(T&C) Act.

The orders in fact made were for treatment and detention in the custody of the Director. The terms of those orders were:

- 1 Detention pursuant to Section 27(2) for a period of one month and that the Respondent be required to remain in the custody of the Director of Mental Health Services at an ACT Mental Health Facility (Woden Valley Hospital, Psychiatric Unit).
- 2 That the Respondent has a psychiatric illness and the Director of Mental Health Services is authorized to administer such psychiatric treatment as he thinks necessary pursuant to Section 27(2)(c) for a period of one month.

**(i) The detention order**

The detention order made relies for its compulsory force on s27(2)(a) MH(T&C) Act.

That provides:

- (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.

The person specified in the order was the Director. The Director was present when the detention order was made. It was not sought by the Director. The Director was not asked to consent to be the "custodian". The Tribunal specified Woden Valley Psychiatric Unit at Woden Valley Hospital as the place of detention. The Director neither consented to nor requested that place to be specified for the purposes of any detention order.

Indeed, although the transcript is far from clear, it does seem that, as soon as the Tribunal articulated its findings and proposed orders, the Director asked for a transcript of the proceedings, "... for the Supreme Court appeal ...".

The Director further expressed his concern in the following terms:

... at the moment I have no beds to put her in. I will have to go and move somebody out into the ward. I know that they are actually already one bed over - they are already one patient over the numbers. I may have to work out some means of accommodating this person by discharging somebody.

The Director also expressed concern as to whether, given the order of the Tribunal, he could grant leave to the appellant to leave his custody. The learned President expressed the opinion that it was probably within the Director's power but the Tribunal could give directions if required.

There was, to my mind, no question but that the Director did not consent to be the "custodian" or to the specification of the place of detention. The Tribunal gave an instruction. That was clear from the following exchange:

Director:           So you are instructing me to hold her for a month?

President           Yes.

In fact, a bed was found and the appellant was kept at Woden Valley Psychiatric Unit until I made an interim order conditionally releasing her on 13 April 1995.

The "custodian" referred to in s27(2) MH(T&C) Act is not necessarily the Director. If it was intended that the "custodian" be the Director, then the "custodian" would have been referred to by that title not as "the custodian". That inference becomes irresistible when it is noted that, in relation to a person who has a psychiatric illness, express provision is made that only the Director may administer or authorise the administration of "psychiatric treatment" pursuant to s27(2)(c).

It is impossible to believe that the legislature could have intended that persons could, without their consent, be appointed "custodian" of a mentally dysfunctional person.

It follows that the Tribunal was not empowered under either s27(2) or s29 MH(T&C) Act to order the Director without his consent to be custodian of the appellant.

That would suffice to require the first order to be set aside.

There is, however, another difficulty. It is true that the Tribunal is empowered under s29(e) MH(T&C) Act to make an order requiring a person who falls within s28(2):

... to reside in a specified place subject to specified conditions (if any).

The custodian may also be empowered pursuant to s27(2)(a) to specify the "premises" at which the person referred to in s27(1) may be obliged to remain.

Again, it is impossible to believe that a place or premises could be specified either by the Tribunal or the custodian unless that place or those premises were reasonably available to accommodate the person. There may be places or premises under a duty to accept the person or at which the person has a right to remain or reside. In that latter case, consent of the person in charge thereof would be otiose. However, nothing in the MH(T&C) Act requires the Woden Valley Psychiatric Unit, even assuming it to be a "psychiatric institution" within the meaning of s4 MH(T&C) Act, to accept a person even if the Tribunal considers that such person should be within such an institution.

There is an express exception to that proposition created by Part V of the MH(T&C) Act (ss37-48) but only for the purposes of emergency detention and care, pending a Tribunal hearing or order.

The existence of such provisions in Part V strengthens the conclusion that the power of the Tribunal does not extend to requiring the persons in charge of an "approved health facility": see s4 and s48(a) MH(T&C) Act, or an "approved mental health facility": see s4 and s48(b) MH(T&C) Act, to accept a person the Tribunal considers should be detained without the consent of such person or persons. *A fortiori*, a residential order would require the agreement of any person, not being the mentally dysfunctional person, who is in charge of such residence unless that person has an existing legal duty to exercise care and control over such person.

This is not to deny the ethical duty of mental health professionals and the Executive Government of the Territory to provide facilities to accept and care for persons the Tribunal identifies as persons who should be subject to confinement and/or treatment.

The need for agreement with relevant mental health professionals in relation to the disposition of a mentally dysfunctional person is highlighted by the terms of s103 MH(T&C) Act. That section provides:

(1) Before making a mental health order the Tribunal shall, as far as practicable, consult -

(a) the mental health professionals most likely to be responsible for providing the treatment, programs and other services proposed to be ordered.

The other persons referred to in s103(1)(b)-(d) are not relevant for present purposes.

It follows that it was not open to the Tribunal to order the person in charge of the Woden Valley Psychiatric Unit or the Director to detain the appellant at that Unit.

More fundamentally, insofar as the Tribunal was invoking the power conferred on it under s27(2)(a) MH(T&C) Act, the power to specify the "premises" at which the person should be held is conferred on the "custodian" not the Tribunal.

**(ii) *The treatment order***

The second order was one which was in terms of s27(2)(c) MH(T&C) Act. It merely conferred a power on the Director. If the Director did not consider that there was any effective or useful treatment to be administered, it was not mandatory for him to do anything pursuant to that authority.

However, the objection raised to the making of the second order was that it depended on a finding that the appellant had a "psychiatric illness". That finding is challenged.

The term "psychiatric illness" is not necessarily to be equated with a recognised and definable disease as recognised by psychiatrists. It is a legal not a medical term. Medical opinion is relevant only insofar as it affirms or denies the existence in fact of the elements of the legal definition contained in s4 MH(T&C) Act.

Whether there is "a condition" or not is a judgment about the constitution of a person implying some current physical or mental state. The state of the person must then be judged to be one which "seriously impairs" that person's "mental functioning". The brain damage suffered by the appellant, having regard to the effects of it, as attested by Dr Cubis, would satisfy this part of the definition.

It is certainly correct, in this case, to regard the appellant's desire to engage in self-destructive behaviour, including alcohol and drug abuse and suicide attempts, as being a consequence induced by the appellant's brain damage and personality disorder, as diagnosed by Dr Cubis. That consequential effect on the appellant's behaviour may be characterised as resulting in "sustained or repeated irrational behaviour".

However, irrespective of any other diagnostic characterisation of the appellant's condition, there must also be present overtly, or as indicated by such irrational behaviour, one or more of the symptoms referred to in (a) to (d) of the definition.

The reason for the appellant's "sustained or repeated irrational behaviour" relates back to her upbringing. There is not a lot of detail given as to that. It may be inferred that the "alcoholic father" to whom Dr Cubis refers in his assessment, played a part in the "drifting" existence in which the appellant engaged up to January 1994.

Until then, her lifestyle was characterised by unemployment, drinking heavily, abuse of drugs and homelessness.

Although these behaviours are undesirable and, to an extent, self destructive, even life-threatening, the decision to engage in them could not necessarily be described as irrational.

Even the suicide attempt in January 1994 can be seen as a not unexpected concomitant of the appellant's lifestyle. Immediately before that suicide attempt, there may have been some mental state present which could then have been described as exhibiting "a severe disturbance of mood" which was itself caused by a condition seriously impairing the appellant's mental functioning. However, there was no material before the Tribunal to enable a finding as to the existence of such a condition. Not all persons who attempt suicide can be regarded as having acted irrationally at the time. Not all persons who do behave irrationally in attempting suicide do so by reason of such a condition or suffer from any of the symptoms referred to in (a) to (d) of the definition.

The terms "delusions" and "hallucinations" are sufficiently well understood English words to require no additional explanation. A delusion is a false perception of things which are, nevertheless, actually occurring. An hallucination is the perception of things not actually present or existing. There is no evidence of any such disorder in the appellant's perception of reality.

The term "serious disorder of thought form" is an unusual phrase. I asked the Director, who offered some helpful submissions on the appeal, to explain what it conveyed to him. He indicated that it was a technical medical term. His explanation of its meaning was as follows:

It relates to a key feature of schizophrenia really, which is called "formal thought disorder" or "disorder of the thought form" which relates to the structural properties of thought, that is, how one idea follows from another. How related ideas are incorporated without losing the determinative flow ...

Its presence may be judged from what a person says or does.

It is clear that the bad judgment of the appellant in engaging in self-destructive and suicidal behaviours is not illustrative of any such symptom being present. No evidence was or has now been presented to warrant a view that she has or ever has had any "disorder of thought form", serious or otherwise.

The Director also indicated that the phrase "severe disturbance of mood" has particular meaning to psychiatrists. He said:

... psychiatrists use "mood" and "affect" in the slightly different ways. "Mood" being a predominant and continuing tone rather than "affect" which is intense emotions of the transient nature, so we can end up saying that somebody can be very miserable, upset transiently has a form of affect, but the clinical diagnosis of depression relates to the lasting tone of mood rather than the momentary manifestations of emotion.

The use of the qualifying words "severe disturbance" indicate to me that the term "mood" is used in the sense of a lasting effect, albeit not permanent. It conveys something more than emotional disturbance of a transient nature, however intense that may be.

After her suicide attempt in January 1994, Dr Cubis diagnosed the appellant as having had "earlier immature personality disorder". That condition was apparently characterised by lack of motivation and by drug and alcohol abuse. Whether the first suicide attempt was the result of a severe disturbance of "mood" or of "affect" I cannot say. It is more likely than not, of course, that there was a "severe disturbance" but whether it indicated a "predominant and continuing tone" or "intense emotions of a transient nature" is unclear. At that stage, therefore, it cannot be concluded that the appellant had a "psychiatric illness".

That first suicide attempt, however, caused or contributed substantially to gross brain damage. That has, understandably, exacerbated the appellant's general sense of misery. She endeavours to relieve herself of those feelings by abuse of alcohol and drugs leading occasionally, but repeatedly, to suicide attempts. That conduct, it seems to me, indicates the presence of a "severe disturbance" of the appellant's emotional state. That disturbance now is a "predominant and continuing tone" rather than transient upset. Thus the disturbance in question is of "mood" not merely of "affect".

The Tribunal correctly concluded, therefore, that the appellant had been shown to have had a "psychiatric illness".

The Director submitted that in clinical terms, the appellant, whilst brain damaged, was not suffering a psychiatric illness as he understood the term. Dr Drew, in an affidavit, also had expressed the opinion that, as at 12 April 1995:

... Ms McLaughlin is not, at this time, a mentally dysfunctional person in the meaning of the Act. She does not have a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation, or emotion. However, she does have impaired judgment concerning whether or not she should use drugs to excess particularly as she is aware of the usual ill-effect of such behaviour.

I have already indicated why, in my view, the appellant was "mentally dysfunctional", as that term is legally defined, at all relevant times. Those findings indicate the difference between legal definitions and medical terms.

However, Dr Drew's clinical judgment does focus on a question relevant for present purposes.

I have already concluded that a detention order should not have been made without the consent of the custodian. There is a further question in relation to whether a treatment ought to have been made when the available psychiatric opinion suggested that the appellant's condition is not one requiring or amenable to "treatment", as the treating psychiatrists understood that term.

"Treatment" seems to me to be distinguishable from "counselling, training, therapeutic or rehabilitation program": see s29(a) and (b) MH(T&C) Act. In context, "treatment" refers to some intrusive intervention such as surgery, administration of drugs, manipulation of limbs or otherwise dealing with or operating upon a disease or affection, a part of the body, or a person in order to relieve or cure. Of course, the distinction between psychotherapy administered by a psychiatrist and psychiatric counselling with a psychologist may be difficult to perceive. Indeed,

although the former might be thought of as psychiatric "treatment" it may well, for the purposes of the MH(T&C) Act, be regarded as within s29(b) rather than s29(a).

Given the restriction on compulsory psychiatric treatment, particularly surgery and convulsive therapy, it seems to me that such restrictions are intended to apply to physically interventionist or intrusive therapies rather than to psychiatric therapy or psychological counselling of a non-physical kind.

Whilst a person may be a person in respect of whom the Director may be authorised to administer or direct treatment, it does not follow that he must do so.

He will be guided by his own professional judgment, whether after advice from others or otherwise. It would be an error for the Tribunal to mandate the administration of treatment by or at the instigation of the Director.

An order under s29(a) MH(T&C) Act is different. It binds the patient to accept specified treatment. That assumes that a qualified person is prepared to administer the same. I do not believe that the Tribunal could (or indeed would, even if it could) order a health professional to administer treatment or therapy which he or she considered inappropriate.

However, that is not the effect of this order. It merely conferred authority. It imposed no duty other than the duty of professional responsibility already carried by the Director.

That order was, therefore, validly made as the appellant was correctly characterised as a person suffering from a "psychiatric illness". It was, therefore, open to the Tribunal to have made an order under s29(a) MH(T&C) Act if it appeared otherwise efficacious so to do.

There remains, of course, the question whether it was appropriate to make such an order.

It is not clear to me, on the material before the Tribunal, whether there was a requirement on the part of the appellant for "treatment". Certainly, a counselling, therapeutic and/or rehabilitation program was a process which may have been considered necessary. It might also have been considered appropriate to make an order under s29(d) to address the abuse by the appellant of alcohol and drugs.

There was no material indicating that a treatment order was appropriate, even though the Tribunal had power, in the circumstances, to make one although it is possible that some intervention which might be regarded as "treatment" could, if more information had been given, be found to be relevant.

### ***Conclusion***

I have indicated that, although the Tribunal was right to conclude that the appellant satisfied s28(2) MH(T&C) Act, it should not have made the detention order it pronounced without the agreement of the proposed custodian. Nor should it have specified a place of detention. That power is vested in the custodian not the

Tribunal. In any event, no place could be specified unless the person or persons in charge thereof could, and would, receive the appellant.

It was open to have made the second order but, given my interpretation of the word "treatment", orders under s29(b) and (d) might have been more appropriate. There was no material warranting an order under s29(a).

In the result, I consider that I should uphold the appeals and remit the respondent's application to the Tribunal to be further considered in the light of these reasons and to be then further dealt with according to law.

I wish to add that this is the first occasion upon which the proceedings of the Tribunal have been subjected to judicial scrutiny. Although I have differed in some respects from the view adopted by the Tribunal, I do not wish to have it believed that the Tribunal has done otherwise than conscientiously pursue its duty.

The matter involving the appellant is a most difficult one. Compassion and concern for our fellow human beings inspires us to wish to protect them, even from themselves. The respondent is a caring mother seeking to protect her child. That child, though an adult, is clearly at risk. The respondent and the Tribunal have each sought only to advance the health and safety of the appellant. If it be considered in the light of these reasons that it over-stepped its legal limitations, it was plainly done both in sincere belief that such limits were being respected and in the interests of the appellant.

That is not to say that the Director, his staff and consultants have any different interest. Indeed, Dr Drew has, I believe, achieved some advances in the interests of the appellant that are quite encouraging.

There was raised on the hearing of this appeal a concern by the Community Advocate that there is no coherent community response to the plight of persons who, lacking the capacity for sound judgment, abuse alcohol and drugs, thereby placing their lives at risk. In the absence of a proper response being available, Ms Macgregor, the Community Advocate, raised the very pertinent question as to whether it is warranted simply to detain such persons involuntarily. That is a very troubling question.

In this appeal, perhaps fortunately, I do not need to address the question as to whether the community's response, through provision of resources to aid those falling outside the traditional "psychiatric patient" model, is adequate. Nevertheless, it is a concern which the proper authorities will need to address.

I certify that this and the 26  
preceding pages are a true copy of the  
Reasons for Judgment herein of his Honour  
Mr. Justice Higgins

Associate

Dated: 29/6/95

*F. Smith*

**J v V**

No. SCA 31 of 1995

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Instructing solicitors: Office of Community Advocate

Date of hearing: 26 April 1995

Date of judgment: 30 June 1995