

Capacity to make treatment decisions: legal perspectives¹

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Introduction

The Mental Health Tribunal Western Australia (the Tribunal) schedules approximately 3,500 hearings per annum. In each of these hearings, the Tribunal must determine whether it is satisfied that a patient is 'still in need' of an involuntary treatment order,² pursuant to which that patient may be detained and or administered treatment³ without informed consent.⁴ The threshold test for whether the patient 'is in need of' an involuntary treatment order is that the patient does not demonstrate capacity to make a treatment decision.⁵ Accordingly, determining a patient's capacity to make treatment decisions is a fundamental part of the work of the Tribunal.

The typical hearing is short and often chaotic. In practice, it is not unusual for the allocated hearing time to be 30 minutes. During that time, the Tribunal must determine, among other issues, whether it is satisfied the patient lacks capacity to make a treatment decision. The Tribunal relies on the treating team to provide the key evidence on this issue.

It is not uncommon in such hearings for the Tribunal to be provided with medical reports which, rather than presenting evidence, present mainly opinions and conclusions such as:

- 'the patient has schizophrenia, does not accept this diagnosis, and is unable to make reasonable treatment decisions';
- 'when given a choice, the patient chooses options which result in poor outcomes, and she does not have mental capacity';

¹ Paper delivered at the WA Chief Psychiatrist's Capacity Forum on 22 November 2018.

² *Mental Health Act 2014 (WA)* s 386(2) and s 387(2).

³ Treatment is defined in section 4 of the *Mental Health Act 2014 (WA)* as the provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness, and does not include bodily restraint, seclusion or sterilisation.

⁴ Informed consent is defined in section 4 of the *Mental Health Act 2014 (WA)* as consent to the provision of the treatment given in accordance with Part 5 Division 2 (ss 16-20 of the *Mental Health Act 2014 (WA)*).

⁵ *Mental Health Act 2014 (WA)* s 25.

- 'I believe it is in the best interests of the patient to continue the CTO';
- 'I believe the patient will not continue with treatment in the absence of the CTO and he will deteriorate'.

As noted recently by the Honourable Justice Kevin Bell AM of the Supreme Court of Victoria:

[167] It has been said that capacity assessments are inherently risky, uncertain and 'epistemologically fallible', driving many capacity assessors to the apparent safe ground of the 'reasonable' outcome as an implicit default criterion. One can understand the natural human tendency of health professionals and judicial officers, among others, to make decisions in the best interests of vulnerable persons, especially where treatment for grievous ill-health, or even the person's life, is at stake. It has been described as the 'protection imperative'.

[168] However well intentioned, such a paternal or beneficial approach is not part of the common law test of capacity. ... It is therefore well-established that the outcome of the decision (as distinct from the reasons for the patient's decision if reasons were given) is not relevant to whether the person has capacity and the focus must be upon the functioning of the person as assessed against the capacity criteria.⁶

For mental health treating teams, the tension between the desire to treat the patient in the patient's best interest and the patient's competing right to self-determination is high. The principle of beneficence is fundamental to medical practice, and it can be counterintuitive to permit a patient to make a treatment decision which is so objectively unreasonable as to suggest irrationality. However, as I explore in this paper, sometimes this is what the law requires.

To understand why, I discuss the current test for assessing a patient's capacity to make treatment decisions under the *Mental Health Act 2014* (WA) (the Mental Health Act) in the context of the theoretical and legal principles underlying that test. First, I briefly review the theoretical principles of autonomy and self-determination which underpin the common law. Then, I demonstrate how these principles are reflected in the current common law approach to consent to medical treatment. I review the extent to which the provisions of the current Mental Health Act reflect the common law, and consider cases which may be useful in enhancing our understanding of the provisions of the Mental Health Act. Finally, I discuss a recent decision of His Honour Justice Bell in which the statutory test for determining capacity in Victoria's mental health legislation was held to have been 'misinterpreted and misapplied' in determining whether the presumption of capacity was displaced. I conclude with some suggestions for treating teams in making capacity assessments, as well as providing evidence to the Tribunal to assist the Tribunal in determining capacity during its hearings.

⁶ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [167] –[168] (Bell J).

Theoretical context

It is generally accepted in western society that individuals should be allowed to make decisions about their lives based on their own beliefs and values, so long as those decisions do not significantly disadvantage others.⁷ This principle is known in bioethics as the principle of autonomy, and it underlies the right to non-interference in personal decision-making.⁸ Although there are many different definitions and theories of autonomy, most refer to concepts of individual liberty and the capacity for intentional or rational action.⁹

The concept of the rational individual as the self-governing holder of fundamental rights was conceived during the Age of Enlightenment. John Locke (1632-1704) first gave voice to the modern western notion that the individual has fundamental human rights which governments should not violate.¹⁰ In his *Second Treatise on Civil Government* (1690) Locke argued that governments exist to protect the natural rights vested in individuals in the state of nature.¹¹ In this state, all individuals were equal and vested with natural rights to life, liberty and property.¹² Locke considered these natural rights of the individual to be inalienable.¹³

Immanuel Kant (1724–1804) argued that ‘rational nature exists as an end in itself’ and since humans possess a rational nature, they are an end in themselves and should be treated as such.¹⁴ Kant posited that respect for autonomy flows from the recognition that all persons have unconditional worth and the capacity to determine their own moral destiny.¹⁵ To violate an individual’s autonomy is to treat the individual as a means, i.e. in accordance with the goals of another without regard to the individual’s goals.¹⁶

In *On Liberty* (1859), John Stuart Mill articulated a vision of liberty grounded in the individuality of autonomous agents.¹⁷ The stated object of that work was to argue that the only justifiable basis for interference with the rights of the individual is prevention of harm to another:

[T]he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so,

⁷ Sascha Callaghan and Christopher James Ryan, 'Refusing Medical Treatment After Attempted Suicide: Rethinking Capacity and Coercive Treatment in Light of the Kerrie Wooltorton Case' [2011] *Journal of Law and Medicine* 811, 812.

⁸ Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and Law for the Health Professions* (Federation Press, 3rd ed, 2009) 83.

⁹ Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and Law for the Health Professions* (Federation Press, 3rd ed, 2009) 83.

¹⁰ Patrick Parkinson, *Tradition and Change in Australian Law* (Lawbook, 4th ed, 2010) 47.

¹¹ Patrick Parkinson, *Tradition and Change in Australian Law* (Lawbook, 4th ed, 2010) 47.

¹² Patrick Parkinson, *Tradition and Change in Australian Law* (Lawbook, 4th ed, 2010) 47.

¹³ Patrick Parkinson, *Tradition and Change in Australian Law* (Lawbook, 4th ed, 2010) 48.

¹⁴ Devereux, J (ed.) *Medical Law* (Taylor & Francis, 2nd ed, 2002), 4. ProQuest Ebook Central [accessed 9 November 2018].

¹⁵ Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 6th ed, 2009) 103.

¹⁶ Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 6th ed, 2009) 103.

¹⁷ Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 6th ed, 2009) 103.

because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.¹⁸

These conceptions of individuality, rationality, and autonomous agency had an enduring impact on the development of western political thought. This, in turn, highly influenced the development of the law. Self-determination and personal autonomy are fundamental values which are well established in the common law.¹⁹ Along with the concepts of personal inviolability and the presumption of capacity, they form the cornerstones of the development of the common law right to refuse medical treatment.²⁰

Common law context

The position at common law is well established: a competent person may refuse medical treatment for any reason, even if it will likely lead to the person's own death or serious injury.²¹ To provide medical treatment without consent, or despite a competent refusal, constitutes a common law trespass.²²

The Supreme Court of Western Australia accepted the common law position in *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 (Martin CJ). In that decision, Chief Justice Martin commented that the position at common law was 'clear and unambiguous' and followed from a number of well-established principles:²³

[23] The first is that a person of full age is assumed to be capable of having the mental capacity to consent to, or refuse, medical treatment: *Re MB (Medical Treatment)* [1997] EWCA Civ 1361; (1997) 2 FCR (UK) 541 (per Lady Justice Butler-Sloss); *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam); (2002) 2 FCR (UK) 1 [10] (per Dame Butler-Sloss); and *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [23] (per McDougall J). ...

[24] Another principle well established at common law is the principle which has been described in the cases as the right of autonomy or self-determination. Lord Hoffmann has described this right as being related to respect for the individual human being and in particular for his or her

¹⁸ John Stuart Mill, *On Liberty* (first published 1859) 16-17 (<https://www.gutenberg.org/files/34901/34901-h/34901-h.htm>).

¹⁹ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [137] (Bell J).

²⁰ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [137] – [147] (Bell J).

²¹ *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 [23] – [31]. See also Sascha Callaghan and Christopher James Ryan, 'Refusing Medical Treatment After Attempted Suicide: Rethinking Capacity and Coercive Treatment in Light of the Kerrie Woollorton Case' [2011] *Journal of Law and Medicine* 811, 813.

²² *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 [31]; Sascha Callaghan and Christopher James Ryan, 'Refusing Medical Treatment After Attempted Suicide: Rethinking Capacity and Coercive Treatment in Light of the Kerrie Woollorton Case' [2011] *Journal of Law and Medicine* 811, 813.

²³ *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 [21].

right to choose how he or she should live his or her life: *Airedale National Health Service Trust v Bland* [1993] AC 789, 826. Included within the right of autonomy or self-determination is the right, described as long ago as 1914 in the United States by Justice Cardozo, as the right of 'every human being of adult years and sound mind ... to determine what shall be done with his own body: *Schloendorff v Society of New York Hospital* 211 NY 125 (1914) , 129.

[25] That right has been recognised in Australia and referred to with approval by the High Court: *F v R* (1983) 33 SASR 189, 192 - 193 (per King CJ); *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479, 487. That right also underpins the established legal requirement that the informed consent of the patient is required before any medical treatment can be undertaken lawfully. That principle has been affirmed by the High Court on a number of occasions: *Secretary of Department of Health and Community Services v B* [1992] HCA 15; (1992) 175 CLR 218 (*Marion's case*), 233 and *Rogers v Whitaker*, 489. Also see the English case of *Airedale NHS v Bland*, 857.

[26] The corollary of that requirement is that an individual of full capacity is not obliged to give consent to medical treatment, nor is a medical practitioner or other service provider under any obligation to provide such treatment without consent, even if the failure to treat will result in the loss of the patient's life. That principle has been established by decisions in each of the major common law jurisdictions, including the United States [citation omitted]; Canada [citations omitted]; the United Kingdom [citations omitted]; New Zealand [citation omitted] and Australia (*Hunter and New England Area Health Service v A*, [9] - [15]).

[27] The principle is applied without regard to the reasons for the patient's choice, and irrespective of whether the reasons are rational, irrational, unknown or even non-existent: [citations omitted]....

[31] Another corollary of the principles to which I have referred is that a medical practitioner or service provider who provides treatment contrary to the wishes of a mentally competent patient breaks the law by committing a trespass against the person of that patient: *Marion's case*, 264 and 309 - 310.²⁴

In determining whether, on the evidence, the patient had the requisite capacity to refuse medical treatment, His Honour the Chief Justice applied the common law test which derives from *Re MB (Medical Treatment)*²⁵ in the context of the available evidence:

[13] Mr Rossiter is assumed to have the mental capacity to give a direction to discontinue the provision of nutrition and hydration unless and until there is evidence which would suggest that he lacks that capacity. There is no such evidence in this case. On the contrary, Dr Benstead deposes that based upon his observations of Mr Rossiter, **he has the capacity to comprehend and retain information given to him in relation to his treatment, and has the capacity to weigh up that information and bring other factors and considerations into account in order to arrive at an informed decision.**

[14] Also in evidence is a report from Ms Rachel Zombor, who is a clinical neuropsychologist. That report is dated 19 February 2009. In that report, Ms Zombor sets out the various observations which she made during her neuropsychological assessment of Mr Rossiter, and the tests which she administered. As a result of those observations, and the results of the tests, she concluded that Mr Rossiter **was capable of making reasoned decisions concerning his**

²⁴ *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 [23] – [31].

²⁵ [1997] EWCA Civ 3093 (Lady Justice Butler-Sloss).

own health and safety, and in particular was capable of making decisions in respect of his future medical treatment after weighing up alternative options, and was capable of expressing reasons for the decisions which he made in that respect. She also reported that, in her view, Mr Rossiter unequivocally demonstrated that he understood the consequences of withholding the provision of nutrition and hydration through the PEG, and displayed insight into the consequences of that decision.²⁶

The use of the word 'reasoned' does not imply that the decision must be objectively reasonable. In *Re MB (Medical Treatment)*,²⁷ Lady Justice Butler-Sloss discussed this aspect of the common law test in the context of a woman who had accepted medical advice to obtain a caesarean section. However, upon admission to hospital, when it became apparent that she would need to be anaesthetised by intravenous means, she refused to consent because of a needle phobia. After three attempts to perform the surgery were aborted because Ms B withdrew her consent, the health authority sought a declaration in the Family Division that the surgery should proceed. The application was successful and Ms B's appeal, which was considered immediately, was dismissed by the Court of Appeal (UK).

In her decision, Lady Justice Butler-Sloss comprehensively reviewed the state of the common law to that date, considering the impact of irrationality, unreasonableness, and mental impairment in the application of the common law test:

[30] ... A competent woman who has the capacity to decide may, for religious reasons, other reasons, for **rational or irrational reasons or for no reason at all**, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In that event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests objectively considered, does not arise.

... Irrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided it could have arrived at it. As Kennedy and Grubb (*Medical Law*, Second Edition 1994) point out, **it might be otherwise if a decision is based on a misperception of reality (e.g. the blood is poisoned because it is red). Such a misperception will be more readily accepted to be a disorder of the mind.** Although it might be thought that irrationality sits uneasily with competence to decide, **panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence.** The graver the consequences of the decision, the commensurately greater the level of competence is required to take the decision: *Re T* (supra), *Sideaway* (supra) at p. 904 and *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 A.C. 112, 169 and 186.

... A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when[:]

²⁶ *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 [13] – [14] (emphasis added).

²⁷ [1997] EWCA Civ 3093.

(a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question.

(b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision. If, as Thorpe J observed in *Re C* (supra), a compulsive disorder or phobia from which the patient suffers stifles belief in the information presented to her, then the decision may not be a true one. As Lord Cockburn C.J. put it in *Banks -v- Goodfellow* (1870) L.R. 5 QB 549 at p.569:-

"One object may be so forced upon the attention of the invalid as to shut out all others that might require consideration."

... The "temporary factors" mentioned by Lord Donaldson M.R. in *Re T* (supra.) (confusion, shock, fatigue, pain or drugs) may completely erode capacity but those concerned must be satisfied that such factors are operating to such a degree that the ability to decide is absent.

... Another such influence may be panic induced by fear. Again careful scrutiny of the evidence is necessary because fear of an operation may be a rational reason for refusal to undergo it. Fear may be also, however, paralyse the will and thus destroy the capacity to make a decision.²⁸

On applying these principles to the facts of the case, the Court of Appeal found that Ms B consented to a caesarean section, but what she refused to accept was not the incision by the surgeon's scalpel but rather the prick of the anaesthetist's needle. They found that Ms B could not bring herself to undergo the caesarean section she desired because, as the evidence established, *'a fear of needles ... has got in the way of proceeding with the operation.'* *'At the moment of panic, ... her fear dominated all.'* *'... At the actual point she was not capable of making a decision at all ... at that moment the needle or mask dominated her thinking and made her quite unable to consider anything else.'*²⁹

On that evidence, the Court of Appeal held that Ms B was incapable of making a decision at all. She was at that moment suffering an impairment of her mental functioning which disabled her. She was temporarily incompetent. In this emergency, the doctors would be free to administer the anaesthetic if that were in her best interests.³⁰

²⁸ *Re MB (Medical Treatment)* [1997] EWCA Civ 3093 [30] (Lady Justice Butler-Sloss) (emphasis added).

²⁹ *Re MB (Medical Treatment)* [1997] EWCA Civ 3093 [30] (Lady Justice Butler-Sloss).

³⁰ *Re MB (Medical Treatment)* [1997] EWCA Civ 3093 [30] (Lady Justice Butler-Sloss). The Court also confirmed that in determining matters such as these, it does not have jurisdiction to take into account and balance the interests of the unborn child: [39].

Mental Health Act 2014 (WA)

Introduction

Western Australia has legislated the control of persons experiencing mental illness since at least 1871.³¹ Under the 1903 version of the Lunacy Act, a person deemed to be insane could be detained if they were ‘without sufficient means of support’ or ‘wandering at large’ or had been ‘discovered under circumstances that denote a purpose of committing some offence against the law’.³²

In the past century and a half, much has changed (thankfully), in accordance with changing community expectations. Where the current Mental Health Act authorises detention, compulsory treatment, or other interference with the right to self-determination, it now requires that this be justified according to contemporary human rights standards, including the least interference principle.³³ Likewise, the Mental Health Act incorporates contemporary notions of shared decision-making and the dignity of risk,³⁴ as well as the more traditional protective factors.³⁵ The Mental Health Act now has a statutory Charter of Mental Health Principles³⁶ which requires mental health services to take a person-centred approach to treatment, and to respect choice and self-determination.³⁷ Any person or body performing a function under the Mental Health Act must have regard to the Mental Health Act’s objectives and the principles set out in the Charter of Mental Health Principles.³⁸

Common law principles reflected in the Mental Health Act

The Mental Health Act regulates the provision of treatment³⁹ without informed consent⁴⁰ in circumstances where a person lacks the necessary capacity to make treatment decisions. For this purpose, the Mental Health Act articulates a statutory test for determining capacity to make specific types of treatment

³¹ *Lunacy Act 1871 (WA)*.

³² *Lunacy Act 1903 (WA)* s 5.

³³ See *Mental Health Act 2014 (WA)* s 10(1)(a): The objects of the Mental Health Act include ensuring that people who have a mental illness are provided the best possible treatment and care with the least possible restriction of their freedom and with the least possible interference with their rights and with respect for their dignity.

³⁴ See *Mental Health Act 2014 (WA)* s 10(1)(a)(iii) and (b) – (d).

³⁵ See *Mental Health Act 2014 (WA)* s 10(1)(e) and (f).

³⁶ *Mental Health Act 2014 (WA)* Schedule 1: Charter of Mental Health Care Principles.

³⁷ See Principle 5 Choice and self-determination: A mental health service must involve people in decision-making and encourage self-determination, cooperation and choice, including by recognising people’s capacity to make their own decisions.

³⁸ See *Mental Health Act 2014 (WA)* s 10(2) and s 11.

³⁹ Treatment is defined in section 4 of the Mental Health Act as the provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness, and does not include bodily restraint, seclusion or sterilisation.

⁴⁰ Informed consent is defined in section 4 of the *Mental Health Act 2014 (WA)* as consent to the provision of the treatment given in accordance with Part 5 Division 2 (ss 16-20 of the *Mental Health Act 2014 (WA)*).

decisions.⁴¹ In doing so, it incorporates a number of aspects of the common law, and places them in a context of treatment and decision-making which demands regard to contemporary standards of human rights.

Presumption of Capacity

As noted recently by Bell J in *PBU & NJE v Mental Health Tribunal*, '[t]he equal birthright of all persons under the common law is the recognition of their legal personality, which embodies the right to have and exercise legal capacity.⁴² The presumption of capacity at common law is rebuttable.⁴³ Accordingly, capacity (or incapacity) is not a 'status' or 'diagnosis bound'.⁴⁴

The rebuttable presumption of capacity for adults is codified for the purposes of the Mental Health Act in section 13(1), which provides that:

For the purposes of this Act, an adult is presumed to have the capacity to make a decision about a matter relating to himself or herself unless the adult is shown not to have that capacity.

Section 13(2) further codifies the concept of substitute decision-making under the Mental Health Act, by confirming that where another person is legally authorised to make decisions on behalf of an incompetent adult,⁴⁵ that person may make such decisions on the person's behalf under the Mental Health Act, within the boundaries of that authority⁴⁶.

The presumption of capacity does not apply to children:

⁴¹ Namely, psychiatric, medical, psychological or psychosocial intervention intended to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness: *Mental Health Act 2014* (WA) s 4.

⁴² *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [143] (Bell J).

⁴³ *Re T (An Adult) (Consent to medical treatment)* [1993] Fam 95, 112 (Lord Donaldson MR).

⁴⁴ Nick O'Neill and Carmelle Peisah, 'Chapter 1: What is Capacity' in Nick O'Neill and Carmelle Peisah (eds), *Capacity and the Law* (Sydney University Press, 2nd ed (v5), 2017) 1, 2 (<http://austlii.community/wiki/Books/CapacityAndTheLaw/>). The authors refer to the following judgments confirming this point: *Dalle-Molle by his next friend Public Trustee v Manos* [2004] SASC 102; *SA v Manonai* [2008] WASCA 168; *L v Human Rights and Equal Opportunity Commission* [2006] FCA 114 and *Lawrence v Federal Magistrate Driver* [2005] FCA 394.

⁴⁵ Such as, via an advance health directive, an enduring guardian appointed under an Enduring Power of Guardianship, a guardian appointed by the State Administrative Tribunal pursuant to section 43 of the *Guardianship and Administration Act 1990* (WA), or a person responsible for the patient under section 110ZD of the *Guardianship and Administration Act 1990* (WA).

⁴⁶ For example, a guardian appointed by the State Administrative Tribunal pursuant to section 43 of the *Guardianship and Administration Act 1990* (WA) will be vested by the order with either plenary or limited authority: s 43(d). Plenary authority includes all of the functions in respect of the person of the represented person that are, under the *Family Court Act 1997*, vested in a person in whose favour has been made a parenting order which allocates parental responsibility for a child; and a parenting order which provides that a person is to share parental responsibility for a child, as if the represented person were a child lacking in mature understanding, but a plenary guardian does not, and joint plenary guardians do not, have the right to chastise or punish a represented person: s 45(1). These powers include the power to make certain treatment decisions for the represented persons: s 45(2)(d). Note however, that 'treatment' is defined by the *Guardianship and Administration Act 1990* (WA) as medical or surgical treatment, or dental treatment, or other health care: s 3. Whether this is broad enough to permit a guardian to make treatment decision (as defined in the *Mental Health Act 2014* (WA), including psychiatric, psychological or psychosocial intervention in respect of a mental illness) has not been judicially determined, but the notes to section 17 of the *Mental Health Act 2014* (WA) would seem to suggest this was anticipated by section 17.

For the purposes of this Act, a child is presumed not to have the capacity to make a decision about a matter relating to himself or herself unless the child is shown to have that capacity.⁴⁷

Where a child lacks capacity to make a decision, the child's parent or guardian may make the decision on the child's behalf.⁴⁸ Consistent with the common law, section 299 of the Mental Health Act requires that in performing a function under this Act in relation to a child, a person or body must have regard to what is in the best interests of the child as a primary consideration.

'Informed' Consent

At common law, consent is rendered meaningless without access to information.⁴⁹ 'Informed consent' for the purposes of the Mental Health Act is defined as 'consent to the provision of the treatment given in accordance with Part 5 Division 2'.⁵⁰ Part 5 Division 2 (sections 16 – 20 of the Mental Health Act) identifies the requirements for informed consent⁵¹ who may lawfully provide it,⁵² when a person has capacity to personally exercise it,⁵³ and what information and in what conditions it must be given.⁵⁴

Section 16 provides that:

- (1) A person gives informed consent to the provision of treatment to a patient (whether he or she or another person is the patient) only if —
 - (a) the requirements of this Division in relation to making a treatment decision about the provision of the treatment are satisfied; and
 - (b) the consent is given freely and voluntarily.
- (2) Failing to offer resistance does not by itself constitute giving consent.

The Mental Health Act contemplates decision-making on behalf of a patient in respect of treatment under the Mental Health Act:

⁴⁷ *Mental Health Act 2014* (WA) s 14(1).

⁴⁸ *Mental Health Act 2014* (WA) s 14(2).

⁴⁹ See *Rogers v Whitaker* [1992] HCA 58 [14]: 'In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession. ... Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment. Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information' (citations omitted).

⁵⁰ *Mental Health Act 2014* (WA) s 3.

⁵¹ *Mental Health Act 2014* (WA) s 16.

⁵² *Mental Health Act 2014* (WA) s 17.

⁵³ *Mental Health Act 2014* (WA) s 18.

⁵⁴ *Mental Health Act 2014* (WA) ss 19 - 20.

Informed consent to the provision of treatment to a patient can be given by —

- (a) the patient; or
- (b) if the patient does not have the capacity to make a treatment decision about the provision of the treatment to himself or herself — the person who is authorised by law to make the treatment decision on the patient's behalf.⁵⁵

The decision-maker will be the adult patient unless the patient lacks capacity to make the treatment decision determined in accordance with section 18 (discussed further below).⁵⁶ For children, the decision-maker will be the patient's parent or guardian unless the child demonstrates the capacity to make the treatment decision.⁵⁷

Section 19 identifies the information which must be provided to the decision-maker to enable that person to give informed consent in accordance with ss 16 and 18(a):

- (1) Before a person is asked to make a treatment decision about the provision of treatment to a patient, the person must be provided with a clear explanation of the treatment —
 - (a) containing sufficient information to enable the person to make a balanced judgment about the treatment; and
 - (b) identifying and explaining any alternative treatment about which there is insufficient knowledge to justify it being recommended or to enable its effect to be predicted reliably; and
 - (c) warning the person of any risks inherent in the treatment.
- (2) The extent of the information required under subsection (1) to be provided to a person is limited to information that a reasonable person in the person's position would be likely to consider significant to the treatment decision unless the person providing the information knows, or could reasonably have been expected to know, that the person is likely to consider other information to be significant to the treatment decision.
- (3) Subsection (1) applies despite any privilege claimed by a person.⁵⁸

Section 20 confirms the decision-maker's right to have sufficient time to consider the matters involved, to discuss them with the health professional, and to obtain further advice or assistance in relation to the treatment decision.

⁵⁵ *Mental Health Act 2014 (WA)* s 17. See footnote 46 above

⁵⁶ *Mental Health Act 2014 (WA)* s 13.

⁵⁷ *Mental Health Act 2014 (WA)* s 4.

⁵⁸ *Mental Health Act 2014 (WA)* s 19.

Test for determining capacity

As discussed above, at common law, a person lacks capacity where he or she is:

- unable to comprehend and retain material information; and/or
- unable to use the information and weigh it in the balance as part of a process of arriving at a decision.⁵⁹

If compulsions, phobias, or misperceptions of reality may ‘stifle belief in the information presented’ to the patient, ‘then the decision may not be a true one’ in that it prevents a proper weighing of all of the relevant information.⁶⁰

The Mental Health Act articulates two separate tests for determining a person’s capacity to make decisions under the Mental Health Act. The first⁶¹ concerns the general capacity of a person to make decisions about a matter relating to him or herself. The second⁶² is the specific capacity to make a treatment decision (namely a decision to give or refuse consent to treatment) in respect of ‘treatment’ as defined by the Mental Health Act.⁶³ Both tests are largely the same, except that:

- the specific capacity to make a treatment decision incorporates by reference the capacity to understand the things that are required under section 19 to be communicated to the person about the treatment;⁶⁴ and
- the general capacity of a person to make decisions about a matter relating to him or herself incorporates the requirement that the decision be freely and voluntarily made.⁶⁵

The test for determining the general capacity of a person to make decisions about a matter relating to him or herself for the purposes of the Mental Health Act requires a person to have the capacity to:

- (a) understand any information or advice about the decision that is required under this Act to be provided to the person; and
- (b) understand the matters involved in the decision; and
- (c) understand the effect of the decision; and

⁵⁹ *Re MB (Medical Treatment)* [1997] EWCA Civ 3093 [19] (Lady Justice Butler-Sloss).

⁶⁰ *Re MB (Medical Treatment)* [1997] EWCA Civ 3093 [19] (Lady Justice Butler-Sloss).

⁶¹ *Mental Health Act 2014* (WA) s 15.

⁶² *Mental Health Act 2014* (WA) s 18.

⁶³ Treatment is defined in section 4 of the Mental Health Act as the provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness, and does not include bodily restraint, seclusion or sterilisation.

⁶⁴ *Mental Health Act 2014* (WA) s 18(a).

⁶⁵ *Mental Health Act 2014* (WA) s 15(2). Specific reference to consent to treatment decisions being freely and voluntarily given is provided for in s 16(1)(b) of the *Mental Health Act 2014* (WA).

(d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the decision; and

(e) communicate the decision in some way.⁶⁶

The test for determining the specific capacity to make a treatment decisions for the purposes of the Mental Health Act is as follows:

A person has the capacity to make a treatment decision about the provision of treatment to a patient if another person who is performing a function under this Act that requires that other person to determine that capacity is satisfied that the person has the capacity to —

- (a) understand the things that are required under section 19 to be communicated to the person about the treatment; and
- (b) understand the matters involved in making the treatment decision; and
- (c) understand the effect of the treatment decision; and
- (d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the treatment decision; and
- (e) communicate the treatment decision in some way.⁶⁷

The Mental Health Act largely (although not precisely) incorporates the elements of the common law in the tests set out in sections 15 and 18. There are two evident variations, however.

First, neither section 15 nor 18 explicitly requires that the patient be capable of **retaining** the information material to the decision. Nevertheless, the requirement to weigh up the relevant factors does imply that a modicum of retention will be necessary.⁶⁸

Second, neither section 15 nor 18 appears to require actual demonstration of understanding. The relevant criterion is whether the person **has the capacity (or ability) to understand** not whether they in fact understand.⁶⁹ Nevertheless, for the purposes of clinical capacity assessment, the issue is largely moot, as it is generally only possible to test the ability to understand information by reference to what the person actually understands.⁷⁰ This issue seems most likely to arise in the context of non-cooperation with the testing process.

⁶⁶ *Mental Health Act 2014* (WA) s 15(1).

⁶⁷ *Mental Health Act 2014* (WA) s 18.

⁶⁸ Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49 *Australian & New Zealand Journal of Psychiatry* 324, 329.

⁶⁹ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [159]–[162] (Bell J). The question 'is not whether the patient has understood the information, which a capacitous individual may choose to do or not do, but whether the person is capable of doing so.' *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [159] (Bell J)

⁷⁰ Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49 *Australian & New Zealand Journal of Psychiatry* 324, 328.

The tests in sections 15 and 18 require that the person tasked with assessing the patient's capacity under the Mental Health Act be 'satisfied' of such capacity. This requires an actual persuasion.⁷¹

Determining capacity under the Mental Health Act

The importance of context

The test for mental capacity under the Mental Health Act reflects a functional approach, and 'is better described as reflecting a capabilities approach because it refers to the capability of the person cognitively to function in the specific domains.'⁷² The assessment of capacity is context specific and accordingly must be undertaken in the specific factual context of the treatment decision to be made.

The need to determine capacity to make treatment decisions under the Mental Health Act arises most frequently in the context of whether the patient is in need of an involuntary treatment order. The test for whether a patient is in need of an inpatient treatment order is set out at s 25(1) of the Mental Health Act:

- (1) A person is in need of an inpatient treatment order only if all of these criteria are satisfied —
 - (a) that the person has a mental illness for which the person is in need of treatment;
 - (b) that, because of the mental illness, there is —
 - (i) a significant risk to the health or safety of the person or to the safety of another person; or
 - (ii) a significant risk of serious harm to the person or to another person;
 - (c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;
 - (d) that treatment in the community cannot reasonably be provided to the person;
 - (e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order.

The test for whether a patient is in need of community treatment order is set out at s 25(2) of the Mental Health Act:

- (2) A person is in need of a community treatment order only if all of these criteria are satisfied —
 - (a) that the person has a mental illness for which the person is in need of treatment;
 - (b) that, because of the mental illness, there is —

⁷¹ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [203] – [205] (Bell J)

⁷² *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [159] (Bell J).

- (i) a significant risk to the health or safety of the person or to the safety of another person; or
 - (ii) a significant risk of serious harm to the person or to another person; or
 - (iii) a significant risk of the person suffering serious physical or mental deterioration;
- (c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;
- (d) that treatment in the community can reasonably be provided to the person;
- (e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order.

Section 25(1)(c) and 25(2)(c) confirm that absence of capacity to make a treatment decision in accordance with in section 18 is a prerequisite to the making of an involuntary treatment order under the Mental Health Act. In other words, the threshold question must be whether the presumption of capacity in section 13 has been rebutted to the actual persuasion of the person tasked under the Mental Health Act with making the decision. This represents a significant change from the Mental Health Act (WA) 1996, which did not demand incapacity as a prerequisite to an involuntary treatment order.⁷³

To determine whether the presumption of capacity in section 13 has been rebutted, the psychiatrist (for the purposes of section 24) or the Tribunal (for the purposes of conducting an initial, periodic, or requested review of the order under sections 386, 387, or 390 of the Mental Health Act) must consider evidence.

The psychiatrist will generally examine the patient to assess capacity. The Tribunal will review the evidence presented in the course of the hearing. In practice this involves consideration of the psychiatrist's evidence as to capacity, which the Tribunal will assess in accordance with the test set out in section 18 in the individual factual context raised. Actual persuasion that the presumption of capacity in section 13 has been rebutted is required.⁷⁴

'Proxy determinants'

There are no 'proxy determinants' for capacity. The case law developed over the past 20 years is clear and consistent: no one factor is a *prima facie* determinant of the presence or absence of capacity. This includes the fact that the decision will result in a terrible outcome, the objective unreasonableness or irrationality of the patient's decision to refuse treatment, the fact that the patient 'lacks insight' into the need for treatment, or that the patient is experiencing delusions, obsession, overvalued thoughts, fear, or panic. In

⁷³ *Mental Health Act 1996 (WA)* s 26 (1)(c): 'the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment'.

⁷⁴ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [203] – [205] (Bell J).

every case, matters such as these must be considered in the context of the extent to which they impact upon the patient's ability to understand the relevant consideration, and weigh up the factors for the purposes of making the treatment decision. Examples from key cases are explored below.

A 'bad' outcome

The adoption of a functional approach to determining capacity rather than the outcome approach reflects the principle that a person should not be treated as lacking treatment capacity merely because the decision is considered unwise.⁷⁵

[167] It has been said that capacity assessments are inherently risky, uncertain and 'epistemologically fallible', driving many capacity assessors to the apparent safe ground of the 'reasonable' outcome as an implicit default criterion. One can understand the natural human tendency of health professionals and judicial officers, among others, to make decisions in the best interests of vulnerable persons, especially where treatment for grievous ill-health, or even the person's life, is at stake. It has been described as the 'protection imperative'.

[168] However well intentioned, such a paternal or beneficial approach is not part of the common law test of capacity and was rejected when the functional approach was adopted. ... It is therefore well-established that the outcome of the decision (as distinct from the reasons for the patient's decision if reasons were given) is not relevant to whether the person has capacity and the focus must be upon the functioning of the person as assessed against the capacity criteria.

[169] Moreover, in relation to something as personal as whether a person should consent to or refuse medical treatment, it is problematic to suggest that one person can necessarily determine that another person's decision is objectively unreasonable: a decision to consent to or refuse such treatment may be so subjectively anchored in the individual values, relationships and life's experience of the person as to make it difficult for another even to comprehend the decision; or even if properly comprehended, it may be so subjectively anchored in those respects as simply to defy objective characterisation at all. This is so whether the person has capacity to consent or refuse or not.⁷⁶

The facts underlying the Court's analysis in *PBU & NJE v Mental Health Tribunal* will be discussed in detail below.

'Unreasonable' or irrational choices

Likewise, the objective 'unreasonableness' of the patient's decision to refuse treatment may constitute evidence of the absence of capacity, but is not necessarily determinative of the issue.

In *St George's Healthcare NHS Trust v S*⁷⁷, the Court of Appeal (UK) considered a situation where a pregnant woman was detained pursuant to section 2 of the *Mental Health Act 1983* (UK)⁷⁸ when she declined

⁷⁵ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [164] (Bell J).

⁷⁶ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [167] – [169] (Bell J).

⁷⁷ *St George's Healthcare NHS Trust v S* [1998] 2 FCR 685 (CA).

⁷⁸ This provision allowed for a person suffering from a mental disorder to be detained for assessment 'in the interests of his own health or safety'.

repeatedly to present herself for an induced delivery.⁷⁹ The woman was a veterinary nurse who was 36 weeks pregnant. She had sought to register as a new patient at an NHS practice in London, and upon presentation was diagnosed with pre-eclampsia and was advised to present to hospital for an induced delivery. Although she understood that refusing this treatment could jeopardise her own life as well as the foetus, Ms S rejected this advice because she wanted a natural birth. The application for involuntary detention made no reference to treatment for a mental disorder. To the contrary, the application indicated clearly that the concern was for Ms S's physical health only. Despite the admitting psychiatrist expressing the view that Ms S's capacity to consent was intact, the matter was referred to the Family Division of the Supreme Court. After a successful *ex parte* application in the Family Division to compel Ms S to undergo a caesarean section, the foetus was delivered by emergency caesarean section later that night.

On appeal, the Court of Appeal rejected that the *Mental Health Act 1983* (UK) could be used to detain an individual merely because their thinking process was '*unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large*'. Further, the court held that a patient detained under that Act for a mental disorder could not be forced into a medical procedure unrelated to her mental condition unless her capacity to consent to treatment had been diminished. The Court of Appeal held that the application for Ms S's detention under section 2(2) of the *Mental Health Act 1983* (UK) was unlawful, and further that she was wrongly detained.

Rather than focusing solely on the reasonableness of the patient's decision, the assessment by a psychiatrist and the Tribunal should instead be on the patient's level of understanding of, and ability to weigh, the relevant factors. The mental processes do not need to be logical or rational to demonstrate the ability to understand and weight, although significant irrationality in the process or the decision certainly may constitute evidence of incapacity.⁸⁰

'Lack of insight'

A patient's 'lack of insight' into their illness may also constitute evidence of the absence of capacity, but is not *per se* determinative:

A lack of insight may impact a person's ability to understand relevant information, but the presence or absence of insight is not a proxy for the presence or absence of decision-making capacity. Insight is an extremely complicated phenomenon that is rarely either simply present or absent. Various aspects of insight – such as insight into diagnosis, insight into the presence or veracity of phenomenology and insight into the need for treatment – may all vary independently. This, in combination with the requirement that a person only needs to understand information

⁷⁹ *St George's Healthcare NHS Trust v S* [1998] 2 FCR 685 (CA).

⁸⁰ Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49 *Australian & New Zealand Journal of Psychiatry* 324, 330. Likewise, 'although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence.' *Re MB (Medical Treatment)* [1997] EWCA Civ 3093 [19] (Lady Justice Butler-Sloss).

that is relevant to the decision being made, means that while a lack of insight may suggest a lack of decision-making capacity, this deficit alone will rarely be determinative.

The relevance of a lack of insight really depends on the degree to which it impacts each element of the capacity test. For example, a person with chronic schizophrenia may disagree with his doctors about his diagnosis, and may not believe that the voices he experiences are a result of mental illness. However, he may acknowledge that the voices are less troublesome when he takes antipsychotic medication. This understanding of the reason for treatment and its effect may be sufficient to fulfil this part of the capacity test.⁸¹

As noted by Bell J in *PBU & NJE v Mental Health Tribunal*:

[193] ...the issue of 'belief is subsumed in the more general requirements of understanding and of ability to use and weigh information'. A person who lacks insight may, not must, be lacking in capacity.

[194] Insight into one's diagnosis and need for treatment varies significantly between different persons and between the same persons in different situations. Insight is potentially affected in nature and degree by various non-capacity influences, including educational background, language proficiency, familiarity with medical issues and family and social relationships (negative and positive) and (often critically) the availability of appropriate support. For these reasons, it is but one of the factual considerations that may be relevant when assessing capacity to give informed consent.

The way in which lack of belief or insight in respect of the illness and the need for treatment is considered when assessing capacity is a matter of importance to people with mental disability. This is because it is not uncommon, for various personal, social and medical reasons, for a person with mental disability to deny or diminish the illness and the need for treatment, or to choose non-advised treatment. Nor is it uncommon, for various personal, social and medical reasons, for persons not having mental disability to deny or diminish illness or the need for treatment, or to choose non-advised treatment. In neither case does this mean of itself that the person lacks capacity.⁸²

The importance of 'insight' in determining capacity must be assessed in the context of determining its impact on the patient's level of understanding of, and ability to weigh, the relevant factors.

'Misperceptions of reality'

Many cases have arisen in the context of delusions, obsessions, overvalued thoughts and other matters which evidence a 'misperception of reality'. Whether such cases give rise to a lack of capacity depends on the extent to which the impairment interferes with the ability to understand and weigh information. Several of these decisions are summarised in the extract below:

The Courts have again and again decided the matter of decision-making capacity by determining whether or not a patient's ability to use and weigh information fell within [the extensive range of ordinary human experience]. In *Trust A v H* the Court decided that the decision-making ability of

⁸¹ Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49 *Australian & New Zealand Journal of Psychiatry* 324, 328-29 (citations omitted).

⁸² *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [193] – [195] (Bell J) (footnotes omitted).

woman with schizophrenia considering a hysterectomy and bilateral salpingo-oophorectomy as treatment for ovarian cancer was being impeded by her delusional belief that she had not yet had children and that this influence took her outside the bounds of a normal ability to use and weigh (*Trust A and Trust B v H (an Adult Patient)* [2006] EWHC 1230 (Fam)). In another case a young woman with anorexia nervosa was found to lack capacity due to 'obsessive fear of weight gain mak[ing] her incapable of weighing the advantages and disadvantages of eating in any meaningful way' (*Re E* [2012] EWHC 1639 (COP), [49]).

Courts have also found an inability to use and weigh in the context of personality disorder. In *NHS Trust v T*, a 37-year-old woman with borderline personality disorder, who frequently cut and bled herself down to life-threatening anaemia, was found to have lacked capacity when she completed an advance directive refusing blood transfusions (*NHS Trust v T (Adult Patient: Refusal of Medical Treatment)* [2004] EWHC 1279 (Fam)). The basis for the Court's decision was Ms T's insistence, recorded in the advance directive, that her blood was evil. Charles J found that this belief rendered her unable to use and weigh the relevant information. Notably some of the psychiatrists who gave evidence did not regard T's insistence as delusional and Charles J characterised it as 'a misconception of reality'.

In another case a health service applied for authority to perform an instrumental delivery and, if that were to fail, a Caesarean section upon a 32-year-old woman, 'W', who had presented to the emergency department in arrested labour (*Norfolk and Norwich Healthcare NHS Trust v W* [1996] 2 FLR 613). W had had no prior antenatal treatment and 'despite the obvious indications to the contrary, she continued to deny that she was even pregnant'. She was seen by a psychiatrist, who did not believe she was mentally ill (in the sense implied by the *Mental Health Act 1983* (UK)). He felt that she understood that she was in an obstetric ward and that Caesarean was proposed but, given that she persisted in denying her pregnancy, he did not believe she could balance the information given her. Johnson J agreed and found her 'incapable of weighing up the considerations that were involved', commenting that she 'was called upon to make that decision at a time of acute emotional stress and physical pain in the ordinary course of labour'.⁸³

Finally, in *Re L (An Adult: Non-consensual Treatment)*,⁸⁴ Ms L was a woman in her early 20's who was in labour with a full term pregnancy. Her labour was obstructed and obstetricians recommended that L proceed to birth by caesarean section within about 30 minutes to guarantee the delivery of a healthy child. L wished to be safely delivered of the child, but because of a needle phobia, refused to consent to the administration of any treatment involving the penetration of her skin (whilst conscious) with a needle. After ruling out the application of other forms of anaesthesia (such as gas inhalation) because of an unacceptably high risk of death, the authority brought this application to declare the lawfulness of the insertion of needles for the purposes of administering anaesthesia and intravenous infusion, as well as the performance of an emergency caesarean section.

The court proceeded to determine L's capacity to refuse medical treatment. It heard evidence that during the day, L had been capable of comprehending and retaining treatment information and believing such information. Subject to her phobia of needles, she had been capable of weighing the information in the

⁸³ Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49 *Australian & New Zealand Journal of Psychiatry* 324, 330.

⁸⁴ [1997] 1 FCR 609 at 610 (FD).

balance to make a choice. Relying on the totality of the evidence relayed to the court, the court concluded as follows:

L wished to be safely delivered of her unborn child. If she were not [safely delivered], her own health and well-being would be put in jeopardy. L apparently consented to any medical procedure necessary to achieve a safe delivery save and except penetration of her skin with a needle whilst she was conscious. I held that her extreme needle phobia amounted to an involuntary compulsion that disabled L from weighing treatment information in the balance to make a choice. Indeed, it was an affliction of a psychological nature that compelled L against medical advice with such force that her own life would be in serious peril. Accordingly, I held that L was incapable of weighing relevant treatment information in the balance and thus, in this instance, lacked the relevant mental competence to make the treatment decision.

With L deemed incapable of refusing consent to treatment, the court ordered that treatment proceed in the best interest of the patient. The court reported that L was later delivered of a healthy baby, and that 'she was delighted with the outcome, and that she had expressed apology that she had caused many people so much trouble.'

The decision in *PBU & NJE v Mental Health Tribunal*

On 1 November 2018, the Supreme Court of Victoria held that the Victorian Civil and Administrative Tribunal (VCAT) 'misinterpreted and misapplied' the statutory test for determining capacity under the Victorian Mental Health Act in *PBU & NJE v Mental Health Tribunal*.⁸⁵ The decision dealt with two separate decisions of VCAT, referred to as PBU and NJE.

In PBU, Mr U did not agree that he had schizophrenia but accepted that he had mental health problems, namely depression, anxiety and post-traumatic stress disorder. He was willing to receive psychiatric and psychological treatment for those conditions but not electroconvulsive therapy (ECT) or anti-psychotic medication or treatment. He wished to be discharged from hospital to a prevention and recovery facility and then return home, which the hospital did not support because he was too unwell.⁸⁶

The Mental Health Tribunal Victoria (VMHT) ordered Mr U to have a course of up to 12 ECT treatments during April and May 2017.⁸⁷ On review, VCAT held that Mr U lacked capacity to give informed consent under section 68(1) of the *Mental Health Act 2014* (Vic) (the Victorian Act).

Section 68(1) provides relevantly:

- (1) 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

⁸⁵ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (Bell J).

⁸⁶ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [277] (Bell J).

⁸⁷ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [8] (Bell J). The order was stayed by VCAT when Mr U applied for review.

- (b) is able to remember the information that is relevant to the decision; and
- (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.⁸⁸

VCAT's decision and reasons are set out within the decision of the Supreme Court in *PBU & NJE v Mental Health Tribunal*:

[13] VCAT found under para 68(1)(a) that PBU understood information he was given about ECT:

There was no dispute before me that PBU had been given information about ECT and that he understood it in the way described in section 68. In the letter handed up at the hearing, PBU demonstrated that he was aware that ECT is used to treat patients with depression and psychosis, in general terms, how it works and the fact that it can have negative effects and disadvantages. That understanding came in part from his earlier experience with ECT.

VCAT did not specifically apply paras 68(1)(b)–(d). Rather, it accepted the contention of the clinical director that PBU did not have capacity because he did not accept the diagnosis of schizophrenia in relation to him:

I find that, as at the hearing date, he did not have capacity to give informed consent to whether ECT should be performed in circumstances where he did not accept the diagnosis for which the treatment was intended to be given. PBU has consistently disputed the diagnosis and the suggestion that ECT might be beneficial for him.

VCAT expressed its conclusion at this level of generality. There is no discussion in the reasons for decision of how PBU's refusal to accept the diagnosis of schizophrenia related to his ability to remember and weigh and use information and communicate his decision.⁸⁹

In other words, VCAT accepted the contention that Mr U lacked capacity because he did not accept the diagnosis of schizophrenia applied to him.⁹⁰ The Supreme Court disagreed that this reflected a correct interpretation of s 68:

[229] PBU's lack of acceptance of the diagnosis of schizophrenia did not mean that he did not accept that he had a mental illness or that he had no insight into the need for treatment. The evidence was that, although PBU did not accept the diagnosis of schizophrenia, he did accept that he had mental health problems. He told VCAT that he was suffering from depression, anxiety and post-traumatic stress disorder, for which he was willing to receive psychiatric and medical treatment, but definitely not ECT (see above). This evidence was at least as relevant to the proper application of the criteria in s 68(1)(a)–(d) as PBU's non-acceptance of the diagnosis of schizophrenia. But VCAT noted these matters as background facts without relating them to the statutory criteria and based its decision upon his non-acceptance of the diagnosis.⁹¹

⁸⁸ *Mental Health Act 2014* (Vic) s 68(1).

⁸⁹ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [13] (Bell J).

⁹⁰ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [228] (Bell J).

⁹¹ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [229] (Bell J).

His Honour Justice Bell held that 'non-belief or non-acceptance of a diagnosis and lack of insight into the need for treatment 'would not be a sufficient basis for rebutting the presumption of capacity at common law ... , and it is not under these provisions.'⁹² He concluded that:

[232] A feature of VCAT's reasoning in the case of PBU is that, other than the domain of understanding in s 68(1)(a), it did not explicitly consider the domain of the ability to remember, use or weigh and communicate in the specified respects in s 68(1)(b)–(d). In particular, VCAT did not examine how non-acceptance of the diagnosis affected PBU's ability to function in these respects. It found that he lacked capacity 'where he did not accept the diagnosis'. Nor did VCAT examine PBU's acceptance of having a mental illness and need for treatment (not including ECT) as considerations tending to suggest that he did have ability in these respects. On VCAT's approach, consideration of these matters was foreclosed by the fact that PBU did not accept the diagnosis.

[233] Read fairly and as a whole, I think it is clear that VCAT based its finding that PBU lacked capacity upon his non-acceptance of the diagnosis for schizophrenia. This represented an error of law either in the interpretation of s 68(1)(a)–(d) or in the application of those statutory criteria. Therefore, in the case of PBU, common grounds 1 and 2 and ground 3(a) will be upheld.⁹³

In the companion case NJE, Ms E was diagnosed with treatment resistant schizophrenia. She was a longstanding patient and had several recent extended involuntary stays in hospital.⁹⁴ In April 2017, the VMHT ordered Ms E to undergo a course of up to 12 ECT treatments.⁹⁵ Ms E's preferred alternative to ECT was remaining in hospital for an extended period and trialling alternative medications, including possibly Clozapine.⁹⁶

On review by VCAT, Ms E's doctor gave evidence that she could read, understand and remember the information given, but that she lacked capacity to use and weigh information because she:

did not accept that she had treatment resistant schizophrenia or indeed a mental illness. As a consequence, NJE did not understand why ECT had been recommended for her or the possible benefits to her.⁹⁷

The doctor observed that:

[21] NJE spoke and wrote about her 'working', while in hospital, as a licensed and registered Master of a modality known as 'Melchizedek Method of Healing'. A nurse in attendance at the hearing described NJE as being frequently active and awake during the night and that NJE would explain her state of wakefulness by saying that she was 'working' as a psychic healer.

⁹² *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [231] (Bell J).

⁹³ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [232] – [233] (Bell J) (emphasis added).

⁹⁴ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [15] (Bell J).

⁹⁵ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [16] (Bell J).

⁹⁶ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [23] (Bell J). The order was stayed by VCT when Ms E applied for review.

⁹⁷ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [20] (Bell J).

Dr A described NJE experiencing grandiose delusions and hallucinations despite believing that she was not hallucinating. NJE had told Dr A that she did not want ECT because it would interfere with her psychic abilities and her 'work' as a healer.⁹⁸

On considering the matter, VCAT found that Ms E had an understanding about ECT treatment as described in section 68 of the Victorian Act in that she could 'understand the information, could remember it and could communicate her wishes and her anxieties'.⁹⁹ Nevertheless, VCAT was not satisfied that Ms E could use and weigh the information relevant to the decision:

To *use and weigh* requires a person to carefully consider the advantages and disadvantages of a situation or proposal before making a decision. NJE could not apply herself in that way. Her decision to refuse ECT was made without prior consideration of the advantages or disadvantages. NJE could not *use and weigh* the information because she could not conceive that it applied to her situation because it was her belief that she did not have a mental illness... It was not that NJE did not understand but rather that she could not be persuaded that the information was relevant to her (*italics in original*)....¹⁰⁰

VCAT found that Ms E lacked the capacity to give informed consent and that, other than ECT, there was no less restrictive way for her to be treated. Accordingly it ordered that she be subjected to a course of that treatment.

On considering the appeal, His Honour Justice Bell was satisfied that in determining capacity, VCAT did not base its finding solely on the fact that Ms E did not accept her diagnosis of schizophrenia. To the contrary, the Court was satisfied that VCAT explicitly considered each of the criteria in section 68. He concluded that 'although some language in the reasons for decision suggests that this conclusion might have been based upon [NJE's] non-acceptance of the diagnosis, read fairly and as a whole, I think that this was treated as relevant, not determinative.'¹⁰¹

Nevertheless, the Court held that VCAT erred in that it articulated a threshold for capacity which was too high:

[237] In the case of NJE, VCAT determined that she satisfied the criteria in s 68(1)(a), (b) and (d). In VCAT's words, NJE 'could understand the information, could remember it and communicate her wishes and anxieties'. But VCAT found that NJE did not satisfy the criterion in para (c) because '[t]o *use and weigh* requires a person to carefully consider the advantages and disadvantages of a situation or proposal before making a decision' (emphasis in original). VCAT went on to say that NJE refused to give consent for ECT 'without prior consideration of the advantages and disadvantages' and 'she could not be persuaded that the information was relevant to her'.

[238] Although VCAT correctly stated the terms of s 68(1)(a)–(d) earlier in the reasons for decision, these and other passages reveal that it actually interpreted and applied the criterion in

⁹⁸ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [21] (Bell J).

⁹⁹ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [23] (Bell J).

¹⁰⁰ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [24] (Bell J).

¹⁰¹ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [234] (Bell J).

para (c) in two related respects that were erroneous in law: (1) it focussed upon whether NJE had actually considered the advantages and disadvantages of the decision, not whether she had the ability to use or weigh relevant information; and (2) it applied a threshold of capacity that required the person 'to carefully consider the advantages and disadvantages of the situation or proposal', which was too high.¹⁰²

His Honour Justice Bell also cautioned as to the need to determine capacity by reference to the statutory criteria rather than decisions or behaviours:

[242] It is important to determine capacity by reference to the statutory criteria, which are based on domains of cognitive functioning, not by reference to decisions or behaviours, which give rise to contestable value judgments. Variation in human behaviour is normal and not necessarily a sign of lacking the capacity to give informed consent. Normal people often believe what to others is extraordinary. Being frequently active and awake during the night is not unheard of in the general population. Many people believe in the power of prayer to heal either individuals or humanity, and actively stay awake at night (sometimes all night) praying with that belief. Some people believe they can heal others by touching or be healed themselves by bathing in or drinking sacred water, and touch others or bath in or drink those waters with that belief. Psychiatric evidence may establish that the belief or behaviour is delusional. ... The capacity assessment needs to go into the relationship (if any) between the delusion and the ability to use or weigh the relevant information, for that is what the statutory criteria and respect for human rights requires.¹⁰³

Ultimately, it is not necessary that a patient make, or be able to make, a rational and balanced decision in relation to the treatment. It is enough that the person, like most people, is able to make and communicate a decision in broad terms as to the general nature, purpose and effect of the treatment.¹⁰⁴

The Court reminded in respect of both cases that:

[282] [P]ersons who are found to lack that capacity do not lose their right to contribute to medical decisions about what should be done to them. In determining whether there is any less restrictive way for the person to be treated, it is necessary to take the person's views and preferences into account if it reasonable to do so. This is a human rights safeguard that reflects the paradigm shift [away from best interests paternalism towards recognition of persons having mental illness as equal rights-bearers, not dependant welfare cases] in the new legislation. The operation of this safeguard is discussed in [this] judgment, especially the importance of supporting the person meaningfully to express their views and preferences.¹⁰⁵

The decision of the Supreme Court of Victoria in *PBU & NJE v Mental Health Tribunal* does not change the existing law regarding the test for determining capacity under the Victorian (or WA) Mental Health Acts. Rather, it serves as a timely reminder of the critical importance of the task of correctly assessing capacity for psychiatrists, as well as Tribunal members.

¹⁰² *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [237] – [238] (Bell J).

¹⁰³ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [242] (Bell J) (emphasis added).

¹⁰⁴ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [280] (Bell J).

¹⁰⁵ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [282] (Bell J).

As highlighted earlier, for health professionals, the tension between the desire to treat the patient in the patient's best interest and the patient's competing right to self-determination is high. The principle of beneficence is fundamental to health care, and it can be counterintuitive for psychiatrists to permit a patient to make treatment decisions which are so objectively unreasonable as to suggest irrationality.

What the decision *PBU & NJE* confirms is that precisely where the line is drawn between an unreasonable decision, lack of insight, and the impact of misperceptions of reality on the one hand, and incapacity on the other, can be difficult to discern. Nevertheless, the balance weighs in favour of self-determination and autonomy. Only in those situations where the psychiatrist (or the Tribunal) is actually persuaded that the patient lacks the ability to understand the relevant factors and weigh them up for the purpose of making a treatment decision will the patient be permitted by the Mental Health Act to be treated without informed consent in his or her best interest.

Furthermore, the threshold level of requisite capacity is low – the level of understanding is limited to the general nature, purpose and effect of the treatment. Likewise, where the patient is suffering from a condition which potentially impacts on cognition (such as misperceptions of reality, lack of insight and irrationality) the psychiatrist (and Tribunal) must be satisfied of both the existence of the relevant facts and the relationship between the symptoms and the ability to understand and weigh the relevant information.

Conclusion

As demonstrated by the discussion above, the presumption of capacity must be displaced to the actual satisfaction of the decision-maker before an adult patient may lawfully become the subject of an involuntary treatment order. It is very easy to slip into a consideration of the best-interests of the patient before determining the threshold question of whether the patient lacks capacity. This must be avoided. By way of conclusion, I will offer some suggestions to assist treating teams in ensuring that their own capacity assessments are performed in accordance with the Mental Health Act, as well as ensuring that the evidence they rely upon is based on objective, demonstrable facts rather than opinions and proxy determinants such as 'lack of insight' or 'unreasonable decisions'.

Firstly, become familiar with the difference between facts and opinions or conclusions. Facts are observable, objective statements that are capable of being proven true or false with the appropriate evidence. They include who did what where and when. Facts going to the question of capacity may be of the following nature:

- 'When I met with the patient today, he told me that he would not speak to me because I am part of a Government conspiracy to silence him because he has been provided with special information from Donald Trump which is harmful to the Australian Government.'
- 'Today the patient told me that she does not have schizophrenia. Rather, she has been diagnosed with a drug-induced psychosis and once she stops using drugs, she will not need her depot treatment.'

- 'Upon the patient's last admission, he punched the admitting nurse and broke his nose. The patient had to be restrained.'
- 'On Monday, the patient told me that if the CTO is discharged, he will not continue to accept his depot medication.'

The truth of such statements can (and should) be objectively assessed by speaking to the participants in, or witnesses to, the conversations or events. Alternatively, it may be possible to ascertain the truth from examining certain contemporary documents (for example, a police report attaching witness statements).

An opinion or a conclusion comes from the application of a fact to further information. This further information may include information which is professional in nature. For example, for lawyers, the further information may be the wording of legislation or a case. For a health professional, the information may be diagnostic information or criteria. The facts set out above are recast below into opinions or conclusions.

- 'The patient is delusional and lacks insight. He lacks decision-making capacity.'
- 'The patient lacks insight into her diagnosis and is refusing treatment. She is incapable of making reasonable decisions.'
- 'The patient is violent and is a significant risk to the safety of others.'
- 'The patient cannot be treated as a voluntary patient.'

An opinion or conclusion may be correct, but to determine whether it is requires a deconstruction of the facts and the applicable principle. Accordingly, the conclusion or opinion itself is of limited assistance isolated from the factors underlying it. It takes significant time to draw out such information in a hearing.

Secondly, don't 'shortcut' your analysis and reasons. Drawing conclusions without a thorough assessment and analysis of each fact and each applicable principle often leads to sloppy decision-making. Even when it doesn't, when you are asked to reconstruct your reasoning (such as upon review by your supervisor or the Tribunal), it may be difficult to recall what you relied on. You may end up making vague statements such as, 'it would have been based on what the patient said to me in the examination' or the like. You (or the person you are accountable to) won't be able to test the integrity of the conclusion or opinion by deconstructing it into its component parts and analysing them. In turn, this may result in what lawyers call 'unreliable evidence' or evidence which 'carries little weight'. If you create a record of your decision in the patient's file, it will be available to use later when preparing a report for the Tribunal.

Thirdly, when preparing a report for the Tribunal, write a comprehensive report which addresses the statutory criteria set out in the Mental Health Act. It is ultimately more efficient to identify the relevant facts, the applicable principles, and the conclusions drawn at the time you prepare the report than to answer the Tribunal's (inevitable) questions at the hearing. Compare the following two report extracts:

- 'The patient lacks insight into her diagnosis and is refusing treatment. She is incapable of making reasonable decisions.'
- 'On the question of whether the patient lacks capacity, the patient told me on assessment today that she does not have schizophrenia. Rather, she says her symptoms are caused by the depot injection. I spoke to her about the fact that there is no medical evidence to support this, but she said her own medical research proves otherwise. According to her file, for some years when she is unwell, she believes that she is an internationally renowned medical research scientist. In fact, she left school at age 15 and has had no formal education since then. She is not presently, and to my knowledge never has been, conducting medical research. Although she told me that when she is on the depot she does feel much better and does not hear voices, and is able to function well in the community, she says that she will not continue to take depot without a CTO because 'depot is poison and everyone knows that it is the cause of my problems, not the solution'. She maintains that the ultimate outcome of continuing depot is that it will cause her to relapse, and she says the only way to avoid this is to stop taking the injection. Based on these facts, I am satisfied that the patient is unable to make a treatment decision because her delusional beliefs interfere with her ability to understand the actual objective effect that her treatment has on her illness. Because she cannot understand the actual effect of the depot, she is unable to weigh up the factors involved in making a treatment decision to continue or cease depot. Hence, she lacks the capacity to make treatment decisions of the sort required to be a voluntary patient.'

The first is a conclusion based on several unarticulated assumptions. It may be correct, but it will require you to be present at the hearing for much longer whilst the Tribunal asks the questions necessary to tease out why your conclusion is correct. If you are unable to attend the hearing and your report was as set out in the first example, the hearing would almost certainly need to be vacated and rescheduled. Alternatively, it may be open to the Tribunal to revoke the CTO if the Tribunal is not satisfied on the evidence that the patient lacks capacity. If you do attend, you will likely face a much more extensive period of questioning, and you will need to search for the information in the patient file, or possibly even hunt down the patient file to be able to extract the information.

With the second example, the Tribunal will likely have far fewer questions for you, and will be able to focus on obtaining evidence from the patient or other witnesses, and testing the evidence.

Finally, if you do prepare a report which is filled with opinions and conclusions, do not be upset that the Tribunal 'challenged' you at the hearing in front of the patient and the treating team. This is the Tribunal's role, and they will ask the questions which they need to ask to be satisfied for themselves as to whether the patient lacks capacity. This isn't because they don't believe you, or respect your opinion, or wish to embarrass you. It is because the Mental Health Act requires that in a review, they (not you) need to be satisfied on each element of the statutory test for need. They would be failing in their statutory obligations

under the Mental Health Act if they made a finding that the patient lacks capacity merely because this is the opinion of the treating psychiatrist.

In my view, patients, treating teams, and the Tribunal itself would all benefit significantly from the Tribunal adopting (as has been done in other jurisdictions) a standard report form which specifically identifies what the Tribunal needs to know for each type of hearing. Having a standard report form which is provided to all participants at least 48 hours in advance would save time for everyone at the hearing, because all parties would have a copy of the evidence in advance, and the focus of the hearing could be on discussing the disputed evidence rather than extracting the primary evidence. The Tribunal's psychiatrist members are presently drafting such a form, which will be circulated for consultation in due course.

In the meanwhile, psychiatrists and treating teams should be prepared to deliver clear and persuasive evidence as to the relevant facts which permit the Tribunal to make the findings of fact necessary to support the statutory test for capacity set out in the Mental Health Act.