MENTAL HEALTH COURT

CITATION:	*In the matter of BAC* [2019] QMHC 4
PROCEEDING:	Appeal 0007/19
DELIVERED ON:	2 May 2019
DELIVERED AT:	Brisbane
HEARING DATES:	2 and 3 April 2019
JUDGE:	Dalton J
ASSISTING PSYCHIATRISTS:	Dr JG Reddan and Dr AE Simpson
DETERMINATIONS:	**1. Appeal allowed.** **2. Set aside the decision of the Mental Health Review Tribunal of 2 November 2018.** **3. Make a Forensic Order (Mental Health) Community Category with the condition at [41] *infra*.** **4. The above orders are stayed for three months, unless this Court orders otherwise.**
CATCHWORDS:	MENTAL HEALTH – APPEAL – DECLARATION OR FINDING OF A DECISION OF THE MENTAL HEALTH REVIEW TRIBUNAL – appeal against a decision of the Mental Health Review Tribunal – whether BAC has a mental illness or a mental condition other than an intellectual disability – whether the Mental Health Act 2016 (Qld) authorises only care, and not treatment under a Forensic Order – whether the provisions of the Mental Health Act 2016 show that treatment is to be provided for people with illnesses; whereas care is to be provided to people with intellectual disabilities – where the resolution of the appeal depends upon the construction of the provisions in the Mental Health Act 2016, the Disability Services Act 2006 (Qld) and the legislative history of those Acts *Disability Services Act* 2006 (Qld), s 145 *Forensic Disability Act* 2011 (Qld) *Guardianship and Administration Act* 2000 (Qld), s 80 *Mental Health Act* 2000 (Qld), s 204, s 288, s 296, s 297, s 309, s 606, s 612 *Mental Health Act* 2016 (Qld) s 2, s 8, s 10, s 134, s 143, s 151, s 152, s 457, s 836, s 851

Alphadale Pty Ltd v Chief Executive, Department of Environment and Heritage Protection [2016] QLAC 6
Rankin; Kumar, and Sciortino [2017] QMHC 8
Re: Langham & Ors [2006] 1 Qd R 1

COUNSEL:	DM Cormack for the appellant LD Reece for the Office of the Chief Psychiatrist AK Lossberg for Crown Law
SOLICITORS:	Queensland Advocacy Incorporated for the appellant The Office of the Chief Psychiatrist Crown Law

NOTE: This judgment is published pursuant to s 790 of the *Mental Health Act 2016.* It has been anonymised.

[1] This is an appeal against a decision of the Mental Health Review Tribunal (MHRT) of 2 November 2018; reasons 27 November 2018. The decision of the MHRT was to confirm the existing Forensic Order (Mental Health) which dates from 2005. The appellant, by the Public Guardian, says that the Forensic Order should be a Forensic Order (Disability), but acknowledges this Court may not have power to make the appropriate change. The appellant does seek that this Court make changes to the Forensic Order so that it allows only involuntary care and not (as it presently does) involuntary treatment.

The Issue Raised on Behalf of BAC

[2] Dr Bayley, psychiatrist, described that prior to committing the offences which were referred to the Mental Health Court in 2005, BAC lived homeless in the community. She describes his situation then as "just terrible" – t 1-11. He was being exploited. He was engaging in risky behaviours, and ultimately offended. She said, "… if you meet this man, you think, 'How on earth can this man have been living without intellectual disability support?'" – t 1-11.

[3] By contrast, she described that BAC was now happy and content. He was safe, looked after, and did things that he enjoyed. This change was as a result of a whole package of care, not just the administration of medication, or one particular medication – t 1-11. BAC currently lives by himself in a unit. He has care workers who attend upon him 24 hours a day to see that he is safe.

[4] However, he is also prescribed Androcur (Cyproterone Acetate). This is a drug which reduces his testosterone production. It has potentially serious side effects. He is also prescribed a range of drugs – Sodium Valproate; Citalopram, and Chlorpromazine (Largactil) – which can have sedating effects, although they may have other effects.

[5] In the past it seems that BAC behaved badly and that these behaviours included violent behaviour and sexual misbehaviour. However, as the file review dated 26 October 2018 shows, from around 2013, at least, these behaviours have been much reduced. Indeed, so

far as sexual behaviour is concerned, he seems to confine himself to hugging or kissing behaviour and inappropriate conversation, such as asking females who he comes into contact with whether they will marry him etc.

[6] Since 2004 the Public Guardian has been involved in BAC's affairs. The present status is that by a QCAT order of 23 October 2017, the Public Guardian is appointed to determine what Restrictive Practices[1] BAC may be subject to, and by a QCAT order of 19 March 2018, the Public Guardian is appointed for decisions about health care service provision and legal matters.

[7] For some years the Public Guardian has been advocating for BAC's doctors to consider reducing the amount of Androcur and other potentially sedating drugs he receives.[2] His treating clinicians have been discussing reducing his dosage of Androcur slowly to see if his behaviour deteriorates. For example, in a letter dated 12 June 2017 Dr Galstuck-Leon, a psychiatrist specialising in disability, recommended to the treating team that BAC receive 50mg reductions in his dose of Androcur at three monthly intervals. This would mean he would be entirely off the drug in one year, provided his behaviour remained stable. The letter also recommended a slow reduction in Sodium Valproate which (the letter stated) was originally prescribed for, "challenging behaviours which are not existent at present."

[8] Dr Bayley gave evidence before me that she thought it possible to undertake a trial of reducing the dosage of Androcur BAC is given. She also would reduce the dose incrementally and slowly – see her report.

[9] In March 2018 Dr Reddy took over BAC's treatment and his interaction with the Public Guardian appears to have been confrontational. This has brought to a head the above issues which have been simmering unresolved for some time. Dr Reddy asserts his authority to prescribe Androcur and other sedating medication to BAC under the Forensic Order. The Public Guardian asserts that Androcur and the other potentially sedating medications cannot be prescribed under the Forensic Order, but only on its authority.

[10] Apparently in reaction to Dr Reddy's attitude, on 28 March 2018 the Public Guardian withdrew consent for Androcur to be prescribed at all. Dr Reddy continues to prescribe it notwithstanding. In the proceedings before me the Public Guardian accepted that Dr Bayley's suggestion of a slow trial in which the amount of Androcur prescribed to BAC is decreased over time is in fact the only sensible course available in BAC's interests.

[11] The resolution of this appeal depends upon the construction of provisions in the *Mental Health Act* 2016 (Qld) and also the *Disability Services Act* 2006. As a preliminary to construing those provisions I set out the definition of "chemical restraint" in s 145 of the *Disability Services Act*:

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1 As defined by s 144 of the *Disability Services Act* 2006 (Qld), this includes the use of "chemical restraint" which is in turn defined by s 145 of that Act as using medication for the primary purpose of controlling someone's behaviour; see [11] below for the complete definition.

2 It appears the Public Guardian obtained a report from Professor O'Brien in 2012 to the effect that BAC's dosage of Androcur should be reduced.

"**145 Meaning of chemical restraint**

(1) *Chemical restraint*, of an adult with an intellectual or cognitive disability, means the use of medication for the primary purpose of controlling the adult's behaviour in response to the adult's behaviour that causes harm to the adult or others.

Note—

Harm to a person includes physical harm to the person and a serious risk of physical harm to the person. See section 144, definition *harm*.

(2) However, the following are not chemical restraint—

(a) using medication for the proper treatment of a diagnosed mental illness or physical condition;

(b) using medication, for example a sedative, prescribed by a medical practitioner to facilitate or enable the adult to receive a single instance of health care under the GAA.

Example of when subsection (2)(b) applies—

sedating an adult before attending a dentist appointment is not chemical restraint

(3) To remove any doubt, it is declared that an intellectual or cognitive disability is not a physical condition.

(4) In this section—

diagnosed, for a mental illness or physical condition, means a doctor confirms the adult has the illness or condition.

mental illness see the *Mental Health Act* 2016, section 10." (my underlining).

Does BAC have a Mental Illness or a Mental Condition?

[12] BAC is 52 years of age. He has a congenital intellectual disability. As well, he suffered from a hypoxic brain injury from near-drowning at age three.

[13] The earliest report before this Court is that of Dr Beech dated 11 May 2005. Dr Beech says:

> "[BAC] is a 38 year old man whose presentation is consistent with moderate mental retardation. From the limited available information, it is apparent that he has been engaged in a range of challenging, antisocial and at times assaultative behaviours and is particularly prone to making inappropriate gestures and behaviours towards women. It is difficult to discern from the available information but it is not apparent that any formalised management plan is currently in place to assist [BAC] in his socialisation.
>
> …

> In my opinion [BAC] suffers from moderate mental retardation. This is a natural mental infirmity that I believe is permanent in nature."

[14] The next report in time is that of Dr Calder-Potts dated 25 November 2005. Dr Calder-Potts notes that psychological testing puts BAC's full IQ at about 47 points. He says that he suffers from the natural mental infirmity of moderate retardation. He says there is no evidence of any mental disease.

[15] I have a report from Dr Lee dated 5 June 2009. Dr Lee reported that BAC suffered from a natural mental infirmity which was of a permanent nature.

[16] I have a psychiatric report dated 18 September 2017 from Dr Roanna Byrnes which begins in its first substantive paragraph, "[BAC] does not have a mental illness, rather an enduring intellectual disability and [acquired brain injury] subsequent to hypoxic brain injury after a near drowning at the age of three years."

[17] I have reports dated 5 April 2018, 17 April 2018 and 24 October 2018 from Dr Reddy. In these reports Dr Reddy diagnoses BAC with moderate mental retardation as a primary diagnosis; personality and behavioural disorder due to brain damage and dysfunction as a secondary diagnosis, and a disorder of sexual preference as another secondary diagnosis. He says:

> "[BAC's] history is suggestive of sexual deviancy ie behaviours of exhibitionism, frotteurism, being attracted to young females and other inappropriate behaviours. This, in my view, is a Disorder of Sexual Preference, which is coded in the International Classification of Diseases (ICD10), and is within the meaning of mental illness.
>
> [BAC] also has alterations in cognition, emotions, personality and behaviours that has been confirmed in his neuropsychological report as having significant problems with executive functioning [sic]. This, in my clinical opinion is Personality and Behavioural Disorder due to brain damage and dysfunction. This is also coded as a mental disorder in the International Classification of Diseases (ICD10).
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> [BAC] has co-occurring mental illnesses with moderate intellectual impairment."

[18] The above quotation is from the report dated 5 April 2018. Then, in the report dated 17 April 2018, in its first substantive paragraph, Dr Reddy incorporates a passage which appears to have been entirely copied from Dr Byrnes' report quoted at [16] above. That is, he signs off on a document which expressly says that BAC does not have a mental illness. Then, in his October 2018 report, Dr Reddy reproduces the paragraphs which I quote at [17] above.

[19] The MHRT commissioned a report from Dr Bayley, a very experienced forensic psychiatrist. Her report is dated 25 September 2018. Under the heading Diagnostic Formulation she says, "[BAC] presents as a 51 year old gentleman, who does not suffer from any major mental illness, but suffers from a congenital and an acquired brain injury,

with behaviours of concern emanating directly from these brain injuries." She diagnoses intellectual disability and major neurocognitive disorder.

[20] Doctors Reddy and Bayley gave evidence before me.

[21] Dr Bayley was clear that BAC's problematic sexual behaviours were not a "stand-alone issue". She saw them as, "falling out of his acquired brain injury". The following exchange took place:

> "HER HONOUR: Do you think he has anything more than an intellectual disability?--- No.
>
> All right?--- But I believe he does have behavioural and psychological disturbances as a result of that.
>
> Yes. Yes. They are features of – or they fall out of his intellectual disability?--- Yes. That's my opinion.
>
> They're not something freestanding that he has alongside?--- No. I don't believe he has, like, a mania or anything like that." – t 1-10.

[22] Further, under examination from counsel for the Attorney-General, Dr Bayley said:

> "… he doesn't have a relapsing, remitting, chronic psychotic or mood disorder that is commonly treated by mental health services, psychiatry services. He has an enduring intellectual disability, both acquired and congenital, which has behavioural and psychological symptoms associated. So he does have a mental condition. It's not a relapsing, remitting type of – illness or disorder or condition. … it's a fairly pervasive, enduring, if that makes sense." – tt 1-13-14.

[23] Dr Bayley explained, when examined by my Assisting Psychiatrist Dr Reddan, why she did not think BAC had any behaviours of exhibitionism, frotteurism, being attracted to young females, or other sexual deviancy. Dr Bayley saw BAC's inappropriate sexual behaviours as a consequence of impaired frontal lobe functioning, ie., as a consequence of brain damage, not as a result of a paraphilia or paraphilias.[3]

[24] Dr Reddy's evidence was very difficult. He was disinclined to co-operate with the Court process and wished to read a written speech to the Court. He repeated his view:

> "I believe there are two mechanisms here. One is he's got a disorder of sexual preference, which is the cause of the behaviours, and there is a problem in his internal regulatory mechanism, which is the mental retardation." – t 1-24.

[25] Dr Reddan, Assisting Psychiatrist, gave me advice that BAC did not have a mental illness, or indeed a mental condition, other than intellectual disability. She said:

> "… the consistent and, I think, well-founded diagnosis, is that of a moderate intellectual disability arising from congenital and acquired factors. If we say that certain behaviours or certain aspects of that constitute a mental condition

[3] This evidence is at tt 1-16-17.

> and are somehow different, we would then be in a position of saying, for example, that his poor memory is a mental condition. And that would be splitting what is the diagnosis into its component parts that are actually symptoms and seeing symptoms as a mental condition that is in some way different to the actual overarching diagnosis." – t 2-26.

[26] Dr Reddan did not think there was any evidence of BAC suffering from a paraphilia. She gives reasons for that at t 2-30. She concluded, "Dr Reddy, I would advise your Honour, is quite incorrect to re-define this as a sexual deviation. And I think that has significant implications practically and legally."

[27] Dr Simpson, Assisting Psychiatrist, agreed with Dr Reddan that BAC did not have a mental illness or mental condition; he suffers from an intellectual disability. She also was critical of Dr Reddy, "So my interpretation of that was that Dr Reddy was trying to justify BAC having a disorder of sexual preference so he could justify then the Androcur and other chemical restraint." – t 2-31.

[28] In submissions the Attorney-General conceded that BAC does not have a mental illness – t 2-15, but contended that he had a mental condition, as defined.

[29] My conclusion is that the MHRT was incorrect in accepting Dr Reddy's evidence that BAC has a mental illness. He does not. He has an intellectual disability and his behaviour, including sexual behaviour, is caused by that. It is not any separate illness.[4] See the definition of "mental illness" at ss 10(1) and (2)(h) of the *Mental Health Act* 2016.

[30] The definition of "mental condition" in the Dictionary Schedule to the 2016 Act is:

> "***mental condition*** includes a mental illness and an intellectual disability."

[31] As BAC has an intellectual disability, he does have a mental condition as defined. I find that he does not have any mental condition other than intellectual disability.

[32] Because BAC does not have anything other than an intellectual disability, he does not have a dual disability as defined in the Dictionary Schedule to the *Mental Health Act* 2016. For this reason I do not believe s 457 of the *Mental Health Act* 2016 applies so as to enable me to make a Forensic Order (Disability) for BAC. I reject the submission made on behalf of the Chief Psychiatrist to that effect.

Legislative History of Forensic Orders

[33] In November 2005 and June 2009 Forensic Orders were made in respect of BAC by the Mental Health Court.[5] On both occasions he was found to be permanently unfit for trial by reason of natural mental infirmity. At that time a Forensic Order was known as a "Forensic Order (Mental Health Court)" – s 288(1) of the *Mental Health Act* 2000 as it

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[4] Dr Reddan's reasoning and my conclusion are consistent with the "non-atomisation" approach taken by Lord Hoffman in *B v Croydon Health Authority* [1995] Fam. 133, 138-139; cited in *Re Langham & Ors* [2006] 1 Qd R 1, [28].

[5] These two orders are now amalgamated as one Forensic Order.

then was. There was no such order as a "Forensic Order (Mental Health Court – Disability)"; that was introduced into the legislation in July 2011 when the *Forensic Disability Act* 2011 (Qld) was enacted. Prior to July 2011, it appears that the term "Forensic Order (Mental Health Court)" was used to distinguish such an order from a "Forensic Order (Criminal Code)"[6] and "Forensic Order (Minister)".[7]

[34] In July 2011 the concept of a Forensic Order (Mental Health Court – Disability) was introduced. Between July 2011 and March 2017 (see below) the Mental Health Court would make a Forensic Order (Mental Health Court) if it found a person unsound or unfit because they suffered from a mental disease, and a Forensic Order (Mental Health Court – Disability) if the finding was a consequence of natural mental infirmity – s 288 of the *Mental Health Act* 2000, as it was after July 2011. Had BAC come before the Court in August 2011, rather than in 2005 and 2009, a Forensic Order (Mental Health Court – Disability) would have been made because the reason for his permanent unfitness was a natural mental infirmity rather than a mental illness.

[35] At the same time that the concept of Forensic Order (Mental Health Court – Disability) was introduced into the *Mental Health Act* 2000, Division 2 was added to Part 5, the Transitional Provisions of that Act. Sections 606 to 612 provided a mechanism for someone like BAC on a Forensic Order (Mental Health Court) to apply to the Court to change his order to Forensic Order (Mental Health Court – Disability). No application was ever made on behalf of BAC. He remained on a Forensic Order (Mental Health Court).

[36] On 5 March 2017 the *Mental Health Act* 2016 came into effect. It allowed the Mental Health Court to make two types of Forensic Orders: Forensic Order (Mental Health) and Forensic Order (Disability) – s 134. Section 836(1) provided that if a person was on a Forensic Order (Mental Health Court) immediately prior to the 2016 Act coming into effect, that order "is taken to be a Forensic Order (Mental Health) under the new Act." Section 837 made the same provision in relation to a person on a Forensic Order (Mental Health Court – Disability); it became a Forensic Order (Disability). The 2016 Act did not contain an equivalent to Part 5 Div 2 of the 2000 Act. That is, it did not contain any mechanism whereby someone like BAC on a Forensic Order (Mental Health) could apply to have his order changed to Forensic Order (Disability).

[37] Had the Mental Health Court made a Forensic Order for BAC at any time after 1 July 2011 he would now be on a Forensic Order (Disability). The 2016 Act contains no specific transitional provisions to allow me to convert his Forensic Order (Mental Health Court) to a Forensic Order (Disability). While lawyers acting on behalf of BAC originally asked me to use s 851(1) of the *Mental Health Act* 2016 to do so, I think it is fair to say that when confronted with the Attorney-General's written submissions they withdrew this submission and accepted that I did not have power to convert BAC's order to a Forensic Order (Disability).

[38] Section 851(1) of the *Mental Health Act* 2016 is as follows:

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6 Section 299 of the 2000 Act, now s 189 of the 2016 Act.
7 Section 302 of the 2000 Act, now abolished.

> "**851 Mental Health Court, tribunal or another court may make orders about transition from repealed Act to new Act**
>
> (1) If this chapter makes no or insufficient provision for the transition to the new Act of a matter before the court, the court may make the order it considers appropriate."

[39] Certainly the words of s 851(1) are very wide. In *Rankin; Kumar, and Sciortino*[8] I observed that I did not think I could use this section to, in effect, give myself jurisdiction. Further, I cautioned that in considering s 851(1) this Court would have to be mindful that while it could construe legislation, it could not legislate.[9] However sensible it may seem to convert BAC's Forensic Order to a Forensic Order (Disability), I do not think this Court has the power to do so. Perhaps in the future if all the parties consented, the Court might be willing to do so. For the moment, while BAC is not on the most appropriate order available, he is not on a wholly inappropriate order, for persons in his position were on such orders between 2000 and 2011.

Treatment and Care

[40] The appellant's main argument before me was that the MHRT erred, in circumstances where BAC does not have a mental illness, in making it a condition of his Forensic Order:

> "That the patient comply with all appointments for follow up and prescribed treatment, including the taking of prescribed medication and undergo random tests for those medications, as required by the treating psychiatrist."

[41] Instead it was said that condition 3 of the Forensic Order ought to read:

> "That the patient comply with all appointments for follow up and the authorised doctor's lawful directions regarding involuntary care."

[42] Essentially, the appellant's argument was that the *Mental Health Act* 2016 authorised only care, and not treatment, to be provided by the authorised psychiatrist under a Forensic Order because BAC had no mental illness and no mental condition other than intellectual disability. The appellant argued that the provisions of the *Mental Health Act* 2016 showed that treatment was to be provided for people with illnesses; whereas care was to be provided to people with intellectual disabilities.

[43] Once again I think it is instructive to look at the history of the legislation. I think that history supports the appellant's contention.

[44] Section 288 of the *Mental Health Act* 2000, as passed, provided that if a person was permanently unfit for trial, the Mental Health Court could make a Forensic Order (Mental Health Court). By s 296 the authorised doctor was to ensure that a treatment plan was prepared for the patient, and was to talk to the patient about the patient's "treatment or care under the treatment plan". Section 297 provided that the administrator of the

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[8] [2017] QMHC 8, [24].

[9] See the Authorities in *Alphadale Pty Ltd v Chief Executive, Department of Environment and Heritage Protection* [2016] QLAC 6, [40] – [43].

authorised mental health service who had charge of the patient on a Forensic Order, "must ensure the patient is treated or cared for as required under the patient's treatment plan." The Dictionary Schedule to that Act defined care as including "the provision of rehabilitation, support and other services." It defined treatment as follows:

> "***treatment***, of a person who has a mental illness, means anything done, or to be done, with the intention of having a therapeutic effect on the person's illness." (my underlining in all three above quotations).

[45] This was the state of the Act at the time BAC was put on Forensic Orders in 2005 and 2009. There were no changes to these provisions in the *Mental Health Act* 2000 until the *Forensic Disability Act* 2011 was passed in July 2011.

[46] Significantly, the *Forensic Disability Act* 2011 amended the *Mental Health Act* 2000 by entirely replacing s 288.[10] That was the section under which the Mental Health Court made Forensic Orders. The new section was consistent with the idea that involuntary treatment is for mental illness, and that a person who has an intellectual disability will receive care and support. In particular, s 288(6) provided that if a person's unsoundness of mind, or unfitness, was not a consequence of intellectual disability, the Forensic Order (Mental Health Court), "must state that the person is to be detained in a stated authorised mental health service for involuntary treatment or care." (my underlining). However, by s 288(7) it was provided that if the person's unsoundness of mind or unfitness was a consequence of an intellectual disability, a Forensic Order (Mental Health Court – Disability) was to be made detaining the person only "for care".

[47] Otherwise the 2011 amendments made substantial changes to the law, adding references to care to existing references to treatment in provisions which applied to both patients with a mental illness and patients with an intellectual disability, for example see the amendment to s 204 of the *Mental Health Act* 2000.

[48] The 2011 amendments made specific provision, by the introduction of Division 2B to the *Mental Health Act* 2000, for the administration of medication to persons with an intellectual disability for particular purposes (for example transferring a patient from one facility to another) if a doctor was satisfied the medication was necessary to ensure the safety of the patient or others. Such provision assumes that the doctor would not have authority otherwise.

[49] The 2011 amendments introduced a new s 309B. That section authorised temporary detention in an authorised mental health service for a person with an intellectual disability. It provided that while a "forensic disability client" was detained in such a facility, that client's "applicable Forensic Order applies as if it were an order for the client's detention in the health service for care." (my underlining).

[50] In my view the *Mental Health Act* 2016 continued the distinction between treatment and care contended for by the appellant.

[51] The Dictionary Schedule to the 2016 Act provides the following definitions:

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[10] s 230 *Forensic Disability Act* 2011, as passed.

> "***care***, in relation to a person who has an intellectual disability, includes the provision of rehabilitation, the development of living skills, and the giving of support, assistance, information and other services.
>
> …
>
> ***treatment***, of a person who has a mental illness or other mental condition, includes anything done, or to be done, with the intention of having a therapeutic effect on the person's illness, including the provision of a diagnostic procedure."

[52] These definitions are not entirely clear. To begin with, both of them are inclusory definitions. Further, the definition of mental condition, see [30] above, is also an inclusory definition. The result is that it could be argued that the definition of care includes the prescription of medication, and it could be argued that the definition of treatment contemplates treatment being given to somebody who has a mental condition other than a mental illness. However, I think that against the historical context which I have outlined above; the context of the other provisions of the 2016 Act which I outline below; the context of the provisions in the *Disability Services Act,* particularly see s 145 at [11] above, and the words of the definitions of "care" and "treatment" themselves, that is not a correct construction.

[53] So far as the last point mentioned is concerned, the definition of "care" is followed by the words "in relation to a person who has an intellectual disability". By way of contrast, the definition of "treatment" begins with the words "of a person who has a mental illness". This tends to support the appellant's argument. It is true that the words "or other mental condition" immediately follow in the definition of "treatment", and this produces an element of ambiguity. However, the later words in that definition, "a therapeutic effect on the person's illness", tend to suggest that the mental condition of intellectual disability is not contemplated, only a mental condition of illness. While I acknowledge that this is not an entirely satisfactory analysis, particularly having regard to the wide definition of "mental illness" in the 2016 Act, I think it is the best analysis available having regard to the words and the context.

[54] As to the context provided by other provisions of the *Mental Health Act 2016,* s 8 of the 2016 Act provides as follows:

> "**8 Application to person with intellectual disability**
>
> To the extent this Act applies to a person who has an intellectual disability –
>
> (a) sections 3 and 5 apply in relation to the person as if a reference in the sections to a person who has a mental illness were a reference to a person who has an intellectual disability; and
>
> (b) a reference in the Act to treatment and care of a person means a reference to care of the person; and
>
> (c) a reference in the Act to recovery of a person means a reference to the rehabilitation, and development of living skills, of the person."

[55] I think this is a clear indication that the 2016 Act contemplates that persons who have only an intellectual disability will receive care but not treatment. Likewise, I think the distinction between ss 151 and 152 of the 2016 Act strongly supports the appellant's argument.

[56] Section 151(1) of the 2016 Act provides:

> "**151 Matters authorised by forensic order (mental health) or treatment support order**
>
> (1) A forensic order (mental health), or treatment support order, for a person authorises each of the following in accordance with the order –
>
> (a) if the person has a mental condition other than an intellectual disability – the provision of involuntary treatment and care for the person's mental illness or other mention condition;
>
> (b) if the person has a dual disability –
>
> (i) the provision of involuntary treatment and care for the person's mental illness; and
>
> (ii) the provision of involuntary care for the person's intellectual disability;
>
> (c) if the category of the order is inpatient – the detention of the person in the authorised mental health service that is responsible for the person."

[57] By contrast s 152(1) of the 2016 Act provides:

> "**152 Matters authorised by forensic orders (disability)**
>
> (1) A forensic order (disability) for a person authorises each of the following in accordance with the order –
>
> (a) the provision of involuntary care for the person's intellectual disability;
>
> (b) if the category of the order is inpatient, the person's detention in –
>
> (i) if an authorised mental health service is responsible for the person – the authorised mental health service; or
>
> (ii) if the forensic disability service is responsible for the person – the forensic disability service."

[58] A Treatment Support Order was a new concept introduced by the 2016 Act. Section 143(1) of that Act gives the Mental Health Court power to make such an order. However, s 143(3) provides:

"**143 Requirements for making treatment support order**

…

(3) This section does not apply if the court considers –

(a) the person's unsoundness of mind was, or unfitness for trial is, because of an intellectual disability; and

(b) the person does not need treatment and care for any mental illness."

[59] In my view the appellant was right in submitting that the scheme of the 2016 Act is that persons who are on a Forensic Order, and suffer from nothing more than intellectual disability, will not receive treatment, but only receive care pursuant to that order.

[60] I think this construction of the *Mental Health Act* 2016 is consistent with, and designed to be consistent with, Part 6 of the *Disability Services Act* 2016. At [11] above I have quoted s 145 of the *Disability Services Act* which is, to my mind, the most pertinent of the provisions in that Act, so far as interpretation of the *Mental Health Act* 2016 is concerned. Furthermore, provisions in the *Guardianship and Administration Act* 2000 (Qld) sit consistently with this interpretation, see for example s 80ZE.

Attorney General's Submissions

[61] I will mention an argument advanced on behalf of the Attorney-General relying upon the case of *Re Langham* (above).[11] In that decision Justice Chesterman interpreted the word "treatment" in the *Mental Health Act* 2000 to include forcibly feeding a man whose schizophrenia was so severe and resistant to treatment that, without forcible feeding, he would have died. In the course of his judgment Justice Chesterman made comments to the effect that treatment must "encompass more than measures which are purely curative" – [17]. He also made comments that while the force feeding was not designed to cure the schizophrenia, it was designed to prevent the patient succumbing to the manifest symptoms of that illness.

[62] The salient point so far as this appeal is concerned is that Justice Chesterman was dealing with the definition of treatment which I set out at [44] above. The section defines treatment "of a person who has a mental illness" to include things done with the intention of having a therapeutic effect on that illness. That definition never applied to BAC, and does not apply to BAC now. He does not have a mental illness. The judgment in *Langham* cannot be used in the way the Attorney-General sought to use it, that is, to justify administering a medication such as Androcur to counter behaviour which is a manifestation of intellectual disability.

[63] Another submission advanced on behalf of the Attorney-General was that when they were made, in 2005 and 2009, the Forensic Orders justified treatment which included the prescription and administration of medication. I am not certain that I would interpret the legislation applying at that time in that way – see the underlined portions of the relevant

[11] See footnote 4.

sections at [44] above. However, whatever may have been the case in 2005 and 2009, the *Mental Health Act* 2016 has the effect that the current Forensic Order is taken to have been made under the 2016 Act. In my opinion, as explained, that Act does not authorise the prescription and administration of medication to a person suffering only from an intellectual disability under a Forensic Order. Further as to this point, it does not avail the respondent to refer to comments made by Justice Philippides in 2009 about treatment and medication in a short ex tempore judgment which did not deal with, or intend to deal with, the issues raised in this appeal.

[64] Lastly, the Attorney-General relied upon the purpose of a Forensic Order which is, in large part, to protect the community. It was submitted that responsibility for determining whether or not someone on a Forensic Order ought to take medication must rest upon the authorised mental health service as part of this scheme. The authorised doctor under a Forensic Order will be a psychiatrist and, it was submitted, in the best position to determine what medication ought to be prescribed and administered both in the interests of the patient and the community. I understand why this submission was made. It is a good policy argument in favour of a different legislative scheme from that which Parliament has chosen to enact.

Implementation of my Determinations, Declarations and Orders

[65] In my view, the condition of the Forensic Order contended for by the appellant at [41] above, is in accordance with the *Mental Health Act* 2016, whereas the condition imposed by the MHRT at [40] above, is not. The condition imposed by the MHRT ought to be replaced with that proposed by the appellant.

[66] It was acknowledged by counsel acting on behalf of the Public Guardian that if BAC's appeal succeeded, time would be required to put his medical affairs on a proper footing. For this reason I will stay the effect of my orders for three months, unless this Court orders otherwise.

[67] It will be necessary for the Public Guardian to have constructive discussions with the authorised doctor under the Forensic Order. It is not medically sensible, on the evidence before me, to simply stop the administration of Androcur. A slow titration down of this medication, together with close observation of any effects on BAC's behaviour, is what is recommended by Dr Bayley, and before her, Dr Galstuck-Leon. As well, it seemed from the questions Dr Reddan asked of Dr Bayley, that there might be newer and better drugs than Androcur for BAC if he is to remain on some such drug. In particular, Dr Reddan suggested Leuprorelin, a GnRH agonist. Dr Reddan thought that medication would have "considerably fewer" side effects than Androcur – t 1-17. Consideration needs to be given by BAC's treating practitioners as to whether or not he should receive this medication, rather than Androcur, and if so, how transition is to be made. As well, the treating doctor and the Public Guardian need to discuss the various sedating medications which are being given to BAC. There is some suggestion in some of the material that the sodium valproate might be used for an anti-epileptic effect, rather than as a chemical restraint.

[68] Constructive communication between the Public Guardian and BAC's treating doctor needs to involve the provision of proper information to the Public Guardian.[12] The Public Guardian will also need to accept medical advice from the authorised doctor under the Forensic Order.

[69] As I understand the evidence in this matter, it is not contemplated that no chemical restraints will be prescribed to BAC, at least not in the short, or even medium term. If BAC's behaviours declined without chemical restraint, it is possible that he might lose his residential unit and community care package – t 1-11. This would be very much against his interests, for the alternative is to live in an inappropriate and impoverished environment. I might add, that without chemical restraints, if BAC's behaviour deteriorated, his carers may be at risk. The Public Guardian will need to give authority which allows the authorised doctor some flexibility during trials aimed at reducing chemical restraints, so that should BAC's behaviour deteriorate suddenly, the authorised doctor is able to respond appropriately in a medical sense.

[70] I will further add for clarity that my decision that the authorised doctor under the Forensic Order is not to prescribe medication for BAC without the consent of the Public Guardian is subject to other provisions of the law relating to treating a patient without consent for example, in times of emergency.

[12] It appears from the Public Guardian's letter to the Chief Psychiatrist, dated 3 April 2019, that this has not necessarily been forthcoming at all times in the past.