CITATION:	*CLM v Northern Territory Civil & Administrative Tribunal & Ors* [2025] NTSC 12
PARTIES:	CLM AND: NORTHERN TERRITORY CIVIL & ADMINISTRATIVE TRIBUNAL First Respondent AND: NORTHERN TERRITORY OF AUSTRALIA Second Respondent
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT exercising Territory jurisdiction
FILE NO:	2024-03526-SC
DELIVERED ON:	3 March 2025
HEARING DATES:	27 February 2025
JUDGMENT OF:	BLOKLAND J

CATCHWORDS:

MENTAL HEALTH – appeal against decision by Tribunal to make involuntary Community Management Order – whether appellant met criteria for 'mental illness' – held appellant met criteria. Insufficient evidence for a finding that appellant likely to cause serious harm to herself or another, however Community Management Order to remain in force until re-consideration or review.

Statutes
Mental Health and Related Services Act; ss 16(b)(ii)(A); 16(b)(ii)(B); 16(b)(iii); 142(3); 6(i)(a); 6(1)(b); 6(3)(n).

CH v Mental Health Review Tribunal & Anor (2017) 320 FLR 417; *Fox v Percy* (2003) 214 CLR 118; *Hunter v Mental Health Review Tribunal & Anor* (2017) 327 FLR 402; *JXC v Mental Health Review Tribunal* [2018] NTSC 62; *KMD v CEO (Department of Health NT) & Ors* [2025] HCA 4 at [20]; *Moore (a pseudonym) v The King* (2024) 98 ALJR 1119; *Warren v Coombes* (1979) 142 CLR 531, cases referred to.

REPRESENTATION:

Counsel:

Appellant:	T Clelland
Respondent:	M Moloney

Solicitors:

Appellant:	N/A
Respondent:	Solicitor for the Northern Territory

Judgment category classification:	C
Judgment ID Number:	BLO2504
Number of pages:	15

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

CLM v Northern Territory Civil & Administrative Tribunal & Ors [2025] NTSC 12
No. 2024-03526-SC

BETWEEN:

CLM
Appellant

AND:

NORTHERN TERRITORY CIVIL AND ADMINISTRATIVE TRIBUNAL
First Respondent

AND:

NORTHERN TERRITORY OF AUSTRALIA
Second Respondent

CORAM: BLOKLAND J

REASONS FOR JUDGMENT

(Delivered 3 March 2025)

BLOKLAND J:

Background

[1] This is an appeal against a decision of the Northern Territory Civil and Administrative Tribunal ('NTCAT') in respect of a Community Management

Order ('CMO') under the *Mental Health and Related Services Act 1998* (NT) ('the Act') following a hearing on 14 October 2024.[1]

[2] The Tribunal found the appellant was suffering from a schizoaffective disorder, likely exacerbated by recent trauma that required a six-month CMO. Implicit in that finding is that without treatment or care, the appellant is likely to cause serious harm to herself or to someone else;[2] or suffer serious mental or physical deterioration;[3] and that she is not capable of giving informed consent to the treatment or care or has unreasonably refused to consent to treatment or care.[4]

[3] The appeal is brought under s 142(1) of the Act. The Court may affirm, vary or set aside the Tribunal's Order, make any decision the Tribunal may have made, remit the matter to the Tribunal and/or make any order that it thinks fit as provided by s 143.

[4] The appeal is by way of rehearing.[5] It is conducted on the basis of the material before the Tribunal. The decision will only be disturbed if error is established.[6] The Court conducts a rehearing on the materials before the decision maker and is authorised to determine whether the Order that is the subject of the appeal is the result of some legal, factual or discretionary

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1 AB at 209.

2 *Mental Health and Related Services Act*; s 16(b)(ii)(A).

3 *Mental Health and Related Services Act*; s 16(b)(ii)(B).

4 *Mental Health and Related Services Act*; s 16(b)(iii).

5 *Mental Health and Related Services Act*; s 142(3).

6 *CH v Mental Health Review Tribunal & Anor* (2017) 320 FLR 417; *Hunter v Mental Health Review Tribunal & Anor* (2017) 327 FLR 402.

error. The task of a court on an appeal by rehearing is the correction of error.[7]

[5] A pre-condition to making a CMO under s 123(5)(c) of the Act is to determine whether or not a person fulfils the criteria for involuntary care or treatment in the community in the terms provided by s 16 of the Act. If so satisfied, the Tribunal must then determine whether or not to impose a CMO. The grounds of appeal challenge the first part of the process.

[6] The grounds of appeal as modified during the hearing are as follows:

1. The Tribunal erred in finding that the appellant has a mental illness.

2. The Tribunal erred in finding that the appellant is likely, without treatment, to cause serious harm to herself or to someone else.

3. The Tribunal erred in finding that without treatment or care, the appellant is likely to suffer serious mental or physical deterioration.

[7] There is no challenge, if it be found that the appellant has a mental illness, that she requires treatment or care under s 16(b)(i). Further, if the finding is that she has a mental illness, there is no challenge to the question of whether she has capacity to consent to treatment or has unreasonably refused under s 16(b)(iii) and that treatment can be provided in the community under s 16(c).

[8] It is accepted the correctness standard is the applicable standard of review. Under that standard, the appellate court determines for itself the correct

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7 *KMD v CEO (Department of Health NT) & Ors* [2025] HCA 4 at [20].

outcome of the relevant issue while making due allowance for such advantages as may have been enjoyed by the primary decision maker.[8]

[9] Having reviewed the evidence before the Tribunal and having had the benefit of counsels' submissions, the criteria for involuntary treatment is made out, save for the finding that the appellant, without treatment is likely to cause serious harm to herself or to someone else. The evidence is deficient on that point. However, that does not invalidate the finding that at the time of the Tribunal hearing, involuntary treatment was required. Nevertheless, the finding that the appellant is likely to cause serious harm to herself or others is a harsh conclusion on very patchy evidence and should be reconsidered by the Tribunal, given the specialist nature of the Tribunal.[9]

[10] Even though error has been made evaluating the material concerning the likelihood of causing serious harm to herself or another person, the CMO will remain in place until the Tribunal has reconsidered the matter or reviewed the order through its usual processes, whichever is the first in time.

Ground 1:

The Tribunal erred in finding that the appellant has a mental illness.

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8 *KMD v CEO (Department of Health NT) & Ors* [2025] HCA 4; *Moore (a pseudonym) v The King* (2024) 98 ALJR 1119 at [14]; *Warren v Coombes* (1979) 142 CLR 531 at 552; *Fox v Percy* (2003) 214 CLR 118 at [23].

9 *CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43 at [37].

[11] Mental illness is defined under the Act as 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'.[10] The person must be suffering from 'at least one' of the symptoms of delusions, hallucinations, serious disorders of the stream of thought, serious disorders of thought forms or serious disorders of mood.[11] Sustained or repeated irrational behaviour indicative of those symptoms will also suffice to meet the definition.[12]

[12] A further matter of significance here, is that 'a person is not to be considered to have a mental illness merely because he or she' has been treated for a mental illness or has been detained in a hospital that provides treatment of mental illness.[13]

[13] The standard of proof requires the *Briginshaw* principles to be applied.[14] A finding that a person suffers from a mental illness should not be lightly made, given the finding is likely to lead to adverse consequences for the person. The standard remains the balance of probabilities. The state of satisfaction is not likely to be reached based on uncertain proof or where findings are reached by drawing indirect inferences.

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10 *Mental Health and Related Services Act*; s 6(1).

11 *Mental Health and Related Services Act*; s 6(i)(a).

12 *Mental Health and Related Services Act*; s 6(1)(b).

13 *Mental Health and Related Services Act*; s 6(3)(n).

14 *JXC v Mental Health Review Tribunal* [2018] NTSC 62 at [34].

[14] In this matter it was important to ensure the finding of a current mental illness was not merely based on a previous diagnosed mental illness. The previous diagnosis is still relevant when the illness is chronic or enduring. However, a current diagnosis cannot ‘merely’ be found on the basis of the previous finding.

[15] There was evidence on the Form 15 which contained general clinical observations. Those were from notes taken by Dr Erickson and Ni Kadek Risyamayanti of the interview with the appellant on 10 September 2024.

[16] A diagnosis of schizoaffective disorder was noted. It was stated that schizoaffective disorder was established during the appellant’s most recent admission in March 2024. The background was said to include numerous episodes of psychosis associated with substance use (methamphetamine), resulting in inpatient admissions with evidence of medication non-compliance once she was discharged from hospital. Further, it was stated that during the last admission there were features of mania, with pressured speech, psychomotor agitation and elevated behaviour. There was a strong psychotic component to her presentation, with grandiose and religiose delusions. Collateral history from her parents was said to indicate evidence of psychotic phenomena. She had experienced delusions regarding religion and hallucinations.

[17] Her presentation at the time of the documenting of the Form 15 material was stated to establish a diagnosis of schizoaffective disorder. The illness was

also described as a diagnosis of schizoaffective disorder complicated by possible stimulant or methamphetamine use. Further, it was said to be an enduring mental illness, or a chronic psychotic illness with a good response to treatment during inpatient admission and that the appellant remained in remission while she was on medication in the community.

[18] From the Tribunal hearing, parts of the evidence relevant to this issue were as follows. When asked to describe why he was seeking a six-month CMO Dr Erickson said the appellant has a diagnosis of schizoaffective disorder in her last admission back in March 2024. It was brought on by psychotic and manic symptoms and after an incident at the Esplanade she was admitted. The admission was quite long, about four weeks. Previously the appellant had multiple admissions of drug induced psychosis but the previous admission with the new diagnosis of schizoaffective disorder was due to the prolonged or protracted nature of the psychotic and manic illness symptoms. Dr Erickson said the appellant requires treatment.

[19] There was evidence of a positive test for amphetamine, however the appellant denied taking methamphetamine but had been taking prescribed duromine.

[20] Dr Erickson also said he had not observed any ongoing psychotic and manic symptoms with her since he had seen her, and that was during a period when she was having medication.

[21] Dr Erickson told the Tribunal the appellant has had four admissions for drug induced psychosis. He noted such psychosis usually requires admission for a couple of days. However, the appellant had protracted admissions in 2021 and 2022. The last admission (March 2024) of a month or so was because it was harder to stabilise her mental state which, he said is quite common for people with recurrent psychosis and mental illness.

[22] Dr Erickson accepted the appellant was subject to extreme stress which may have contributed to a psychotic episode. The stressors included dealing with the death of her brother, quite a serious assault in December 2023, the murder of her son and the aftermath of prosecution processes.

[23] In terms of the basis of the opinion that the diagnosis should be schizoaffective disorder rather than what was suggested as a brief episode of psychosis that resolved, Dr Erickson said a month is not a brief episode, a brief episode would resolve quite quickly. He accepted substance use, including duromine use, and stress will contribute to psychosis but not everyone in those circumstances will have a psychotic episode. Dr Erickson explained that he did not know how long it was before the appellant came to the attention of services but it took over a month to resolve the illness and that is not representative of a brief or reactive psychosis, nor is it indicative of drug induced psychosis.

[24] Dr Erickson accepted that the appellant may have had a brief psychotic episode but he thought that was unlikely due to the fact she had been in the

community for much longer and only came to their attention due to her behaviours on the Esplanade. An incident on the Esplanade was the trigger which led to the previous admission. He accepted it was speculative in terms of how long the appellant may have been unwell as he did not know what had happened prior to her previous admission. Since that time she has been on medication and has not had another psychotic episode despite ongoing stressors. He thought that being on medication was keeping her well. Dr Erickson added that usually with a brief psychotic episode there is not an element of mania, which was present in her case.

[25] There is no doubt the previous admission and diagnosis informed the diagnosis under question, but that was not the only factor leading to the current diagnosis. The mental illness was of an enduring or chronic nature. The underlying mental illness was present but under control with medication. The diagnosis was also based on the appellant's interview of September 2024. Dr Erickson properly considered the alternative hypothesis, that the appellant had suffered a brief episode but ruled it out due to the presence of mania. That he was open to other alternatives does not detract from his final conclusion.

[26] Having regard to all of the material, in my view the finding that there was a mental illness at the time of the Tribunal hearing was not in error.

Ground 2:

The Tribunal erred in finding that the appellant is likely, without treatment, to cause serious harm to herself or to someone else.

[27] Dr Erickson's opinion was that the appellant, if untreated was likely to cause serious harm to herself or to someone else.

[28] The Form 15 states that the appellant remains a high risk of vulnerability with a history of acute deterioration in her mental state secondary to medication non-compliance, with impaired judgement and intrusive behaviour with the members of the public. It states 'collateral history and review of her clinical file also notes previous alleged domestic violence, of which CLM is both the alleged victim and perpetrator. There is a high risk of violence towards others when CLM is acutely mentally unwell, including her immediate family and members of the community – as evidenced by her violent and threatening behaviour towards council workers precipitating her last admission via police/ambulance.'

[29] The focus of the evidence in relation to risk to herself or others is almost entirely with respect to the March 2024 admission. It is stated the appellant is a 'high risk to others when unwell including threatening to kill Council workers prior to last admission in March 2024.'

[30] At the time of the admission in March 2024 which those observations relate to, the appellant was under acute distress, which included the aftermath of

the murder of her son. The risk of harm to herself and to the public was effectively the reason for the earlier admission in March 2024.

[31] Asked about a reference to a domestic violence incident with her daughter and Dr Erickson said “no, I am not sure, this was handed over to me by the impatient team, sorry. All I know is that there is a history of domestic violence”. At no point is the history of domestic violence detailed in the evidence. The appellant, it seems, may have also been a survivor of domestic violence, which although puts her at risk in a general sense, is not what is contemplated by the Act as being a risk to others.

[32] There is no doubt the events leading to the March 2024 admission would have been alarming to those members of the community and council workers. Police and ambulance officers were called to the Esplanade. The appellant was highly agitated and made threats while in a likely psychotic state. She was also in a stressed state when still dealing with the aftermath of the murder of her son. There is no material indicating any physical harm to any person. That is not to say that the threats must have caused significant apprehension. The material falls short of establishing a risk of causing serious harm, either to members of the public or in any domestic setting. No details of allegations were given of the latter.

[33] Dr Erickson also spoke of the propensity to violence of people with psychotic illness, in the sense that there is a higher risk of violence than in the general population, if they become unwell. That can be accepted.

However, that statistical factor of itself or taken with the evidence of threats enlivening a previous admission falls short of what is required to be proven. It is a strong negative finding to make against the appellant on the known material. It is a finding which may be thought to be stigmatising. There may be other relevant material that was not brought forward but the assessment can only be made on the evidence before the Tribunal.

[34] The finding is in error.

[35] Ground 2 will be allowed.

Ground 3:

The Tribunal erred in finding that without treatment or care, the appellant is likely to suffer serious mental or physical deterioration.

[36] The Form 15 states:

> "[The appellant] presents a high risk of deterioration in her mental state and physical health without ongoing treatment of her schizoaffective disorder. She has a high risk of deterioration in a mental state secondary to the medication non-compliance owing to her chronically impaired capacity to consent to treatment, poor insight into her psychiatric diagnosis and long-standing scepticism towards psychiatric treatment. In the event of a deterioration in her mental state, risk to her physical health include deterioration secondary to neglect as well as serious injury through misadventure related to risky and impulsive behaviour."

[37] Reference is made in the Form 15 to the appellant's ongoing refusal of medication, with a background of no insight into her mental illness. She has expressed a long-standing opposition towards all psychiatric medication, her

diagnosis and any insight into her need for treatment despite repeated attempts at psycho education.

[38] Dr Erickson was asked why he was seeking the six-month CMO and he said that the appellant had adamantly denied the fact that she has any mental illness and therefore does not have any insight into the need for medication. He thought that because of her lack of insight, she had not retained capacity to self-care when she is unwell and that she risks deterioration when not medicated.

[39] There was not any real challenge to the evidence of risk of mental or physical deterioration. The only challenge was through a suggestion that the appellant's previous deterioration in mental state was a result of substance use as opposed to cessation of medication. Dr Erickson agreed that substance use could lead to a relapse, but that it was unlikely to occur while the person was taking medication.

[40] The evidence as a whole shows the appellant at the time of the review was unlikely to voluntarily comply with the treatment regime or would unreasonably refuse to consent to treatment.

[41] Ground 3 is dismissed.

MFI 1 and MFI 2

[42] The appellant filed material received as MFI1 and MFI2. It was not a case where fresh evidence would have been admissible. As the appellant was

anxious to be heard herself, I agreed to read the filed material on the basis that it not form part of the decision-making on the appeal. I am grateful to counsel for the respondent for consent to that course, given the appellant's vulnerabilities and anxiety that she explain certain personal matters.

[43] Having now read the material, it is clear the appellant has been through some extreme personal challenges including grief at a most fundamental level. She is in need of social support. As her case will be reviewed in due course by the Tribunal, it is important that she ensure her lawyers have the material to determine whether it should be placed before the Tribunal.

[44] The appellant has raised her significant trauma history and her being labelled a risk to society has contributed to her suffering. It is important for mental health practitioners to develop trauma informed practices so that such labels are not unnecessarily attached to people who may not be such a risk.

Orders:

1. The appeal is allowed in part.

2. Ground 2 is allowed, grounds 1 and 3 are dismissed.

3. The finding that without treatment the appellant is likely to cause serious harm to herself or to someone else is quashed.

4. (a) The matter is remitted to the Tribunal to reconsider whether without treatment or care the appellant is likely to cause serious harm to herself or to someone else in accordance with s 16(b)(ii)(A) of the Act; or

   (b) reconsider the same issue in the context of the next review of the Community Management Order, if the Tribunal has not re-convened before the next review of the Community Management Order to re-consider s 16(b)(ii)(A).

5. The Community Management Order is to remain in place until the next review by the Tribunal.

6. If any party is applying for costs, leave is granted to contact Chambers within 28 days to make appropriate orders or confirm any consent order.

7. The decision and orders will be forwarded to counsel by email today.
