| | |
|---|---|
| CITATION: | *JXC v Mental Health Review Tribunal & Anor* [2018] NTSC 62 |
| PARTIES: | JXC<br><br>v<br><br>MENTAL HEALTH REVIEW TRIBUNAL<br><br>and<br><br>NORTHERN TERRITORY OF AUSTRALIA |
| TITLE OF COURT: | SUPREME COURT OF THE NORTHERN TERRITORY |
| JURISDICTION: | SUPREME COURT exercising Territory jurisdiction |
| FILE NO: | LCA 58 of 2017 (21756120) |
| DELIVERED ON: | 5 September 2018 |
| HEARING DATES: | 14 February 2018 |
| JUDGMENT OF: | BLOKLAND J |

**CATCHWORDS:**

APPEAL – Mental Health Review Tribunal Appeal – appeal against decision by Tribunal to make involuntary Community Management Order – whether Tribunal failed to apply correct standard of proof, made decision on insufficient evidence or came to mistaken conclusion when finding not open on evidence – whether appellant met criteria for "mental illness" under *Mental Health and Related Services Act* (NT) ("*MHRSA*") – *Briginshaw* standard of proof applicable to Tribunal's fact-finding – appellant had significant history of paranoid schizophrenia and other disorders – positive evidence of mental illness must exist to satisfy Tribunal – forensic psychiatric evidence before Tribunal equivocal and inexact about whether

appellant suffering from mental illness at latest relevant assessment but clear that appellant suffered other conditions – no symptoms of psychosis or schizophrenia displayed for at least five years prior to assessment before Tribunal hearing – substance abuse disorder and antisocial personality disorder not "mental illnesses" under *MHRSA* – Tribunal could not make finding on balance of probabilities that criteria for mental illness made out – Community Management Order set aside – appeal allowed.

*Mental Health and Related Services Act* (NT) ss 6, 6(1), 6(1)(a), 6(1)(b), 6(3), 6(3)(n), 16, 16(a), 16(b), 123(5)(c), 142, 142(3), 142(4), 142(5)

*Briginshaw v Briginshaw* (1938) 60 CLR 336; *CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43; *Minister of Immigration and Ethnic Affairs v Pochi* (1980) 44 FLR 41; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170; *Shaun v Wolf* (1999) 163 ALR 205; *WCH v Mental Health Tribunal* [2016] VCAT 199; *Willcox v Sing* (1985) 2 Qd R 66, referred to.

**REPRESENTATION:**

*Counsel:*

| | |
|---|---|
| Appellant: | A Clunies-Ross |
| Respondent: | R Sanders |

*Solicitors:*

| | |
|---|---|
| Appellant: | Northern Territory Legal Aid Commission |
| Respondent: | HWL Ebsworth Lawyers |

| | |
|---|---|
| Judgment category classification: | B |
| Judgment ID Number: | BLO1807 |
| Number of pages: | 30 |

IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

*JXC v Mental Health Review Tribunal & Anor* [2018] NTSC 62
No. LCA 58 of 2017 (21756120)

BETWEEN:

**JXC**
Appellant

AND:

**MENTAL HEALTH REVIEW TRIBUNAL**
First Respondent

AND:

**NORTHERN TERRITORY OF AUSTRALIA**
Second Respondent

CORAM: BLOKLAND J

REASONS FOR JUDGMENT

(Delivered 5 September 2018)

**Background**

[1] JXC appeals from a decision of the Mental Health Review Tribunal ("the Tribunal") made on 6 November 2017. On that date, which followed a review on 23 October 2017 of a previous order, the Tribunal made an involuntary Community Management Order ("CMO") for 6 months. The Tribunal conducted a full hearing as required when reviewing a previous

order. The CMO was made pursuant to s 123(5)(c) of the *Mental Health and Related Services Act* (NT) *("MHRSA")* which provides that if a person fulfils the criteria for involuntary treatment or care in the community, the Tribunal may make a CMO in relation to the person for not longer than 6 months.

[2] The appellant claims the Tribunal was in error by making the CMO. He claims the criteria in s 16(a) of the *MHRSA* when read with s 6 which defines "mental illness" were not made out. Further, he says the Tribunal was in error as the criteria set out in s 16(b) of the *MHRSA* were not made out. It is argued the Tribunal failed to apply the standard of proof correctly and made a decision based on insufficient evidence or came to a mistaken conclusion that the appellant suffered from a mental illness when such a finding was not open. Section 16 of the *MHRSA* provides the criteria for involuntary treatment in the community as follows:

> The criteria for involuntary treatment or care of a person in the community are:
>
> (a) the person has a mental illness; and
>
> (b) as a result of the mental illness:
>
> (i) the person requires treatment or care; and
>
> (ii) without the treatment or care, the person is likely to:
>
> (A) cause serious harm to himself or herself or to someone else; or
>
> (B) suffer serious mental or physical deterioration; and

(iii) the person is not capable of giving informed consent to the treatment or care or has unreasonably refused to consent to the treatment or care; and

(c) the treatment or care is able to be provided by a community management plan that has been prepared and is capable of being implemented.

[3] Section 6 of the *MHRSA* defines "mental illness". The relevant parts of the definition are as follows:

> (1) A mental illness is a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised:
>
> (a) by the presence of at least one of the following symptoms:
>
> (i) delusions;
>
> (ii) hallucinations;
>
> (iii) serious disorders of the stream of thought;
>
> (iv) serious disorders of thought form;
>
> (v) serious disturbances of mood; or
>
> (b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).
>
> .....
>
> (3) A person is not to be considered to have a mental illness merely because he or she:
>
> .....
>
> (f) uses alcohol or other drugs; or
>
> (g) has a personality disorder or a habit or impulse disorder; or
>
> .....

(n) has been treated for mental illness or has been detained in a hospital that provides treatment of mental illness; or

.....

[4] A person aggrieved by a decision of the Tribunal may appeal to the Supreme Court against the decision pursuant to s 142 of the *MHRSA*. The appeal is to be by way of rehearing.[1] This appeal has proceeded on the material that was before the Tribunal. I agree with Hiley J in *CH v Mental Health Review Tribunal & Anor*[2] to the effect that the nature of an appeal under the *MHRSA* is more restricted than an appeal *de novo* and involves the identification of errors in the original decision rather than instituting a completely fresh decision-making process.

[5] The Court was not asked and did not consider the exercise of powers under s 142(4) to suspend the operation of the current order being appealed or under s 142(5) to refuse to hear the appeal on the grounds *inter alia* that it had not been filed in good faith.

**Outline of material before the Tribunal**

[6] These reasons will not summarise in depth all of the material before the Tribunal; however, it may be noticed the appellant's reasonably significant history of mental illness and the associated reports and material together with previous applications and orders concerning involuntary treatment were before the Tribunal. Some history is required to consider properly the Tribunal's reasons and the submissions made to the Court on appeal. A

---

1 *MHRSA*, s 142(3); *CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43.

2 [2017] NTSC 43 at [19]-[20].

number of extracts from the records are before the Court,[3] as well as transcripts of the evidence given and submissions made at the Tribunal hearing. The Tribunal provided clear and informative reasons on 6 November 2017.

[7] Although the appellant has been treated since 2011 for schizophrenia following his first admission to the acute mental health unit at Royal Darwin Hospital and has had a number of admissions since then, he was not exhibiting symptoms of a psychotic illness at the time of being assessed before the Tribunal hearing. Furthermore, according to the preponderance of the evidence before the Tribunal, symptoms of mental illness in terms of at least psychotic symptoms had not been firmly noted since 2012. Since the first diagnosis in 2011, he has, however, largely been under the care of the Top End Mental Health Service, receiving long-acting injectable antipsychotic ("LAI") medication.

[8] The evidence about his condition at the time of the latest relevant assessment is equivocal on the question of whether he has a mental illness in terms of the Act, namely, a condition "that seriously impairs" the areas set out in s 6(1) of the *MHRSA* by the presence of symptoms set out in s 6(1)(a). More particularly, both doctors who gave evidence before the Tribunal said that the last time the appellant presented with psychotic symptoms was in 2012. The definition of "mental illness" requires the presence of "delusions,

---

3 Extracts from Tribunal file, 14 February 2018.

hallucinations, thought disorders, serious disturbances of mood" or "sustained or repeated irrational behaviour" that may be taken to indicate one of the symptoms in s 6(1)(a).[4] There is a live question about whether or not the appellant has an underlying mental illness, the symptoms of which are mitigated by the efficacy of the medication.

[9] During the hearing of the appeal, the respondent abandoned reliance on a "fallback" position that "mental illness" for the purposes of the *MHRSA* may be established by polysubstance disorder combined with a personality disorder. Clearly the appellant suffers from an antisocial personality disorder. The descriptions of the disorder indicate it is severe; however, as is evident from the definition of mental illness under s 6 of the *MHRSA*, a personality disorder by itself cannot constitute a mental illness for the purpose of the *MHRSA*. Similarly, dependence on certain substances by itself is not sufficient to constitute mental illness under s 6(3)(f) of the *MHRSA*, although it is clear the appellant suffers a form of substance abuse disorder.

[10] In November 2011, an application for a CMO was made after the hospital admission from 25 August 2011 until 19 October 2011. The relevant Form 15 (documenting the clinical details and management plan for a CMO, also referred to as a "clinical report") notes that for a period of one year, the appellant suffered from a decline in his social functioning and deteriorating

---

[4] *MHRSA*, ss 6(1)(a)-(b).

mental state. He experienced increasing paranoid delusions and engaged in violence directed towards family members. He had also spent time in custody as a result of breaching domestic violence orders ("DVOs"). He was lacking insight with a high risk of violence, had a lack of empathy towards others and had ongoing paranoid delusions. Reports of troubling delusions are set out in the Form 15. The first diagnosis of schizophrenia was made at around that time. The Form 15 stated that his condition had improved with a combination of psychopharmacology (antipsychotics) as well as removal of THC and ETOH. It was observed that the antipsychotic medication had helped decrease his delusional ideas and resulting paranoia. Mention was made that without treatment he was likely to relapse. Concerns were expressed about repeated assaults on, and threats towards, family members. It was also noted he did not fully understand his mental health issues and had poor insight, impulse control and lack of respect for rules and orders such as DVOs.

[11] The appellant was again admitted to the secure acute mental health unit for nine days in 2012 following a psychotic episode. Warrants were required for his apprehension and treatment. Following that admission he was discharged on a CMO.

[12] A CMO was made by the Tribunal for 6 months on 11 September 2013. The relevant Form 15 notes the appellant insists he does not have a mental illness and does not require antipsychotic medication. He was not making himself available for medication to be administered. Side effects from the

medication were also mentioned. The relevant mental illness was confirmed as chronic schizophrenia (paranoid type). The symptoms were stated to have been responsive to antipsychotic medication in the past when the appellant was adherent to the medication on a regular basis. Throughout 2013 the records indicate the appellant was extremely challenging, avoidant to treatment and hostile and abusive to staff during interactions. The history of aggression towards clinicians continued and is a feature throughout the appellant's psychiatric history. He was admitted again to the Joan Ridley Unit ("JRU") in October 2013 with a diagnosis of paranoid schizophrenia and antisocial personality disorder. Warrants had been sought prior to his admission to the JRU.

[13] A warrant was again applied for and obtained on 4 December 2013, as the appellant appeared to be evading his medication that was specified in the CMO. The application for the warrant referred to a short admission to the JRU in October 2013 after a warrant was executed; however, it was stated that since discharge from the hospital, he had been evading his case manager and had expressed his desire on a number of occasions not to continue with treatment. Further details were provided in the application for the warrant about the appellant's behaviour along with significant evidence of his lack of insight or understanding of the need for medication. The appellant's efforts to evade his case manager were well documented.

[14] From between September 2013 to March 2014, six warrants were applied for to ensure the administration of treatment. The appellant's associated social

problems increased as he was evicted from his apartment in September 2013. He continued to evade his case manager. Due to his non-compliance and deterioration in early 2014, he was admitted to the JRU on 3 March 2014 for recommencement of his medication. He was aggressive and would not engage with the treating team, insisting he did not have a mental illness and did not need medication. Once admitted, he refused to comply with giving urine samples for the purpose of drug testing. He settled after receiving medications including depot medication and agreed to be available for medications in the future, although he did not acknowledge the need for them. He was discharged on 12 March 2014 on a CMO.

[15] In 2015 the appellant attended the Tamarind Centre for his depot medication regularly, with prompting from his case manager through his mother. Due to concerns about staff safety, a decision was made that he receive the LAI at the JRU. After the appellant's parents moved to Daly River, home visits were required to administer his medication as he did not have transport to attend the JRU. His high level of aggression towards staff, including at times when police were in attendance, is documented during this period. This pattern continued throughout 2015, with refusals by the appellant to accept treatment, the use of warrants and administering depot at the JRU. All of the appellant's admissions to the JRU had been in the context of non-compliance with medication and/or continued substance misuse.

[16] The Form 15 of 9 October 2017 which was before the Tribunal in relation to this matter provides an excerpt illustrating the difficulties with the appellant

drawn from the discharge summary following an admission to the JRU in 2016:

> [JXC] was irritable, sarcastic and uncooperative. He didn't want to stay in Darwin, once he gets [sic] discharged and didn't want to take any medication. He admitted throwing coffee on the doctor who has visited his home recently to give Depot. He didn't think it was intentional and stated as [sic] accident. He didn't want to be locked up and didn't want to stay in the hospital. He was making abusive and sarcastic comments to the doctors throughout his admission. He denied any psychotic symptoms. He was given Depot Zuclopenthixol decanoate 250 mg on 21/12/16 and was discharged to Frogs Hollow hostel.

[17] The appellant's social circumstances at the time of the review and application were recorded as living at St Vincent De Paul Bakhita Centre for homeless men. He has been unemployed since 2012 and at times has been estranged from family members due to previous aggressive and assaultive behaviours towards them. It was also stated on the Form 15 of 9 October 2017 that 2012 appeared to be the last time the appellant presented with psychotic symptoms which was in the context of a pending court appearance. It was also observed that in 2017 the CMO was required to be suspended approximately every two weeks, whenever the appellant's LAI medication was due, as police were requested to attend in order to administer the medication.

[18] The comments from the Forensic Mental Health team from earlier in 2017 are also included by Dr Spice in the Form 15 in relation to a proposal to

transfer the appellant back to the adult community team. The Forensic Mental Health Team commented:[5]

> Mr JXC has diagnosis *[sic]* of paranoid schizophrenia, antisocial personality disorder and polysubstance abuse. He has recently been case managed by the FMHT due to staff burnout from Mr JXC's aggressive behaviour towards his previous case management team [Palmerston]. Mr JXC poses a high risk to others, with an extensive history of assaultive behaviour. He does not display any insight regarding his diagnosis and treatment, and is highly reluctant to engage with mental health services. He refuses to engage with mental health services outside of receiving his depot medication under the terms of the *MHRSA*.

[19] The Forensic Mental Health Team listed the "current key issues" affecting the appellant and his care as follows: aggression/violence towards others, symptom relapse, vulnerability/homelessness, disengagement with services, alcohol, cannabis and ice abuse, and a refusal to engage with services including metabolic monitoring.

[20] The principal conclusions set out in the Form 15 are as follows:

> Despite the unsatisfactory brevity of the review due to JXC's uncooperative and hostile manner, Dr Spice was able to assess JXC as not exhibiting any symptoms of a psychotic illness at this time. Whether this is because of the efficacy of the medication JXC receives or possibly because JXC does not have an underlying mental illness (and his previous psychotic presentations might therefore, have been the result of, for example, drug-induced psychosis) is not able to be determined from this review. The fact that there is no documentation indicating that JXC has exhibited psychotic phenomena since 2012, or possibly 2011, may perhaps suggest that he does not currently have a psychotic illness.

---

5 Form 15, 9 October 2017 at p 2.

> This view is supported by staff at the two facilities where JXC has resided in the past two years (Bakhita and Sunrise) who have stated that JXC did not and does not currently display psychotic symptoms nor any of the aggressive behaviours at these residences that he has consistently exhibited towards Top End Mental Health staff in recent years.
>
> JXC does, however, have a substance use disorder and antisocial personality disorder.

[21] Against that background, evidence was given to the Tribunal by Dr Spice, the authorised psychiatric practitioner who submitted the Form 15 and reviewed the appellant, and Dr Weerasundra, who was responsible for the appellant's treatment during the 2011 admission and was consulted from time to time about the appellant's conditions and treatment. In his evidence before the Tribunal, Dr Spice said when he reviewed the appellant, consistent with reports from other psychiatric registrars who had observed him, he did not find that the appellant exhibited positive symptoms of schizophrenia, nor negative symptoms. He said he found that the appellant exhibited "very, very strong antisocial personality disorder symptoms and, by his own admission, he uses substances; and my reckoning is that he uses substances so frequently that he has a dependence on certain substances."[6]

[22] Dr Spice said his review was reasonably thorough, noting that the appellant's admissions to hospital are mostly around his conduct and behaviours "rather than specifically around a mental illness as defined under

---

**6** Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 3.

the Act."[7] Dr Spice also observed that the earlier admission history "very early on" strongly suggested the presence of a psychotic illness. However, Dr Spice was clear that the last time symptoms of mental illness were manifest was possibly in 2012, in the context of significant cannabis use at a time of high levels of anxiety.

[23] Dr Spice referred to a note of thought disorder in 2014 but he did not think it "formal thought disorder" and it was not presenting in a psychotic way.[8] Dr Spice also said he believed very strongly that the medication was efficacious and, as a result, the appellant does not exhibit psychotic symptoms, or symptoms of schizophrenia. He added the medication also helps to dampen some of the symptoms that are seen in antisocial personality disorder, consequently minimising potential harm to himself or the community.[9] In respect of assaults against his family, Dr Spice said they were not necessarily an aspect of a psychotic illness.[10] Dr Spice's evidence raised the possibility that the 2012 admission commenced due to drug-induced psychosis and that the admission was unusually lengthy due to behavioural issues.[11]

[24] In terms of addressing whether the appellant had a mental illness, Dr Spice said his "feeling" was the appellant has a mental illness. He qualified this

---

7 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 4.

8 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, pp 5-6.

9 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 4

10 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 7.

11 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, pp 11-14.

statement acknowledging “the evidence is not strong”; however, he said the appellant had been on a high dose of Zuclopenthixol for a long period of time and the psychotic symptoms were well treated.[12] He said it was possible, if given sufficient time for the medication not to be in his system any longer, the appellant may begin to exhibit psychotic symptoms as he did in 2011 and 2012. Dr Spice said it was not easy to make a case definitively that the appellant had recently exhibited psychotic symptoms, but he posed the question, “[I]s it because the medication has been so effective?”[13] He also acknowledged the appellant is an extremely disagreeable person at times but he said, “I didn't see any evidence of a psychotic illness”.[14]
Dr Spice also told the Tribunal that a reduction in the appellant's medication is the safest way to determine whether it is the medication that is keeping the appellant well or whether the psychotic illness has resolved and he no longer requires medication.[15] Dr Spice thought there was a possibility the appellant will become unwell between four to six weeks after stopping medication, but it could be done.[16]

[25] Dr Spice informed the Tribunal that rather than reducing the medication, given the appellant's complaints of its side effects, the tendency had been to increase the dosage in response to his increased hostility and aggression towards treating clinicians. The Forensic Mental Health Team had increased

---

12 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 10.

13 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 11.

14 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 11.

15 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 11.

16 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, pp 17-18.

the dose of medication from 200 mg per fortnight to 400 mg when they took over management of his dosage. It was reported the appellant's hostility decreased and they were able to engage with him more.[17] In answering why Dr Weerasundra was being called due to his recent limited involvement with the appellant, Dr Spice said "There is a real question here as to whether or not there is a mental illness that is being suffered..."[18]

[26] Dr Weerasundra told the Tribunal that after 2012 there "have been no documented or well-established symptoms of psychosis".[19] In terms of the potential risks of ceasing involuntary treatment, Dr Weerasundra prefaced his comments by stating "[I]f he does have a mental illness..."[20] In those circumstances he outlined the escalating risk of aggressive and hostile behaviours increasing.

[27] Dr Weerasundra referred to the fact the appellant has had continuous medication from October 2011 until October 2017 and that in spite of that medication there has been an exacerbation of his behaviour and mental state from time to time. He also noted the appellant's marked antisocial personality disorder. However, after 2012 he said there have been no documented or well-established symptoms of psychosis. He agreed behavioural issues could have lengthened the first admission, but were not

---

17 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, pp 14-15.

18 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, pp 20-21.

19 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, p 3.

20 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, pp 4-5.

the sole factor.[21] Dr Weerasundra thought the 2011 admission was too long to indicate drug-induced psychosis.[22]

[28] Dr Weerasundra said that given the lack of established psychotic symptoms from 2012 until now, whether he does have a mental illness or not, he favoured observing the appellant to potentially reduce the amount of medication, and review and monitor him to establish the facts. He said that because of the appellant's personality traits and his antisocial personality, this process has not been possible.[23] Dr Weerasundra referred to the high level of risk of the appellant to himself and the community, in particular his family "if he does have a mental illness that is untreated".[24] He said it was the Forensic Mental Health Team's opinion, from two forensic psychiatrists, that the appellant suffered from schizophrenia. He also thought the appellant would become mentally unwell quickly if the depot medication were suddenly ceased.[25] Dr Weerasundra was asked whether the appellant's aggression and hostility were solely related to his interactions with the Forensic Mental Health Team. He said, "[I]t is possible that the aggression is driven by the fact that he has been medicated for so long against his wishes. That is possible".[26] However, Dr Weerasundra thought the polysubstance use and the antisocial personality disorder aggravated the

---

21 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, pp 13-14.

22 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, p 4.

23 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, p 3.

24 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, p 5.

25 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, p 8.

26 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, p 11.

aggressive and hostile behaviours, but the past paranoid delusions could not be totally explained by those factors.[27]

[29] The appellant gave evidence at the hearing. He spoke about his current living circumstances at the Bakhita Centre and his time at the Sunrise Centre when he was engaged in a program for homeless persons. There was other evidence supportive of a reasonably positive arrangement at the Bakhita Centre including evidence from his caseworker who told the Tribunal the appellant had adhered to the rules and regulations at Bakhita. There was evidence of a complaint about one occasion when the appellant was alleged to have verbally abused another person at Bakhita. The caseworker told the Tribunal that she considered that complaint to be quite minor. Dr Spice drew attention to the need for the appellant to adhere to a "behaviour management agreement" when he was at the Sunrise Centre participating in the Homelessness Program. The appellant told the Tribunal he had participated in cooking and other activities while at the Sunrise Centre. The program also dealt with motivation, taking responsibility, physical health, drug and alcohol misuse, managing money and personal administration including mental and emotional health. He told the Tribunal he would like to return to the workforce but could not operate machinery while on the medication. He indicated he thought he would be able to obtain work or an apprenticeship if he was not on the medication. He said he wanted work in a trade. He also said he thought his life was lost to him over the period of taking the

---

27 Mental Health Review Tribunal, transcript, 21 December 2017, vol 2, p 12.

medication, as he was unable to live a normal life due to the side effects of the medication including drooling in association with drowsiness, as well as muscle spasms.

**Reasons of the Mental Health Review Tribunal**

[30] The Tribunal accepted submissions made on the appellant's behalf that the relevant standard of proof when reviewing a CMO is the enhanced civil standard derived from *Briginshaw v Briginshaw*.[28] It proceeded on the basis outlined in *Briginshaw* that if a positive finding in respect of a person would produce grave or adverse consequences for them, the evidence to support such a finding should be clear, compelling and of high probative value. It was also accepted that "reasonable satisfaction" of a fact in issue should not be produced by inexact proofs, indefinite testimony or indirect inference.[29] The Tribunal also accepted the following statement from *Minister of Immigration and Ethnic Affairs v Pochi*[30] was applicable, namely that proof of conduct alleged against a party:

> … should be established, on the balance of probability, to its satisfaction by some rationally probative evidence and not merely raised before it as a matter of suspicion or speculation or left, on the material before it, in the situation where the Tribunal considered that, while the conduct may have occurred, it was unable to conclude that it was more likely than not it had.

---

**28** Mental Health Review Tribunal, reasons for decision delivered 6 November 2017 ("Reasons") at [25]; *Briginshaw v Briginshaw* [1938] HCA 34; 60 CLR 336.

**29** *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361, per Dixon J.

**30** [1980] FCA 85; 44 FLR 41 at 62, per Deane J.

[31] After confirming the correctness of the diagnosis in 2011 (and noting its correctness was unchallenged), the Tribunal found on the evidence that it was more likely than not that psychotic symptoms of paranoid schizophrenia had not been exhibited by the appellant since 2012 because the symptoms had been effectively managed by the continuous administration of antipsychotic medication. After summarising the relevant evidence, the Tribunal made the following significant finding:[31]

> The tribunal finds that it is not necessary for a person who is suffering from a mental illness to have exhibited psychotic symptoms of that mental illness when reviewed by an authorised psychiatric practitioner prior to the hearing of an application to review a community management order or within the recent past, because the tribunal accepts Dr Rajiv Weerasundra's evidence to the effect that it is possible that such symptoms can be effectively managed (without the underlying mental illness being cured) by the administration of antipsychotic medication.

[32] More particularly, the Tribunal found more likely than not the following:[32]

(i) When JXC was treated in the acute care facility in Royal Darwin Hospital in 2011, the length and manner of the period of this treatment (which included being trialled on several types of antipsychotic medication) indicates that he was then suffering from paranoid schizophrenia rather than simply from a drug-induced psychosis;

(ii) JXC is still suffering from paranoid schizophrenia;

(iii) The psychotic symptoms of that mental illness have not exhibited themselves since 2012, because they have been treated by the antipsychotic medication administered since the mental illness was first diagnosed;

---

**31** Reasons at [30].

**32** Reasons at [31].

(iv) JXC is suffering from a mental illness as defined in the MHRS Act;

(v) The finding that JXC is suffering from a mental illness as defined in the MHRS Act is not dependant *(sic)* on other diagnoses of JXC suffering from personality disorder or substance abuse disorder;

(vi) JXC requires treatment or care;

(vii) Without the treatment or care JXC is likely to cause harm to himself or to someone else;

(viii) JXC has previously unreasonably refused to consent to the treatment or care; and

(ix) The treatment or care, is able to be provided by a community management plan, that has been prepared and is capable of being implemented.

[33] After making the CMO and approving the management plan, the Tribunal found it was possible that modifications to the antipsychotic medication may assist with the side effects reported by the appellant. It was observed this could include a change in the type of medication or a reduction of the current medication with regular monitoring. However, the Tribunal noted the difficulties in embarking on this course because of the appellant's lack of cooperation in the past.

**Discussion of the Tribunal's decision in the light of issues raised on appeal**

[34] It is accepted the Tribunal was, with respect, correct to apply the standard of proof as expressed by *Briginshaw*, given the adverse consequences of a finding that the appellant suffered a mental illness requiring involuntary treatment. In a variety of settings it has been held that when adverse

consequences will flow, the relevant findings should "not lightly" be made.[33] However, it is still the ordinary standard of proof that is required, on the balance of probabilities, bearing in mind that the strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what it is sought to prove.[34]

[35] A finding that a person has a "mental illness" as defined by the *MHRSA* has significant consequences, specifically involuntary treatment, if it is also found the circumstances envisaged by s 16(b) of the *MHRSA* are made out. As mentioned above, the appellant gave evidence about the particular adverse consequences to himself. As pointed out by counsel for the respondent, it is important to appreciate *Briginshaw* applies to the Tribunal's fact-finding and does not curtail the manner in which a medical expert can reach an opinion about a diagnosis. The task of the diagnosis, in this case of an underlying medical illness, is entrusted to the psychiatrist's clinical opinion based on their expertise. If the medical opinion favours or confirms a diagnosis, it is open to the Tribunal to suffiently accept the diagnosis to "feel an actual persuasion of its occurrence or existence."[35] The standard required the Tribunal to actually be persuaded that the mental illness, in terms of the Act, existed to its reasonable satisfaction. That state of satisfaction is not likely to be reached based on uncertain proofs or evidence or where findings are reached by drawing indirect inferences.

---

**33** See eg *Willcox v Sing* [1985] 2 Qd R 66; *Shaun v Wolf* (1989) 83 FCR 113.

**34** *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* [1992] HCA 66; 67 ALJR 170.

**35** *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361-2.

[36] While it is accepted this is the approach, the difficulty with the conclusion of the Tribunal is that the opinion of the psychiatrists who gave evidence was that there was no more than a *possibility* that the appellant had an underlying mental illness in terms of the Act at the time of the review, or alternatively, that it was unsettled on whether the ongoing medication mitigated the symptoms of a continuing underlying mental illness. By way of contrast, their evidence was clear that the appellant has a substance abuse disorder and a very serious personality disorder, neither of which by themselves constitute "mental illness" under the Act. The evidence as to the underlying "mental illness" under scrutiny was inexact when compared with the clear direct evidence on those other conditions. Although a cautious approach on the part of the psychiatrists who gave evidence is entirely understandable and commendable, when the totality of their evidence is read, the tenor of their evidence is that they remain quite unsure about whether currently there is an underlying mental illness as opposed to a past diagnosis coupled with the symptoms of personality disorder at times aggravated by substance abuse. The Tribunal, as indicated from paragraph 30 of their Reasons, set out above, adopts Dr Weerasundra's evidence in terms of it being "possible" the symptoms are managed without the underlying mental illness being cured.

[37] The Tribunal made reference to Dr Spice's evidence and stated it was noteworthy that when JXC was being transferred back to the Adult Community Mental Health Team in 2017, the Forensic Mental Health Team

made the clinical notes set out above, referring to the diagnoses and the difficulties with his behaviour, lack of insight and refusal to engage with services.[36] The Tribunal also took into account the involuntary admissions in 2013, 2014 and 2015.[37] It was also noted those admissions were due to outbursts of erratic behaviour and not necessarily psychotic symptoms. The Tribunal also took into account the evidence on the file of the previous diagnosis of paranoid schizophrenia, and that JXC has a marked antisocial personality disorder and that that had been the opinion of other psychiatrists who had seen JXC.[38]

[38] It was obviously open to the Tribunal to find, and was clear on the evidence of Dr Weerasundra, that the lengthy 2011 admission of 55 days was consistent with a diagnosis of schizophrenia and not a characteristic of drug-induced psychosis.[39] However, on the core opinion drawn from Dr Weerasundra's evidence, the Tribunal adopted the term "possible", that is, it was "possible" that symptoms of paranoid schizophrenia had not been exhibited because they had been successfully treated by antipsychotic medication which continued.[40]

[39] As mentioned above, the Tribunal found that a psychiatrist expressed an opinion that it was more likely than not that the psychotic symptoms were

---

**36** Reasons at [9](m); full clinical note set out in para [19] above.

**37** Reasons at [17](d).

**38** Reasons at [17](h), (n).

**39** Reasons at [17](n).

**40** Reasons at [17](o).

not exhibited because they had effectively been managed by the medication.[41] The difficulty with this finding is that the doctors who gave evidence did not state in clear terms that JXC was more likely at the relevant time to be suffering from a mental illness in the terms of the Act or that he suffered serious impairment by virtue of the matters set out in ss 6(1)(a) and (b) of the *MHRSA*. That is evident in the finding at paragraph [30] of the Tribunal's Reasons referred to already. The comments of the Forensic Mental Health Team were not, on the face of it, references to any observed symptoms, but rather, the possibility of symptom relapse in the context of the past diagnosis of paranoid schizophrenia was noted in the list of "current key issues".[42] It is clear the treating team relied on the earlier diagnosis and referred to a possibility that symptom relapse may occur. Dr Spice did not see or interpret that comment as a symptom of a mental illness as defined by the Act. Dr Spice thought his own opinion was consistent with the reports from other psychiatric registrars, that there were no positive or negative symptoms of schizophrenia.[43]

[40] This appeal raises a similar issue to that encountered in *WCH v Mental Health Tribunal*.[44] There the Victorian Civil and Administrative Tribunal ("VCAT") dealt with a matter where the applicant had received medication for paranoid schizophrenia under CMOs for the previous 16 years. It was

---

41 Reasons, at [29](b)(iv).

42 Above paragraphs [19, [20].

43 Mental Health Review Tribunal, transcript, 21 December 2017, vol 1, p 3.

44 [2016] VCAT 199.

argued on his behalf that because he had not experienced symptoms for up to around four years, the evidence before the Victorian Mental Health Tribunal did not reach the requisite standard of proof to support a finding that he had a mental illness. In that matter, additional evidence was provided by another psychiatrist before VCAT to the effect that it is possible for a person to have an episode of an illness, for it to resolve, and that symptoms may not occur because of the effectiveness of the treatment or because there is not any need for treatment. That evidence is not applicable to this case; however, there are similarities in the issues of proof when the evidence is inexact on the crucial question. A further similarity with *WCH v Mental Health Tribunal* was that VCAT was told the only way to safely determine the issue was by conducting a medication reduction trial. In terms of determining whether, at the relevant time, the applicant in *WCH* had a mental illness, the VCAT presiding member determined that given there were no symptoms of episodes of the illness for such a lengthy period of time and there was a possibility that the previous illness had resolved or subsided, she could not be satisfied to the requisite standard that the criteria under the Victorian Act had been met.

[41] Taking the evidence as a whole, it is difficult to see how the Tribunal in this matter concluded on the balance of probabilities that the symptoms of mental illness as defined by the *MHRSA* persisted in the light of the inexact opinion given by the psychiatrists.

[42] While it was not necessary for the psychiatrists who gave evidence to express themselves in terms of the "balance of probabilities" or "likelihood" of the presence of mental illness, the tenor of the evidence was that it was unclear or unsettled whether a mental illness, as opposed to the appellant's other conditions, persisted. This may be compared with the clear expression of opinion in relation to the appellant's other conditions. It is not necessary that the opinions of the psychiatrists be couched in the terms used by the Act, but the evidence at its heart is they do not know if the appellant currently suffers a mental illness, or there is an unsettled view about that. While there is no onus of proof as such, there must be positive evidence of the existence of a mental illness to satisfy the Tribunal. The diagnosis was made in 2011 and 2012 and no symptoms of the kind that would satisfy the definition of mental illness in the *MHRSA* were found since that time. No evidence was given before the Tribunal on the question of the permanence or otherwise of paranoid schizophrenia or its symptoms.

[43] There was a mention in the evidence of "chronic schizophrenia" in respect of the 2011 admission; however, the use of that term some 6 to 7 years previously does not appear to add anything to the question of whether JXC currently suffers a mental illness. In any event, it is important the principle set out in s 6(3)(n) of the *MHRSA* not be contravened, namely, that a person is not to be considered to have a mental illness merely because he or she has been treated for mental illness or has been detained in a hospital that provides treatment for mental illness. Whether the earlier diagnosis was

"chronic" or not, that conclusion cannot by itself, in the terms of the *MHRSA*, prove the existence of the condition some 5 to 6 years later.

[44] It is accepted that notwithstanding a mental illness cannot be established by reason of a history of mental illness, the history is important. The history may provide strong circumstantial evidence of the presence of a mental illness. Both the psychiatrists and the Tribunal are entitled to take those matters into account. The patient's history is one of the most important factors for the psychiatrist to have regard to.[45]

[45] The Extracts From Tribunal File document contains the history relevant to the appeal, comprising warrant applications and the relevant Forms 15 for previous CMOs. A review of those documents[46] reveals principally descriptions of difficult issues associated with aggression and non-compliance, and an apprehension of symptom relapse from the 2011/2012 diagnosis. In 2014 there is a note that "Dr Corbu's impression was that he continued to suffer from residual positive symptoms and that he was insightless", however there is no further elaboration of symptoms.[47] This may have led Dr Spice to think the evidence was "not strong" in relation to the presence of a mental illness. In March 2017 a Form 15 states the

---

45 *CH v Mental Health Review Tribunal* [2017] NTSC 43 at [50], [55].

46 Form 15 CMO Application dated 19 October 2011; CMO annexing Form 15 CMO Application dated 11 September 2013; Form 8 Warrant Application dated 4 December 2013; CMO annexing Form 15 CMO Application dated 27 August 2014; CMO annexing Form 15 CMO Application dated 1 March 2017; CMO dated 21 August 2017 annexing Form 15 CMO Application dated 15 August 2017; CMO dated 16 October 2017 annexing Form 15 CMO Application dated 9 October 2017 and CMO annexing Form 15 CMO Application dated 23 October 2017. It is noted the final Form 15 dated 23 October 2017 was not provided in the Extracts form Tribunal File. Instead, the previous Form 15 dated 9 October 2017 was provide twice.

47 Form 15, 27 August 2014.

appellant's beliefs did demonstrate a degree of magical thinking, but that most were not of "delusional intensity".[48]

[46] Even given the history, which the psychiatrists were aware of, neither were able to state with confidence that the mental illness persisted. Both had concerns about the sudden withdrawal of treatment, and that symptoms may re-emerge after withdrawal from treatment, but that did not remove the need for clear evidence of the presence of a mental illness. The evidence on that point remained in the realm of possibilities.

[47] One of the difficulties in this matter, and is no doubt a difficulty for the psychiatrists and other health professionals who treat the appellant, is his difficult and aggressive behaviours as a result of the antisocial personality disorder. The clear evidence is that the medication may assist in managing the difficult behaviours associated with the antisocial personality disorder; however, obviously it would not be a permissible approach under the *MHRSA*, however tempting or convenient, to continue involuntary treatment under those circumstances.

[48] I agree with the proposition put on behalf of the respondent that the evidence and opinions of Dr Spice and Dr Weerasundra are not the only material relevant to the determination of the question of whether the appellant has a mental illness under the *MHRSA*. Much of the historical

---

**48** Form 15, 1 March 2017.

material before the Tribunal and the Court[49] refers back to the original diagnosis, with, as indicated, very little additional evidence of symptoms that were attributable to the diagnosis. As can be seen from the brief summary above, much of the material relates to the symptoms relevant to the personality disorder and associated dysfunction. It is accepted there may be overlapping symptoms; however, the evidence as to the presence of a mental illness under the *MHRSA* was unclear. It is not of course necessary that the symptoms of the mental illness be present at the time of the review, but evidence of a settled opinion or other material sufficient to satisfy the Tribunal that mental illness actually exists is required.

[49] After careful consideration and genuinely acknowledging the expertise of the Tribunal, I have concluded error occurred, as the state of the evidence was such that a finding could not be made on the balance of probabilities that the criteria for mental illness under the *MHRSA* were made out. I will order the CMO be set aside.

[50] That being the case, it is not necessary to determine ground 2 in terms of whether the appellant requires treatment. If I have been in error finding ground 1 is made out, I would dismiss ground 2. The evidence is clear that *if* the appellant had a mental illness, he would require the treatment identified in the CMO and the treatment plan, but on the evidence, the first step is not made out.

---

**49** Extracts from Tribunal File.

[51] It is unknown whether circumstances have changed since the review of the CMO. As the case dealt with possibilities, it is acknowledged the appellant possibly does continue to have a mental illness; however, he should take up the opportunity voluntarily and consistent with his medical advice to commence a trial of reduction of medication if he has not already done so. It is important he follow his medical advice. He has the opportunity to do so voluntarily.

[52] Should the appellant's mental state deteriorate, or should symptoms re-emerge, nothing in this decision prevents any future application from being made before the Tribunal or any other application or action under the Act.

**Orders**

[53] The appeal is allowed. The order of the Tribunal of 6 November 2017 is set aside.

[54] I will hear the parties on any further orders.

---