

DECISION-MAKING CAPACITY AND THE VICTORIAN MENTAL HEALTH TRIBUNAL

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ABSTRACT

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) has led to a re-thinking of traditional mental health law around the world. Since Australia's ratification of the CRPD, all but one of its eight jurisdictions have introduced reforms to mental health legislation. These are aimed, in part, towards compliance with the Conventions articles. This paper examines the meaning and operation of the reforms introduced in Australia's second most populous state – Victoria.

We first describe the criteria for involuntary treatment set out in the new *Mental Health Act 2014* (Vic) (Austl.) (the Act). We then argue that when making an order for Involuntary Treatment, the Victorian Mental Health Tribunal (the Tribunal) is obliged to carefully consider a person's decision-making capacity as part of ensuring that treatment is provided in the least restrictive way, and to only authorise the involuntary treatment over a person's competent objection in very limited circumstances.

Having established the way in which the Act *should* operate, we then present two empirical studies which analyse the decisions of the Statements of Reasons of the Tribunal to gain some appreciation of how the Act is working. These indicate that seldom does the Tribunal consider the decision-making capacity of people brought before it, and that, even when this is considered, the relevant information is not being used protectively so as to uphold a right to competently refuse treatment. Instead, the Tribunal uses the presence or absence of decision-making capacity, insight or poor judgement, to determine if a person is mentally ill or if treatment is required to prevent serious harm. We conclude that the Tribunal's practice is inconsistent with the principles of the Act and consequently the intention of Parliament.

I. INTRODUCTION

It is well established that an adult's competent refusal of general medical treatment must be respected. This is the case, even if that refusal might be regarded as foolish or irrational and even if it will result in the person suffering serious harm, or even death.¹ Generally, an adult may only be given medical treatment contrary to her/his stated objection, if it can be shown that the person lacks decision-making capacity around that decision. That is to say, it must be shown that the person either cannot comprehend and retain the information relevant to the decision or cannot use and

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¹ *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18; [1993] Fam 95 ('*Re T*'); *Re MB (Medical Treatment)* [1997] EWCA 3093; [1997] 2 F.L.R. 426.

weigh that information.² Until very recently this strong legal principle did not apply to psychiatric treatment in Australia. Prior to 2013 no Australian jurisdiction used the presence, or absence, of decision-making capacity as a deciding factor for the imposition of treatment without consent.³

In July 2008, Australia ratified the UN Convention on the Rights of Persons Disabilities (CRPD)⁴ and since that time, as each Australian jurisdiction has reformed its mental health legislation, those reforms have been motivated, in part, by the articles of the Convention and a desire to address the disparities regarding the role of decision-making capacity.⁵ The meaning of the CRPD with respect to involuntary psychiatric treatment is not straightforward and has led to considerable debate.⁶ However, almost everyone has concluded that art 12(2) of the instrument (“States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”), requires that recognition of the right of competent adults to refuse psychiatric treatment.

Four jurisdictions – Queensland, South Australia, Tasmania and Western Australia – have attended to the matter by reforming their mental health legislation so that a competent mentally ill person can refuse psychiatric treatment.⁷ The Australian Capital Territory, New South Wales and Victoria have approached this disparity by a series of different, less straightforward, reforms.⁸

In this paper, we consider the Victorian *Mental Health Act 2014* as a case study illustrative of the current tensions in considering decision-making capacity and mental health legislation. This Victorian case study has implications for other jurisdictions, as studies have shown that many people, both in inpatient units and on community

² *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

³ Christopher James Ryan, ‘Capacity as a Determinant of Non-Consensual Treatment of the Mentally Ill in Australia’ (2011) 18(2) *Psychiatry, Psychology and Law* 248.

⁴ (United Nations [UN]) 2515 UNTS 3, UN Doc A/RES/61/106, Annex, GAOR 61st Session Supp 49, 65. (Adopted) 13th Dec 2006, (Opened For Signature) 30th Mar 2007, [Entered into Force] 3rd May 2008.

⁵ See for example: Australian Capital Territory Parliamentary Counsel, *Revised Explanatory Statement, Mental Health (Treatment and Care) Amendment Bill 2014* (2014); NSW Ministry of Health, Review of the NSW Mental Health Act 2007. Report for NSW Parliament: May 2013. Summary of Consultation Feedback and Advice (2013); Panayiotis Tyllis, The Review of the Mental Health Act 2009. A Report by the Chief Psychiatrist of South Australia (2014); *Explanatory Guide, Mental Health Bill (Tas) 2011 (Exposure Draft)* (2011); State Government of Victoria, *Exposure Draft Mental Health Bill 2010. Explanatory Guide* (2010); *Explanatory Memorandum, Mental Health Bill 2013 (WA)* (2013).

⁶ Sascha M Callaghan and Christopher Ryan, ‘An Evolving Revolution: Evaluating Australia’s Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law’ (2016) 39 *University of New South Wales Law Journal* 596.

⁷ These jurisdictions have incorporated a new criterion into the criteria that must be met to provide involuntary treatment that requires that the person lack decision-making capacity. See for example: *Mental Health Act 2016 (Qld)* s 12(1)(b); *Mental Health Act 2009 (SA)* s 21(1)(ba), as inserted by, *Mental Health (Review) Amendment Act 2016 (SA)* s 17(3); *Mental Health Act 2013 (Tas)* s 40(e); *Mental Health Act 2014 (WA)* s 25(1)(c).

⁸ New South Wales, for example, inserted a new mental health principle into its Act requiring clinicians to make “every effort that is reasonably practicable” to monitor patients’ capacity to consent and to obtain consent when developing treatment plans: *Mental Health Act 2007 (NSW)* s 68(h1); Christopher James Ryan and Sascha Callaghan, ‘The Impact on Clinical Practice of the 2015 Reforms to the NSW Mental Health Act’ (2017) 25 *Australasian Psychiatry* 43.

treatment orders, retain decision-making capacity relevant to some decisions about their treatment.⁹ This is a question of concern for both those who have capacity and who express a desire to refuse treatment, and those who do not have capacity and are 'voluntarily' receiving it without formal legal authority.¹⁰

Under the Act, Treatment Orders, facilitating psychiatric treatment without consent, are made by the Victorian Mental Health Tribunal (the Tribunal). The Act has specific mechanisms, which require the Tribunal to make a determination about a person's capacity at hearings authorising electroconvulsive treatment (ECT) and neurosurgery aimed at treating mental illness.¹¹ ECT and neurosurgery are not considered in this paper, which focuses instead on treatment orders which authorise other involuntary psychiatric treatment and detention for the purpose of providing that treatment. The Act does not specifically require the Tribunal to consider a person's decision-making capacity when deciding whether or not to make an order, but it does require treatment to be provided in the 'least restrictive way possible', with a preference for voluntary treatment.¹²

The first section of this paper will argue that in order to ensure treatment is provided in this least restrictive way, the Tribunal *must* have careful regard to the decision-making capacity of people brought before it and only authorise the involuntary treatment of a person over their competent objection in very limited circumstances.

In the second section, we present findings from two parallel studies that illustrate the way the Tribunal has responded to the issue of capacity when making decisions about involuntary treatment. These studies demonstrate that while the Tribunal rarely considers a person's decision-making capacity in a protective sense, so as to uphold their competent refusal of treatment, it regularly takes into account a person's ability to make decisions when determining if they have a mental illness, or if they require treatment for their mental illness.

II. CAPACITY AND THE ACT

While the Mental Health Act 2014 (Vic) (Austl.) does not provide an absolute right to competently refuse psychiatric treatment, there are a number of factors which suggest that a consideration of the treatment criteria requires, in turn, a consideration of a person's decision-making capacity. Capacity is defined in s 68 of the Act:

*A person has the **capacity to give informed consent** under this Act if the person—*

- (a) understands the information he or she is given that is relevant to the decision; and*
- (b) is able to remember the information that is relevant to the decision; and*

⁹ David Okai et al, 'Mental Capacity in Psychiatric Patients' (2007) 191(4) *The British Journal of Psychiatry* 291; Duncan Milne, Anthony O'Brien and Brian McKenna, 'Community Treatment Orders and Competence to Consent' (2009) 17(4) *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists* 273.

¹⁰ Beth Ranjit, 'Can the Use of the Mental Health Act Be the "Least Restrictive" Approach for Psychiatric in-Patients?' (2016) 2016 (22) *International Journal of Mental Health and Capacity Law* 51.

¹¹ *Mental Health Act 2014* (Vic) ss 96, 102.

¹² *Mental Health Act 2014* (Vic) s 11(1)(a).

- (c) is able to use or weigh information that is relevant to the decision; and*
- (d) is able to communicate the decision he or she makes by speech, gestures or any other means.*

As with other Australian mental health Acts, the Victorian legislation provides that a person may only be subject to involuntary treatment if certain criteria are met. These qualifications are set out in s 5:

*The **treatment criteria** for a person to be made subject to a Temporary Treatment Order or Treatment Order are—*

- (a) the person has mental illness; and*
- (b) because the person has mental illness, the person needs immediate treatment to prevent—*
 - (i) serious deterioration in the person's mental or physical health; or*
 - (ii) serious harm to the person or to another person; and*
- (c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and*
- (d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.*

We argue that the final criterion, the least restrictive criterion, requires a consideration of a person's decision-making capacity. A competent person is already 'enabled' to receive the immediate treatment, as they are 'able' to make the decision themselves, and receive the treatment voluntarily.¹³ As voluntary treatment must be preferred, forcing a competent person to receive treatment will almost never be the less restrictive means available to enable a person to receive medical care.

This reasoning means that the Act requires the Tribunal to consider any assessment of the patient's capacity, and requires that such an assessment has taken place. To understand the role that the presence or absence of decision making capacity plays in whether or not a person with a mental illness can be treated involuntarily under the Act, it is necessary to examine the treatment criteria, especially the least restrictive criterion, in the context of the rest of the Act.

While the process of statutory interpretation is fluid and contested, the Tribunal must adopt a construction of the Act which would 'promote the purpose or object underlying the Act'.¹⁴ This requires an analysis of the relevant provisions of the Act, and other indicators of its purpose.¹⁵ These include other relevant provisions of the Act, the intention of Parliament, other laws and international treaties, and relevant case law.

III. THE PROVISIONS OF THE ACT

Perhaps the most relevant provision of the Act in considering capacity is s 70(1), which requires that '[b]efore treatment or medical treatment is administered to a person in accordance with this Act, the informed consent of the person must be sought' and '[t]he person seeking the informed consent of another person to a treatment or medical

¹³ The definition of the word, 'enable', is 'to make able; give power, means, or ability to; make competent; authorise' Macquarie Dictionary, *Enable* (Macquarie Dictionary Publishers, 2017).

¹⁴ *Interpretation of Legislation Act 1984* (Vic) s 35(a).

¹⁵ Michelle Sanson, *Statutory Interpretation* (OUP Australia & New Zealand, 2012).

treatment must presume that the other person has the capacity to give informed consent'. This presumption of capacity clearly applies to psychiatrists and other treating clinicians empowered by the Act, but can also be read to bind the Tribunal, as the making of a treatment order is a necessary precursor to administering compulsory treatment. If s 70(1) is held to bind the Tribunal, the Tribunal must seek the informed consent of people who it considers making orders about, and presume that the person has capacity.

Supporting this interpretation, s 55 requires the Tribunal to have regard to 'the person's views and preferences about treatment of her/his mental illness and the reasons for those views and preferences...'. In the context in which the Tribunal operates, it seems impossible to have regard to a person's views about treatment and the reasons for those views, without considering their capacity to consent to that treatment.

In addition to ss 55 and 70, the Act sets out clear objectives in s 10, including "to enable and support persons who have mental illness or appear to have mental illness ... to make, or participate in, decisions about their assessment, treatment and recovery" and "to protect the rights of persons receiving assessment and treatment". Similarly, the mental health principles, in s 11, require that people "be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected". They must also "be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk" while they "have their rights, dignity and autonomy respected and promoted".

The objectives and principles of the Act strongly reinforce the presumption that a patient's competent refusal should carry considerable weight when the Tribunal decides whether there is no less restrictive way for the patient to be treated, even in the face of an envisaged harm that might result from that refusal. One purpose of the Act is to protect human rights, including the right to make decisions about treatment – a right generally enjoyed by all competent Victorians with respect to medical treatment, and a right which the Tribunal has a responsibility to safeguard.

IV. THE INTENTION OF PARLIAMENT

Introducing the *Mental Health Bill 2014* (Vic) ("the Bill") into Victorian Parliament, the Health Minister proclaimed that it was "about maximising individual choice, autonomy, opportunity and wellbeing during a person's life" and that at "the very heart of the bill" was a supported decision making model that would "enable patients to make or participate in decisions about their assessment, treatment and recovery and to be provided with the support to do so".¹⁶ In doing so the Minister highlighted the fact that under the Act, patients would "be presumed to have capacity to make their own treatment decisions" though that presumption could be displaced. She also noted that a person may only be made subject to an involuntary order "if there is no less restrictive means reasonably available to enable the person to be assessed or treated" and that this includes "whether the person can receive mental health treatment voluntarily".

¹⁶ Victoria, *Parliamentary Debates*, Legislative Assembly, 20 February 2014, 470 (Mary Wooldridge).

Despite this, the Minister endorses the fact that the Act would also facilitate the treatment of some people despite a competent objection, stating that this was “necessary to ensure that patients receive treatment at times when ... the person needs treatment to prevent serious harm to the person or another person or to prevent serious deterioration in the person's mental or physical health”.¹⁷ The use of the word ‘ensure’ here is inconsistent with the wording of the Act, which does not ‘ensure’ that people receive treatment, but ‘enables’ it.

Reading these somewhat contradictory aims together, it appears that the intention of Parliament was to only allow the override of competent refusal in a very limited set of circumstances when treatment was necessary to ensure the prevention of serious harm.

V. OTHER LAW

In the second reading speech, the Government also claimed that the Bill was compatible with the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Austl.).¹⁸ Section 32 of the Charter stipulates that “[s]o far as it is possible to do so consistently with their purpose, all statutory provisions must be interpreted in a way that is compatible with human rights” and that “International law ... relevant to a human right may be considered in interpreting a statutory provision”.

This allows the consideration of art 12 of the CRPD, which requires that states ensure that ‘persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life’ and to ‘take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity’. An analysis of the compliance of the Act with the CRPD has been undertaken elsewhere,¹⁹ but any analysis would indicate that it requires States Parties to ensure that a person is as able as possible to participate in their own decision making. This must include some consideration of a person’s decision-making capacity.

The Act, read as a whole, restricts the cases where a competent decision can be overridden to options of last resort – quite literally the least restrictive option. Even if a person is assessed as requiring support to exercise their decision-making capacity, or is assessed as needing to have a substituted decision-maker, an assessment of capacity must take place at some point.

What little case law exists supports this analysis.²⁰ To date no court of record has ruled

¹⁷ Victoria, *Parliamentary Debates*, Legislative Assembly, 20 February 2014, 475 (Mary Wooldridge).

¹⁸ *Ibid.*

¹⁹ Chris Maylea and Asher Hirsch, ‘The right to refuse: The Victorian Mental Health Act 2014 and the Convention on the Rights of Persons with Disabilities’ (2017) 42(2) *Alternative Law Journal*.

²⁰ There is an automatic right to have decisions of the Tribunal reviewed by the Victorian Civil and Administrative Tribunal (VCAT) under s 201 of the Act. This review is not an appeal, but a *de novo* hearing, which is in turn appealable, by leave, to the Victorian Supreme Court or Court of Appeal. While a theoretical avenue for review of a Tribunal decision may rest in the inherent jurisdiction of the Supreme Court, under order 56 of the *Supreme Court (General Civil Procedure) Rules 2005* (Vic), in

on the way the treatment criteria are applied, and only one has been decided by the Victorian Civil and Administrative Tribunal (VCAT). This case, *WCH v Mental Health Tribunal (Human Rights)*,²¹ is entirely consistent with the reading of the Act proposed here.

WCH was a gentleman diagnosed with schizophrenia who had been subject to Community Treatment Orders (CTOs) made by the Tribunal and its predecessor (the Mental Health Review Board), for 16 years. WCH did not believe himself to have schizophrenia but agreed he had been depressed from time to time and was willing to take treatment for this. WCH felt the CTO infringed “his freedom of thought and rights”²² pursuant to the 2006 Charter and wanted it set aside. He proposed that he would slowly decrease his current antipsychotic medication and voluntarily undergo supervision by his current treating team for a year to allow monitoring for relapse. In revoking the order, the presiding Member emphasised being “satisfied that, having regard to WCH’s intention to undertake a managed and supervised medication reduction under the care of the service – a course of action which has been described as ‘a reasonable therapeutic strategy’ – there is a less restrictive means of treatment available to WCH and so that criterion is not met”.²³

In addressing the least restrictive criterion specifically, and having noted that the independent expert psychiatrist had consider WCH’s plan “a reasonable option”, the Member opined:

Allowing WCH to become a voluntary patient engaging in treatment in order to reduce and potentially eliminate the medication he has been receiving for 16 years is consistent with his dignity as a person and principle 1(d). That is because it would allow him to make decisions about his own treatment and recovery having assessed the risk associated with that treatment. It would also be consistent with VCAT’s section 55(2) obligation to take into account WCH’s views and preferences and WCH’s Charter rights²⁴

The Member also declared herself satisfied that WCH had “the capacity to give informed consent to this course of action in the way discussed in sections 68 and 69”²⁵ of the Act [107], and noted that “[i]n that light, WCH falls squarely within the MH Act’s objective of being treated in the least restrictive way possible with the least possible restrictions on his Charter rights and human dignity”.²⁶ She continued, “It is also consistent with the MH Act’s objectives to enable people to make and participate in decisions about treatment and recovery and to promote recovery”.

practice it is extremely difficult to have a decision of the Tribunal subject to judicial review – only decisions of VCAT. For an example of this occurring in practice in Western Australia, see: *LS-v-Mental Health Review Board* [2013] WASCA 128. Decisions made by VCAT may be persuasive, and strongly influence decisions of the Tribunal, but the Tribunal is not bound by these decisions. Questions of law may be referred by the Tribunal itself to the Supreme Court under s 197 of the Act, however this has not yet occurred. This means that unlike, for example, the English and Welsh Mental Capacity Act 2005, a body of case law for interpreting the Act has not been generated.

²¹ *WCH v Mental Health Tribunal (Human Rights)* [2016] VCAT 199.

²² *WCH v Mental Health Tribunal (Human Rights)* [2016] VCAT 199, para 2.

²³ *WCH v Mental Health Tribunal (Human Rights)* [2016] VCAT 199, para 6.

²⁴ *WCH v Mental Health Tribunal (Human Rights)* [2016] VCAT 199, para 106.

²⁵ *WCH v Mental Health Tribunal (Human Rights)* [2016] VCAT 199, para 107.

²⁶ *WCH v Mental Health Tribunal (Human Rights)* [2016] VCAT 199, para 108.

This clearly supports the argument that an assessment of a person's decision-making capacity should be undertaken when considering which option is the least restrictive. There is nothing in the Act that would prevent the Tribunal from legitimately coming to the view that treatment should be given and override the patient's competent refusal, but the construction of the Act places very significant constraints on the circumstances where this would be a reasonable conclusion to draw.

VI. ARGUMENTS AGAINST

This analysis of the Act which has been put forward is not universally accepted. The main argument against reading a requirement to consider a person's capacity into the least restrictive criterion is that the previous Act, the now repealed *Mental Health Act 1986* (Vic) (Austl.), included a distinct capacity criterion, which is no longer present.²⁷ Had Parliament intended to require the Tribunal to consider a person's capacity, it would have explicitly said. This is a generally accepted tenant of statutory interpretation, however the 'strongest statutory presumption is that legislation cannot, in the absence of clear words, abrogate fundamental rights.'²⁸ As the rights of bodily integrity, freedom of movement and competent refusal of medical treatment are fundamental rights, the legislation should be read so as to be compatible with those rights, so far as is possible.

Additionally, the CRPD arguably requires preservation of the legal right to refuse treatment, even when a person lacks decision-making capacity.²⁹ Despite this apparent inconsistency, the presumption that legislation should be read so as to conform with international law requires that it should be read to be consistent 'as far as its language admits',³⁰ and an approach which supports competent refusal protects more rights than an approach which ignores it.³¹

As with any process of statutory interpretation, in the absence of judicial consideration, the lower Tribunal is required to interpret the Act as best it can. The remainder of this paper examines how this has played out in practice.

VII. CAPACITY AND THE TRIBUNAL

The Tribunal publishes many of its statements of reasons concerning its determinations. Statements are usually only generated if a party requests one under s 198 of the Act.

²⁷ *Mental Health Act 1986* (Vic) s 8(1)(d). Notably this treatment criterion was not of the sort that excluded people who retained decision-making capacity from being subject to involuntary treatment as the reformed treatment criteria in Queensland, South Australia, Tasmania and Western Australia do. Rather it stipulated that for involuntary treatment to be applied it must be the case that "the *person has refused* or is unable *to consent to the necessary treatment* for the mental illness" [emphasis added]. Therefore, it was not a "capacity criterion" in the more contemporary sense: Christopher James Ryan, 'Capacity as a Determinant of Non-Consensual Treatment of the Mentally Ill in Australia' (2011) 18 *Psychiatry, Psychology and Law* 248.

²⁸ Sanson, above n 15, 206.

²⁹ Maylea and Hirsch, above n 19.

³⁰ *Jumbunna Coal Mine NL v Victorian Col Miners Association* (1908) 6 CLR 309, 363.

³¹ Maylea and Hirsch, above n 19.

Up until October 2015, it was the Tribunal's practice to publish all such statements of reasons on the Australian Legal Information Institute's (AustLII) website, unless the case was deemed particularly sensitive or difficult to anonymise. After October 2015, the Tribunal changed this practice so that it only publishes statements which meet certain criteria, such as those which address complex or novel legal questions, are informative examples of decision-making and those which highlight the principles of the Act.³² This means that while they may not be representative of all Tribunal hearings, the selection bias should tend towards decisions which the Tribunal would like to be seen as representative.

This section will now detail the findings of two studies which examined these statements of reasons to determine the way the Tribunal engages with the issue of decision-making capacity.

VII. 1 First Study

The first study aimed to examine the extent to which the presence or absence of decision-making capacity was relevant to the Tribunal's reasoning in its application of the least restrictive criterion as reflected in its statements of reasons.

Method

Consideration of all 206 statements of reasons available as of the 31 July 2016, covering the period from 1 January 2015 to 30 June 2016 which included a determination as to whether the least restrictive criterion had been met. This excluded statements of reasons for electroconvulsive treatment or where the least restrictive criterion was not considered.

The statements of reasons were characterised into five groups as outlined below.

Group 1 consisted of those statements in which the Tribunal clearly noted that it had considered the presence or absence of a patient's decision-making capacity as a factor in its determination of whether the least restrictive criterion had been met.

Group 2 consisted of those statements in which the Tribunal did not refer directly to the presence or absence of decision-making capacity, but did refer to the patient's ability to understand, use and weigh, or recall, information or the ability to communicate a decision, and this appeared to be a factor in the its determination of whether the least restrictive criterion had been met.

Group 3 statements were those in which the Tribunal referred neither to decision-making capacity nor its elements, but made reference to either the patient's beliefs or insight and this reference appeared to be a factor in its determination of whether the least restrictive criterion had been met.

³² Grace Horzitski, 'General Enquiry Statements of Reasons on AustLII (Pers. Comms. Mental Health Tribunal)', 16 June 2016.

Group 4 statements were those in which the Tribunal made no reference to any of the concepts mentioned above, but made note of the importance of autonomy, or of the right to take risks, or of the mental health principles in subsections 11(1)(e) or 11(1)(d) that respectively refer to these rights, and this consideration appeared to be a factor in its determination of whether the least restrictive criterion had been met.

Finally, a statement was assigned to Group 5 if none of the above applied. That is, decisions where, with respect to its consideration of the least restrictive criterion, nothing in the Tribunal's statement of reasons contained a suggestion that the patient's decision-making capacity had been considered.

A statement of reasons was only allocated to one of the first four groups if it was clear that the concepts relevant to each group formed part of the Tribunal's rationale for finding the least restrictive criterion either was met or not met. If, for example, the Tribunal reported that the patient's legal representative had argued that the patient "understood" h/she was ill or needed treatment, but the Tribunal had not appeared to refer to the patient's understanding as a relevant factor in its determination, then that decision was allocated to Group 5 not Group 2.

If a case had elements that would allow classification into more than one of the groups above, it was allocated to the group of the smallest number. So, for example, if a statement referred to both a patient's "understanding" and the importance of respecting autonomy, it was assigned to Group 2 rather than 4.

When a Tribunal returned a split decision, as it did in eight of the cases,³³ only the reasoning of the majority was taken into account. The percentage of times the Tribunal found that the least restrictive criterion was met and not met was reported for each group.

Results

Cases in Groups 1 and 2 in which it is clear the Tribunal considered decision-making capacity

The presence or absence of the patient's decision-making capacity was explicitly documented as a factor in the Tribunal's determination of whether the least restrictive criterion had been met in only 3 of the 206 cases. In the first of these Group 1 cases,³⁴ the Tribunal found the patient's "ability to make treatment decisions was impaired due the severity of her mental illness" and related to this, reasoned she "would not be able to receive immediate treatment in a less restrictive manner and that compulsory treatment was required".

In the second, the patient's legal representative submitted that the patient could be

³³ *WMJ* [2015] VMHT 17; *TMR* [2015] VMHT 22; *WRH* [2015] VMHT 27; *YPO* [2015] VMHT 105; *VTK* [2015] VMHT 111; *OED* [2015] VMHT 121; *STU* [2015] VMHT 197; *NYW* [2016] VMHT 45.

³⁴ *WRH* [2015] VMHT 27.

treated voluntarily because she was consenting to treatment.³⁵ However, the “Tribunal was not satisfied that the patient was able to sustain consent” and in its view the patient’s “understanding of her illness and her acceptance of treatment were not sufficiently consistent for her to agree to treatment.”

In the third case,³⁶ the Tribunal focused particularly on the competence of the patient’s desire to go overseas for treatment and listed a number of factors relevant to its least restrictive criterion determination that included: his being still unwell and “not in a fit condition to make his own considered decision” on the matter and; his delusions having an “impact on his decision making”.

In all three of the cases, the Tribunal found that the patient lacked decision-making capacity (though in none did it use exactly that phrasing) and in all three it found that the least restrictive criterion was met.

In a further 17% of cases (n=36) (Group 2 cases) the Tribunal made reference to one or more of the statutory requirements for “capacity to give informed consent” and it was clear that this had formed a part of its reasoning in relation to whether or not the least restrictive criterion was met. The majority of these Group 2 cases referred to the patient’s understanding (or lack of), though a minority referred to the patient’s “appreciation” (which by its context appeared to be used in a manner that was similar to “understanding”), or the patient’s ability to weigh up³⁷ information or the patient’s “judgement”³⁸ (which by its context appeared to be used in a manner that was similar to a determination about the patient’s ability to use and weigh the information). No case made reference to the patient’s ability to either remember the information or communicate the decision – the other elements referred to as required to give informed consent.³⁹

By way of example, in one of these Group 2 cases⁴⁰ the Tribunal “accepted that [the patient] was now better informed [than on admission] and had gained knowledge and an *appreciation* of her condition”.⁴¹ Related to this, the “Tribunal was not satisfied that there were no less restrictive means reasonably available to enable [her] to receive the immediate treatment that she requires”, and noted “[s]pecifically, in view of her statements about continuing with treatment, and her positive attitude to her treating team ... that a less restrictive option reasonably available at this time was for [her] to be treated as a voluntary patient”. The Tribunal also found that it was relevant that the patient’s change in attitude was “considered and informed”, and related to this, it “was satisfied that [she] could and would accept necessary treatment for her condition without the need for a Treatment Order” and therefore it “was not satisfied that the requirements of section 5(d) were met”.

³⁵ *MKP* [2015] VMHT 108.

³⁶ *TBH* [2015] VMHT 144.

³⁷ *UFG* [2016] VMHT 7.

³⁸ *SXY* [2015] VMHT 117; *YJW* [2015] VMHT 216.

³⁹ *Mental Health Act 2014* (Vic) s 68(1).

⁴⁰ *AUJ* [2015] VMHT 43.

⁴¹ *AUJ* [2015] VMHT 43 (emphasis added).

In another of these Group 2 cases⁴² the Tribunal stated that there was evidence before it which “indicated that [the patient’s] understanding of her mental illness and the immediate need for treatment was lacking” and having regard to this and other evidence it “was of the view that [her] immediate need for treatment to stabilise her mental health, could only be obtained pursuant to a Treatment Order”. The Tribunal was satisfied that the least restrictive criterion was met in 21 of these 36 Group 2 cases.

Taken together the Group 1 and 2 cases represent the cases where it was clear that Tribunal had made some consideration of the patient’s decision-making capacity and that this was relevant to its least restrictive criterion determination. This means that this mode of reasoning was clearly documented in only 19% of cases.

Cases in Groups 3 and 4 in which the Tribunal may have considered decision-making capacity

While not referring to either decision-making capacity or its required elements, the Tribunal indicated that a patient’s beliefs or insight was a factor in its least restrictive criterion determination in a further 17% of cases (n=36). In one example of these Group 3 decisions,⁴³ the Tribunal found the least restrictive criterion was met and that it was relevant to this finding that the patient did not “believe” he had a mental illness and had “little or no insight into his mental illness”.

In 31 of these 36 Group 3 cases the Tribunal found the least restrictive was met and only in five did it find it was not met.

Group 4 cases comprised a further 11% (22) of cases. In these the Tribunal made mention of the importance of autonomy or the associated mental health principle (s. 11(1)(e)), or the importance of being allowed to make decisions that involved a degree of risk (almost always in relation to the associated mental health principle (s.11(1)(d)). The extent to which these mentions might have been signifiers of the Tribunal considering the patient’s decision-making capacity varied enormously but cases where these concepts were mentioned were included in group 4 unless it was possible to confidently conclude that these concepts were not related to a consideration of decision-making capacity, or not related to the Tribunal’s determination on the least restrictive criterion.

In one example of these group 4 cases⁴⁴ the Tribunal stated that “[in] coming to its decision [it] was mindful of the principles under the Act, in particular section 11.(1)(d) and (e)” and, by a majority, it found that “immediate treatment for [the patient’s] mental illness could occur voluntarily, which involves a degree of risk, but would be less restrictive of [her] autonomy and dignity”.

In many of these statements of reasons the reference to the section 11.(1)(d) preceded a conclusion that the risk involved in the patient being made voluntary was relatively

⁴² *DLG* [2015] VMHT 82.

⁴³ *ANV* [2015] VMHT 95.

⁴⁴ *OED* [2015] VMHT 121.

minor. This common approach to documentation likely accounts for the fact that in only 4 of these 22 Group 4 cases did the Tribunal find that the least restrictive criterion was met.

Cases in Group 5 in which there is no evidence the Tribunal considered decision-making capacity

If one combines the cases categorised to Groups 3 and 4, which represent those cases where the Tribunal might have considered the patient's decision-making capacity, with those cases in Groups 1 and 2, where it is clear that the Tribunal did consider the patient's decision-making capacity, it becomes apparent that even under the most generous interpretation of the data, the Tribunal did not consider whether the patient's refusal of the proposed treatment was competent in 53% of the cases reviewed.

In these 109 Group 5 cases, the Tribunal made a determination on the least restrictive criterion without reference to anything that could have signified that it had given consideration to the patient's decision-making capacity. In these cases, if a patient's understanding or appreciation or beliefs or insight was mentioned in statement of reasons at all, that phenomenology was not linked to the Tribunal's rationale for its decision and there was no mention of autonomy or right to take risks that in any way suggested the patient's decision-making capacity had been considered.

Under the reasoning set out above, the only valid reason that the Tribunal might not make reference to the patient's decision-making capacity about the proposed treatment being refused, was if it were to form the view that in this instance the presumption of capacity could not be displaced. However, if it were the case that the patient was competently refusing the proposed treatment then, again using the reasoning above, the Tribunal should have found that the least restrictive criterion was met in only a minority of cases. In fact, the reverse was true. The Tribunal found the least restrictive criterion was met in 92 of the 109 Group 5 cases (84%).

VII. 2 Second Study

The second study was an exploratory thematic analysis, which sought to identify the way the Tribunal made decisions. One of the early emergent themes was 'capacity', which forms the basis of the second study analysis presented here.

Method

The second study reviewed 339 statements of reasons, those hearings held from 2 July 2014 to 1 May 2016. Of these, 45 were excluded, 1 hearing was adjourned, 34 hearings were for ECT applications only, and 10 where applications were made for both ECT and Treatment Orders.

Of the remaining 294, treatment orders were made in 69% (202) cases. Unlike the first study, cases where the least restrictive criterion was not considered were included, on the basis that a person's decision-making capacity may have been assessed in

consideration of another criterion.

The samples of the first and second studies overlapped for the period between 1 January 2015 and 1 May 2016, together covering a continuous period between the commencement of the Act on 1 July 2014 through to 30 June 2016. This study consisted of a complete reading of all statements of reasons, using NVivo qualitative data analysis software. This was supplemented by automatic text coding, in this case for words including, 'capacity', 'judgement', 'insight', 'weigh', 'ability', 'consent' and the phrase 'involve a degree of risk'.

Themes were developed using grounded theory, with this examination of capacity forming part of a much larger analysis. Each statement was classified according to various attributes, such as if the person was legally represented, if the order was made out, and which criterion was not made out if the order was not made out.

Themes were identified as having been considered by the Tribunal, irrespective of which party had raised the issue, on the basis that the statement of reasons represents factors which were taken into account in the decision of the Tribunal.

Results

Several themes were developed under the notion of 'decision making', including 'capacity', 'judgement' and 'insight'. The theme of 'capacity' related to explicit considerations of a person's decision-making capacity, and often overlapped with the theme of 'judgement', which related to a value assessment of the decision. The theme of 'insight' related to the degree to which the person agreed with or understood their diagnosis. These three themes can be easily linked to the definition of capacity to give informed consent in s.68 of the Act, which requires understanding of, and the ability to remember and use, the information relevant to the decision.

Similar to the first study, the second study found that the Tribunal only explicitly considered a person's capacity in a very limited number of cases (n=19) (2%). In 89% (n=17) of these cases, the person had legal representation, compared to 68% (n=201) more generally.

In cases where the Tribunal explicitly considered capacity, they made an order in a lower percentage of cases when capacity was considered (63%, n=12) than when it was not (69%, n=202), though given the small sample size this difference is unlikely to be statistically significant.

In every case where capacity was explicitly considered and an order not made (n=7), the criterion which was not met was the least restrictive criterion, compared with 60% (n=51) of the cases where capacity was not explicitly considered and an order was not made (n=85). This suggests some relationship between the way the Tribunal considers capacity and the least restrictive criterion.

The different approach and parameters used for the second study add support to the results of the first study. For example, the second study identified an explicit rejection

of the notion that the Tribunal should consider capacity, in *BFW*⁴⁵; 'the Tribunal does not have to decide whether BFW is refusing treatment or is incapable of giving consent to treatment, as was the case under the previous Act.' This approach was repeated in *LAO*⁴⁶ in which it was found that unlike under the 1986 Act, under the 2014 Act 'capacity to give informed consent is no longer a determining factor for the Tribunal.' Despite this, the second study found that the Tribunal did occasionally consider a person's decision-making capacity in its consideration of the least restrictive criterion, such as *EPK*⁴⁷, where the patient was found to be 'ready and willing to consent to the required treatment as a voluntary patient and would remain in the ward.'

The second study also examined the notion of capacity irrespective of who it was raised by, rather than just considering the decision-making process of the Tribunal.

For example, in *QDE*⁴⁸, where the treating team asked for the order to be made so that, among other things, the patient's capacity to consent to treatment could be assessed. QDE's solicitor countered that QDE 'was capable of making an informed decision as to her future treatment'. Legal representatives often raised the issue, such as *MKP*⁴⁹, in which the solicitor '...submitted that MKP could be treated voluntarily because she was consenting to treatment.' In response, the Tribunal considered this submission, but 'was not satisfied that MKP was able to sustain consent'. In the Tribunal's view, MKP's understanding of her illness and her acceptance of treatment were not sufficiently consistent for her to agree to treatment.' This is a clear example of the Tribunal engaging in the reasoning laid out above making an assessment of a person's capacity, and making a decision based, in part, on this assessment.

The second study was also not limited to the Tribunal's considerations of the least restrictive criterion. This meant that while it reinforces the conclusion of the first study, that the Tribunal is only rarely considering capacity in determining if treatment is restrictive, it uncovered a tendency to consider capacity in relation to other criteria. Up until this point, we have focused on a person's decision-making capacity to refuse treatment, however the Tribunal considered a person's decision-making capacity in a number of different ways, not just in relation to their ability to refuse treatment.

Poor or impaired judgement was raised in 12% (n=35) of cases, and insight, lacking or otherwise, was considered in 48% (n=141) of cases.

A notable finding of the second study is that the different themes related to capacity were considered under different criteria. As Figure 1 below illustrates, the theme of capacity was most often considered under the least restrictive criterion, whereas, of these three, insight was the factor most often considered in establishing if a person had a mental illness.

⁴⁵ *BFW* [2014] VMHT 17.

⁴⁶ *LAO* [2015] VMHT 116.

⁴⁷ *EPK* [2015] VMHT 47.

⁴⁸ *QDE* [2015] VMHT 207.

⁴⁹ *MKP* [2015] VMHT 108.

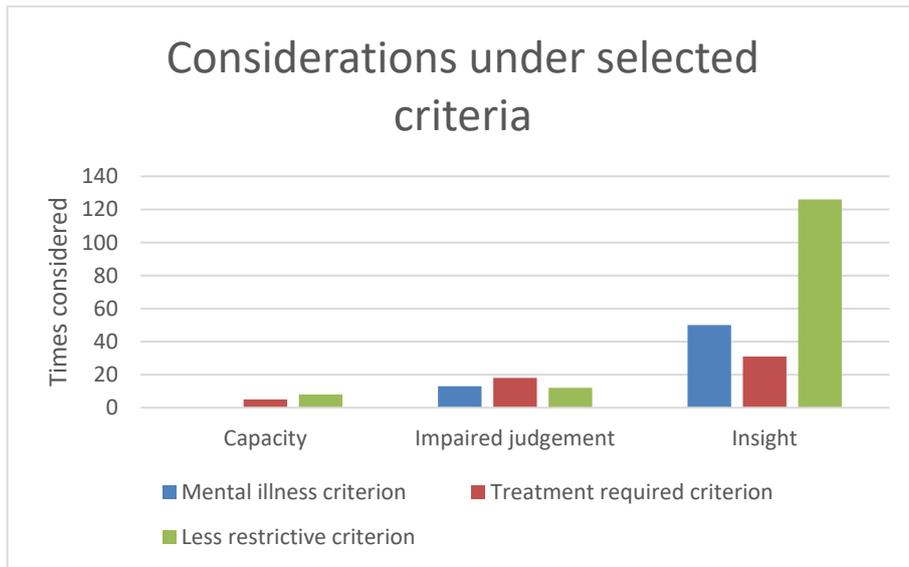


Figure 1 - Considerations under selected criteria⁵⁰

Judgement was considered relatively evenly, but more often in the treatment required criterion. This supports the hypothesis that capacity, or at least a person’s judgement or insight, is being considered, but it is being considered when establishing the presence of a mental illness, not as a protective factor in recognising a person’s right to competent refusal. It was not possible to clearly determine how the presence of capacity, ‘good’ judgement or insight was related to the decision, as when these issues were raised, they were usually raised in the context of a disagreement, and the Tribunal only rarely made a specific finding one way or the other. What is clear, is that when these issues were considered, they had some correlation with the outcome of the hearing.

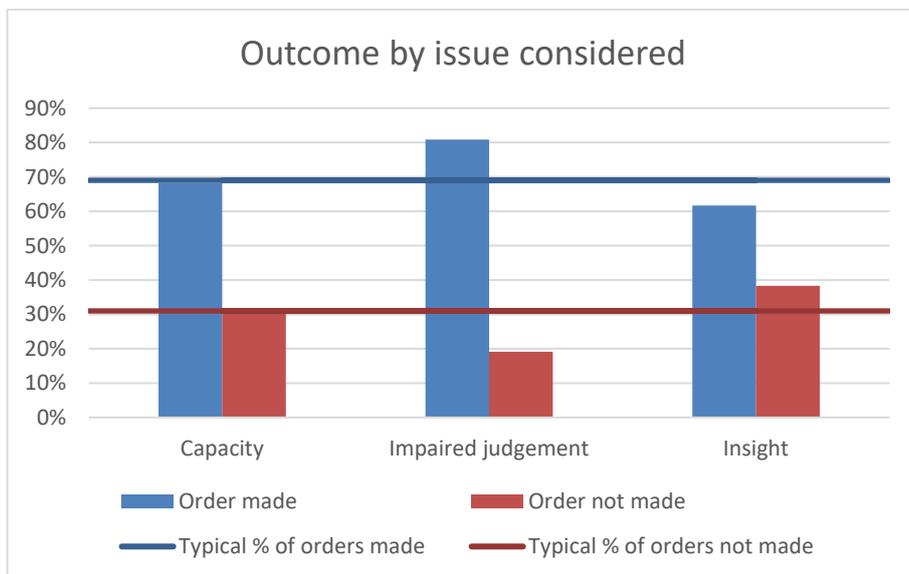


Figure 2 - Outcome by issue considered

As Figure 2 shows, where a person’s judgement was considered by the Tribunal, it made 12% more orders than it made on average. In cases where their insight was in

⁵⁰ Note that these considerations may have occurred multiple times in a single statement of reasons.

question, it made 7% fewer orders than it made on average. When the tribunal explicitly considered capacity the outcomes reflected the average frequencies. Again the relatively small numbers mean that these figures did not reach statistical significance.

As Figure 1 illustrates, a person's judgement was regularly (n=43) used to establish the first criterion, that a person had a mental illness. This was evident in *TLX*⁵¹, where both poor decision-making and lack of insight was one of the symptoms identified and relied on as evidence that TLX had a mental illness:

He was again admitted to hospital as an involuntary patient. He presented with poor judgement, risky and disinhibited behaviour, and an elevated and expansive mood. He was said to have no insight. After two weeks TLX left hospital against medical advice and declined any ongoing contact with the community mental health service. After one week his wife contacted the mental health service due to TLX engaging in risk taking behaviours, which included driving at high speed with passengers in his car and running red lights. His mood was again reported to be elevated, with poor judgement and no insight. He was readmitted to hospital and commenced on a depot anti-psychotic medication.

At other times, an alleged lack of capacity was used to explain why the Tribunal believed that a person needed treatment to prevent harm to themselves or others, and therefore meet the second treatment criterion. For example, in *UKR*⁵², the Tribunal heard that UKR's 'beliefs about how he would be cared for were driven by his persecutory delusions, and he did not have capacity to make decisions of this kind.' Similarly, reduced decision-making capacity was used to explain why less restrictive treatment was not available, in *TBH*⁵³, where the Tribunal decided TBH could not be treated less restrictively, amongst other considerations, due to:

...the fact that TBH is currently still quite mentally unwell and vulnerable, and not in a fit condition to make his own considered decision about whether to travel overseas away from his wife and children; and the fact that TBH is currently suffering from delusional beliefs about his wife which might impact on his decision making.

As in *TLX*, this was often related to the notion of insight, which was highlighted in the Group 3 cases of the first study. Considering the need for immediate treatment in *OFO*⁵⁴, the Tribunal highlighted the connection between insight and consent, viewing insight as a prerequisite to consent:

OFO, though improved, still needs some assistance with residual symptoms and indicated her intention to co-operate with her general practitioner and the treating team in that regard. Presently, there is a need for immediate treatment to prevent a relapse and continue the improvement made and OFO is receptive to the need for such treatment. She is co-operative to that need for treatment and has sufficient insight to consent and does consent.

This criterion is accordingly not met as OFO appreciates the need for immediate treatment and has consented to it and is engaged with the service.

⁵¹ *TLX* [2015] VMHT 214.

⁵² *UKR* [2016] VMHT 12.

⁵³ *TBH* [2015] VMHT 144.

⁵⁴ *OFO* [2014] VMHT 13.

This indicates a consistent theme in the statements of reasons, which is that a person's capacity to consent to treatment is directly linked with their compliance with the proposed treatment. While compliance and capacity are not treated as synonymous, the Tribunal demonstrates an inclination to accept that people have capacity when they are compliant, and reject that contention when people are not. This can be seen in *MKP*⁵⁵, where the Tribunal seems to conflate the two:

[MKP's legal representative] submitted that MKP could be treated voluntarily because she was consenting to treatment. The Tribunal was not satisfied that MKP was able to sustain consent. In the Tribunal's view, MKP's understanding of her illness and her acceptance of treatment were not sufficiently consistent for her to agree to treatment. For example, the evidence of all parties showed MKP's ambivalence towards lithium medication, which the treating team considered a cornerstone of her treatment.

In *MKP*, the Tribunal seems to suggest that insight, characterised as understanding and acceptance, is a precursor to capacity, and relied on this inability 'to sustain consent' as justification for deciding that MKP could not be treated less restrictively.

In other decisions, such as *EPK*⁵⁶, the Tribunal separated the 'poor decision making' from the ability to make decisions. The report outlined a series of reasons EPK was at risk:

The Report also noted EPK consumed alcohol once whilst out on a group outing against staff advice. EPK struggled to follow given directions. EPK had engaged in inappropriate sexual activities and therefore remained vulnerable due to her poor judgement. EPK had failed to return from unescorted leave at the designated time and had absconded for a few days. EPK had got into cars with strangers. She had befriended strangers, slept in their homes and had a history of vulnerability to males.

Despite this evidence, the Tribunal declined to make an order based on her willingness and ability to consent to the treatment:

The evidence before the Tribunal indicated that EPK's current symptoms were not severe. EPK had a good understanding of the treatment she was receiving and what was proposed by the treating team and she had a clear view in respect to her own recovery objectives. She was ready and willing to consent to the required treatment as a voluntary patient and would remain in the ward.

What is implied here is not that these people lack decision-making capacity in a strict legal sense, but that the Tribunal does not believe that they will make good decisions, or decisions which the treating team would have preferred they make. This approach was most clear in *WRH*⁵⁷:

The majority view was that WRH's ability to make treatment decisions was impaired due the severity of her mental illness. WRH's exclusion of her family, who may have been a protective factor, lead the members to agree that there was no less restrictive option for immediate

⁵⁵ *MKP* [2015] VMHT 108.

⁵⁶ *EPK* [2015] VMHT 47.

⁵⁷ *WRH* [2015] VMHT 27.

treatment. Accordingly, the majority view was that WRH would not be able to receive immediate treatment in a less restrictive manner and that compulsory treatment was required.

While the Tribunal states that WRH's ability to make treatment decisions is impaired by her mental illness, what it appears to mean is that WRH's ability to make 'good', or compliant, treatment decisions is impaired. WRH expressed a preference for natural therapies, and stated that her opposition to the proposed treatment was based on long held spiritual beliefs. As outlined above, if WRH did not have a mental illness, and was assessed as having capacity, she would be entitled to refuse the proposed treatment. As the Tribunal has not assessed her capacity, this decision seems to rest only on the subjective assessment of the quality of those decisions. EPK had documented symptomology, but as she was assessed as being likely to comply with treatment, she was viewed as having capacity to make decisions. WRH, with her own symptomology, was viewed as unlikely to comply, and viewed as not having that capacity.

There is a similar conflation of capacity with medication compliance, a topic which dominated many of the statements of reasons, and was considered in 63% (n=186) of all reviewed cases. In *YOB*⁵⁸, the Tribunal explicitly linked diminished capacity and the role on the Act in enforcing medication compliance:

The Tribunal did not accept the submission that intervention to ensure adherence did not amount to treatment for the purposes of the Act. Indeed, such involvement is often central to the provision of treatment for a person believed to be mentally ill and who may not have their usual capacity to understand and appropriately respond to the need to receive necessary treatment.

The Tribunal clearly sees a key part of its role as making sure people get the medication they need when they are not able to make 'good' decisions about taking that medication. Sometimes, however, an alternative view was raised, such as by the dissenting member in *WYV*⁵⁹, who, in finding the least restrictive criterion was not met, found:

...the Tribunal is required to consider the principles of recovery and autonomy within a background of presumed capacity. The relevant principles also include that a person should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk. Another way this may be expressed is as a dignity of risk whereby a person may exercise their autonomy and independence by making choices that, in a similar situation, someone else might not make.

This view, largely consistent with the position put forward in the first section of this paper, is not widely evident in the data. The overall trend illustrated in the second study is that the Tribunal does regularly consider a person's decision-making capacity, either explicitly or in terms of insight or judgement, but it does not tend to undertake that consideration either with a presumption of capacity or of a recognition of the fundamentally restrictive process of denying a competent person their right to refuse treatment.

⁵⁸ *YOB* [2015] VMHT 124.

⁵⁹ *WYV* [2014] VMHT 30.

VIII. DISCUSSION

On the basis of the arguments put forward in the first section, the Tribunal is obliged to carefully assess the patient's decision-making capacity when applying the least restrictive criterion. The first study found that a large majority of the Tribunals that heard these cases failed in that obligation. Even if the assertion that the Tribunal *should* be assessing the decision-making capacity of these patients is not accepted, there is reason to be concerned about the apparent diversity of approaches found when the reasoning set out in the statements is reviewed. These results suggest that there is no clear or coherent approach to this issue.

The second study confirms this, but also found that that while capacity is often considered by the Tribunal, and as part of the least restrictive criterion, it is not being considered in a way that is protective of a person's right to competently refuse treatment, but in a way that promotes what Gostin and Gable have called 'the myth of incompetency'.⁶⁰ They write that 'Competency is not an all or nothing proposition. It is tied to specific services, decisions, or functions.' When a person's capacity is used as a determination that a person has a mental illness, or as evidence that they need treatment for a mental illness, the link between the capacity to make the decision and the actual decision is lost. While the idea that capacity is intrinsic to mental illness is a long-standing assumption in philosophical debates,⁶¹ Gostin and Gable write that 'Policies that assume a constant state of incompetency or impute a finding of incompetency in one area to apply to all other areas of decision making misunderstand mental disability and violate human rights standards.'⁶²

While the Tribunal has not regularly assessed a person's capacity to determine if their competent refusal should be overborn, it has regularly considered insight, poor judgement and capacity in order to determine if a person is mentally ill or if treatment is required to prevent serious harm. This apparent assumption that a loss of capacity is inherently linked to mental illness is not defensible, and is at odds with the principles of the Act and therefore the intention of Parliament.

VIII. LIMITATIONS

The methodology of the both studies contain a number of issues that urge caution in interpretation. There is an element of sampling bias, in that the Tribunal only publishes statements of reasons in a limited number of cases, such as where a statement of reasons is requested. It is likely that statements will be requested in cases where one of the parties to the hearing disputes, or is at least troubled by, the outcome. The published cases represent only a fraction of all cases that the Tribunal determines and it is unlikely that they comprise a representative sample of all the cases heard. As noted above, treatment orders were made in only 65% of published statements of reasons examined in the second study, orders are actually made in around 94% of hearings for

⁶⁰ Lawrence O Gostin and Lance Gable, 'Global Mental Health: Changing Norms, Constant Rights' (2008) 9(1) *Georgetown Journal of International Affairs* 83, 84.

⁶¹ Gerben Meynen, 'Free Will and Mental Disorder: Exploring the Relationship' (2010) 31(6) *Theoretical Medicine and Bioethics* 429.

⁶² Gostin and Gable, above n 60, 84.

treatment orders.⁶³ Similarly, of the total hearings with published statements of reasons examined in the second study, 66% had legal representation, while the actual percentage of hearings with legal representation is closer to 18%.⁶⁴

Compounding the sampling issue, statements of reasons are reserved in that they are written at some point after the actual hearing and are constructed using contemporaneous brief handwritten notes and recordings of the hearing. While the clearest indicators that a consideration of the patient's decision-making capacity was conducted would be an explicit mention of the same or clear reference to the elements of decision-making capacity, it is important to recognise for the purposes of this exercise that the Tribunal may have considered this issue at the hearing without either of these clear indicators ending up in the published statement of reasons.

It is also inevitable that there will be an element of subjectivity involved in the allocation of some of the cases into groups, or the process of thematic analysis. While efforts were made to make the categories and themes as reliable and valid as possible, this is an inherently subjective process. Even using text queries, as in the second study, only reduces this factor, as longer statements of reasons will necessarily have more words in them, and will generate more returns, and the process of removing irrelevant returns will be as subjective as group or thematic allocation. The statements of reasons were not written with the intention of being thematically analysed, and considerations are often recorded in unrelated sections. This reduces the reliability of findings that certain aspects of capacity were considered in relation to certain criteria.

Despite this, these statements of reasons provide a valuable insight into the decision-making process of the Tribunal, and the two studies, undertaken in isolation and by unrelated researchers from different professional backgrounds, produced largely consistent results.

VIX CONCLUSION

Both authors have argued elsewhere for a capacity criterion which would restore the right of people with a mental illness to competently refuse treatment.⁶⁵ The current Victorian Act does not have an explicit capacity criterion, however the arguments laid out in this paper make it clear that given the fundamentally restrictive and discriminatory nature of denying this right, it should only be breached in a limited number of cases.

The two studies presented in this paper suggest that there is reason to believe that when applying probably the most important of the Act's protections of the rights of people with mental illness, the Tribunal is frequently not taking proper account of whether or not the patient is competently refusing the proposed treatment. In addition,

⁶³ Victorian Mental Health Tribunal, 'Performance against Key Performance Indicators - 1 January to 31 March 2016' <<http://www.mht.vic.gov.au/wp-content/uploads/2016/04/Performance-against-KPIs-January-to-March-2016.pdf>>.

⁶⁴ Victorian Mental Health Tribunal, 'Mental Health Tribunal Annual Report 2014-15'. <<http://www.mht.vic.gov.au/forms-and-publication/mental-health-tribunal-annual-reports-2/>>.

⁶⁵ Ryan, above n 3; Maylea and Hirsch, above n 19.

the Tribunal is using evidence of a lack of decision-making capacity, closely tied to notions of judgement and insight, as indication that a person meets other criteria. This, along with the heterogeneity of the Tribunal's approach to this issue, should be cause for concern.