IN THE SUPREME COURT OF VICTORIA
AT MELBOURNE
COMMON LAW DIVISION
JUDICIAL REVIEW AND APPEALS LIST

Not Restricted

S CI 2017 02464

PBU — Plaintiff
v
MENTAL HEALTH TRIBUNAL — First Defendant
and
MELBOURNE HEALTH — Second Defendant

S CI 2017 02771

NJE — Plaintiff
v
MENTAL HEALTH TRIBUNAL — First Defendant
and
BENDIGO HEALTH — Second Defendant

JUDGE:	BELL J
WHERE HELD:	Melbourne
DATE OF HEARING:	14 and 15 August 2017, 26 April, 8 June, 4 October 2018
DATE OF JUDGMENT:	1 November 2018 (revised 22 January 2019)
CASE MAY BE CITED AS:	*PBU & NJE v Mental Health Tribunal*
MEDIUM NEUTRAL CITATION:	[2018] VSC 564

ADMINISTRATIVE LAW – appeal – decisions of Victorian Civil and Administrative Tribunal ('VCAT') that two persons with mental illness be compulsorily subjected to electroconvulsive treatment ('ECT') – determination that they lacked the capacity to give informed consent to or refuse treatment – whether VCAT properly interpreted and applied requirement that person be able to 'use or weigh' information relevant to decision – further requirement that there be no less restrictive way for the person to be treated – whether this requirement only met where treatment immediately needed to prevent serious deterioration in person's health or serious self-harm or harm to another – 'capacity to give informed consent' – *Mental Health Act 2014* (Vic) ss 68, 69, 70, 72, 93 and 96.

HUMAN RIGHTS – two persons having mental disability found by VCAT to lack capacity to give informed consent to or refuse ECT – whether incompatible with human rights to self-determination, to be free of non-consensual medical treatment and to personal inviolability – assessing capacity compatibly with those rights and the right to health – applicable principles – dignity of risk – *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss 8(3), 10(c), 13(a), *International Covenant on Economic, Social and Cultural Rights* art 12(1), *Convention on the Rights of Persons with Disabilities* arts 12(4), 24.

APPEARANCES:	Counsel	Solicitors
For the plaintiffs	E M Nekvapil with A Lord (14 and 15 August 2017, 26 April 2018) and J Taylor (8 June 2018)	Victoria Legal Aid
For the defendants	No appearance	
For the Secretary of the Department of Health and Human Services	C M Harris QC	Solicitor for the Department of Health and Human Services

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HIS HONOUR:

INTRODUCTION

1 These two separate appeals under s 148(1) of the *Victorian Civil and Administrative Tribunal Act 1998* (Vic) raise common issues. PBU and NJE challenge orders of the Victorian Civil and Administrative Tribunal ('VCAT') that they be compulsorily subjected to courses of electroconvulsive treatment ('ECT').[1] The orders were made under the *Mental Health Act 2014* (Vic) after VCAT determined that PBU and NJE lacked the capacity to give (and therefore to refuse) informed consent to the treatment, and that there was no less restrictive way for them to be treated.

2 Under the *Mental Health Act*, a decision by a compulsory patient to not to have ECT must be legally respected, unless the Mental Health Tribunal ('MHT') or (on review) VCAT is satisfied that the patient does not have the capacity to give informed consent. PBU and NJE were compulsory inpatients at hospitals operated by Melbourne Health and Bendigo Health respectively. They both disputed their psychiatrists' diagnosis that they suffered from schizophrenia. In proceedings in both the MHT and VCAT, an authorised psychiatrist at the hospitals sought, and PBU and NJE opposed, the making of orders for compulsory ECT. The MHT made and VCAT confirmed the orders. The orders were stayed pending appeal.

3 The ground of these appeals is that VCAT erred in law in determining that PBU and NJE lacked capacity to give informed consent. Among other things, they contend that VCAT misinterpreted the relevant provisions of the *Mental Health Act*, failed to give effect to their human rights and respect their human dignity as required by the objectives and principles of that Act, and made decisions that were incompatible with their human rights under the *Charter of Human Rights and Responsibilities Act 2006* (Vic). As is usual in appeals of this nature, the hospitals and VCAT took no part in the hearing and the Secretary of the Department of Health and Human Services assisted the court as the official contradictor.

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1 As defined in s 3(1) of the *Mental Health Act 2014* (Vic), ECT means 'the application of electric current to specific areas of a person's head to produce a generalised seizure'.

PROCEEDINGS IN VCAT

PBU v Mental Health Review Board

4 PBU had been hospitalised in a psychiatric unit of a hospital since December 2016. He had been first diagnosed with schizophrenia in 2011 and had been admitted to hospital on a number of occasions. He was the subject of an inpatient treatment order under s 45(3) of the *Mental Health Act*. He had little family support or social engagement. He displayed limited insight into his psychiatric condition. His medical history is complex and was summarised by VCAT by reference to the evidence given at the hearing and the hospital file, which was in evidence in the proceeding in this court.

5 In February 2017, VCAT made an order for a course of six ECTs on the application of PBU's authorised psychiatrist. Five of these were administered in early to late February and PBU's condition improved dramatically in consequence. He was demonstrating reasonable insight into his present psychotic episode but not into his longer-term schizophrenia condition. After the fifth ECT he was initially agreeable to the treatment continuing.

6 In late February 2017, PBU was reviewed by an authorised psychiatrist who determined that he had capacity to decide whether he wanted ECT to continue. When PBU stated that he did not, the treatment was stopped.

7 A further application for ECT was made to the MHT in March 2017. The hospital contended that PBU's condition had declined. The MHT decided that he did not then require ECT and that the treating team should offer more information to him and explore other treatment options.

8 On 19 April 2017, on the application of hospital medical staff, the MHT ordered that PBU have a course of up to 12 ECTs in the period 19 April to 23 May 2017. This order was stayed by VCAT when PBU applied for it to be reviewed.

9 The hearing of PBU's application in VCAT was held at Northern Hospital on 23 May 2017. Extensive medical evidence was given, including by PBU's treating

psychiatrist and the clinical director of the Mental Health Service for the Northern Area. This evidence, which was carefully reviewed by VCAT, was that ECT was the only currently available appropriate treatment for PBU, that his mental state was slowly deteriorating, that he had refused to take Clozapine, and that only ECT would allow him to become well enough to engage in his treatment and improve sufficiently to leave hospital.

10 PBU wrote a letter to VCAT and attended the end of the hearing. His evidence was that he did not agree that he had schizophrenia. But he accepted that he had mental health problems. He said he was suffering from depression, anxiety and post-traumatic stress disorder. He was willing to receive psychiatric and psychological treatment for those conditions. PBU did not wish to have ECT or other anti-psychotic medication or treatment, which he did not believe were appropriate or necessary for his condition. He wished to be discharged from hospital to a prevention and recovery facility and then return home, which the medical staff did not support. VCAT's reasons for decision discuss the evidence of his somewhat erratic behaviour at the time. It found that he spoke very clearly and capably about his views and experiences.

11 In determining the application for review, VCAT accepted that it was acting as a public authority under s 38(1) of the Charter and also had to interpret the provisions of the *Mental Health Act* as far as possible consistently with the Charter (s 32(1)). It considered that 'liberty is a foundational human right' and that cases of this kind engaged a number of human rights, including the right to freedom from medical treatment without full, free and informed consent (s 10(c) of the Charter), the right to move freely within Victoria (s 12) and the right not to have one's privacy unlawfully or arbitrarily interfered with (s 13(a)). Citing *Kracke v Mental Health Review Board*,[2] VCAT stated the limitations on these rights imposed by the *Mental Health Act*, including in respect of ECT, were reasonable and justifiable under s 7(2) of the Charter.

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2 (2009) 29 VAR 1, 158 [784] (Bell J) ('*Kracke*').

12 Under s 96(1)(a)(i) of the *Mental Health Act*, VCAT had to decide whether it was satisfied that PBU did not have capacity to give informed consent under s 68(1) and, if so satisfied, whether there was no less restrictive way for him to be treated. As will be discussed in more detail below, s 68(1) specifies four domains of cognitive functioning: understanding information relevant to the decision (para (a)), and the ability to remember (para (b)) and use or weigh that information (para (c)), and communicate one's decision (para (d)).

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.

14 VCAT went on to determine under s 96(1)(a)(ii) that there were no less restrictive treatment options available. In doing so, it rejected a contention made on behalf of PBU that the purposes of the treatment criteria specified in s 5 of the *Mental Health Act* were relevant to this issue.

NJE v Mental Health Review Board

15 NJE also suffered from treatment resistant schizophrenia. Since 2004, she had received voluntary and involuntary treatment in the community and in hospital. In 2016, she had several extended involuntary stays in hospital. In January 2017, she was placed on a community treatment order by the MHT, but it was revoked and she was made the subject of an involuntary treatment order. In March, NJE was transferred to the secure extended care inpatient unit at Bendigo Hospital.

16 Three applications for ECT were made by the Bendigo medical staff. The first was in early March 2017, which was refused by the MHT by reason of legal uncertainties concerning NJE's detention in hospital. The second was made in late March 2017 and refused because the MHT was not satisfied that NJE lacked capacity to give informed consent (notwithstanding that she displayed no insight into her condition) or that no less restrictive treatment options were available. The third was made in April 2017 and granted by the MHT, which ordered that NJE undergo a course of 12 ECTs. She only had minutes to prepare for this hearing, contacted Victoria Legal Aid the day after, applied to VCAT for a review and obtained a stay of the MHT's order.

17 Changes to NJE's oral medication resulted in a slight improvement in her medical condition in April 2017. At the time of the hearing before VCAT in June 2017, she was compliant with her oral and depot medication regimen. The medical evidence was that she still needed ECT and lacked the capacity to give (or refuse) informed consent, especially because of her grandiose delusions and behaviour.

18 NJE was legally represented at the hearing, which she attended and in which she participated, including by tendering a letter for VCAT's consideration.

19 There had been limited engagement about the proposed ECT treatment between the treating team and NJE. As explained in the evidence of Dr A, who was NJE's treating psychiatrist, this was because oral discussions distressed NJE and aggravated the antagonism that she felt towards the treating team. It had been

determined that providing written information was preferable, which was done in mid-April.

20 Dr A deposed that NJE could read, understand and remember the information given to her about ECT (paras 68(1)(a) and (b) of the *Mental Health Act*), but Dr A was of the view that NJE lacked capacity to use and weigh information (para 68(1)(c)). Dr A deposed that:

> [T]his was because NJE 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.

21 Dr A gave evidence of his observations of NJE:

> 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.
>
> 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.

22 NJE's legal representative was critical of the hospital treating team. She contended that it should have made greater attempts to engage with NJE in relation to ECT. She submitted that, as late as early March 2017, the MHT had found that NJE had the capacity to make an informed decision notwithstanding her lack of insight. VCAT did not accept this submission.

23 VCAT found that NJE met the criteria in paras 68(1)(a), (b) and (d):

> I was satisfied that NJE had an understanding about ECT treatment as described in section 68 of the MHA in that she could understand the information, could remember it and could communicate her wishes and her anxieties.

It is reasonable to infer that VCAT accepted that, in doing so, NJE understood that ECT was a procedure that would result in her having seizures and that she was concerned that it may cause her to have memory problems, as her legal representative submitted. It is reasonable to infer that, in doing so, VCAT also

accepted the submission made for NJE that her preferred alternative to ECT was remaining in hospital for an extended period and the trialling of alternative medications, possibly Clozapine.

24 However, VCAT found under s 68(1)(c) that NJE could not use and weigh 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)…

25 VCAT did not consider that NJE's capacity to give informed consent would be enhanced by the provision of more or differently formatted information. It accepted the evidence of Dr A that additional attempts to discuss, or provide more written information about, ECT only aggravated NJE. VCAT found that '[i]t was not that NJE did not understand but rather that she could not be persuaded that the information was relevant to her'.

26 Moving to whether there was no less restrictive way for NJE to be treated, it was submitted for NJE that the purposes of the treatment criterion in s 5(b) informed consideration of this issue under s 96(1)(a)(ii). VCAT did not proceed in this way but applied the latter provision according to its terms, as had been done in PBU's case. It is clear from the evidence that NJE did not need immediate treatment to prevent a serious deterioration of her health or harm to herself or others.

27 NJE's strongly and consistently expressed view and preference, of which VCAT made note, was to remain in hospital and continue to receive depot and oral medication. VCAT said that it gave weight to the medical evidence that 'ECT was the only treatment that has a chance to address both positive and negative symptoms' of NJE's schizophrenia.

28 VCAT acknowledged NJE's fears that ECT 'would interfere with her psychic powers which she values'. But it treated her beliefs about these powers as 'positive symptoms (hallucinations and delusions that she is able to treat and cure others) …'. In the analysis of whether no less restrictive treatment option was available, NJE's beliefs in this connection constituted a consideration in favour of ECT:

> I read with concern the reports which described NJE's fixed delusions. NJE spends several nights per week without sleep believing that she is working and that she has psychic healing powers.[3]

29 In rejecting NJE's preference for maintaining the present treatment as a less restrictive option, VCAT held that s 93(2)(a) required that it 'consider NJE's views and preferences in respect of any "*beneficial*" alternative treatments' (emphasis in original). Taking into account the definition of 'treatment' in s 6(a) and following the decision of VCAT in PBU's case, it held that the treatment had to be one that remedied or alleviated the symptoms and reduced the effects of the person's mental illness.

30 VCAT accepted the medical evidence that multiple anti-psychotics had been unsuccessful in treating NJE. As the least restrictive option, it accepted the treating team's proposal of ECT followed by a trial of Clozapine (with appropriate blood testing) followed by engagement with NJE about the 'lifestyle choices' that she made in the community, which would only be possible after her health likely stabilised after ECT.

31 VCAT did not accept the submission made for NJE that the least restrictive treatment option was to act on her improved mental state and allow her current less restrictive medication to continue. It held that NJE was still experiencing negative and positive symptoms by reason of her mental illness and that ECT offered the best hope of the optimum therapeutic outcome, and promotion of recovery[4] and full participation in community life.

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3 The evidence was that she was frequently active and awake during the night: see above.

4 On the significance of the concept of recovery in the statutory scheme, see below.

LEGAL ISSUES FOR DETERMINATION

Secretary's applications for intervention

32 The Secretary applies:

- to be joined as an intervener in the two proceedings pursuant to r 9.06 of the *Supreme Court (General Civil Procedure) Rules 2015* (Vic);
- alternatively, to be joined as an *amicus curiae* (friend of the court) in the proceedings pursuant to the court's inherent jurisdiction.

33 PBU and NJE oppose the primary applications and do not oppose the alternative applications.

34 The Secretary was not a party to the proceedings before the MHT and VCAT. In the proceedings before the MHT, the parties were PBU and NJE on the one side and the hospitals on the other side. In the proceedings before VCAT, the parties were PBU and NJE on the one side and the MHT and the hospitals on the other side.

35 The parties in the appeal proceedings in this court reflect the position in the proceedings before VCAT. PBU and NJE stand on the one side and the MHT and the hospitals stand on the other side.

36 As is usual and appropriate, the MHT has filed submitting appearances in accordance with *R v Australian Broadcasting Tribunal; Ex parte Hardiman*.[5]

37 For whatever reason, hospital parties in proceedings like the present sometimes take no part, leaving the patient to run the case. This has occurred in the present proceedings. However, in order to ensure that legal issues are fully addressed, it is common, with the leave of the court, for the Secretary to perform the role of proper contradictor in proceedings that take this course.

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5 (1980) 144 CLR 13, 35–6 (Gibbs, Stephen, Mason, Aickin and Wilson JJ).

38 Understandably, the Secretary would prefer to be joined as an intervener in these proceedings under r 9.06, because this would mean that the Secretary would have all the rights of a party, including appeal rights.[6] But the authorities make very clear that joinder on this basis can only be ordered where the applicant's legal interests would be directly affected by the outcome of the proceeding.[7] On no view is this so in relation to the Secretary in the present cases and therefore the applications for joinder of the Secretary as an intervener under r 9.06 must be refused.

39 It is different with applications to be heard as *amicus curiae* (friend of the court). The grant of leave for a person to appear in this way 'is not dependent upon the same conditions in relation to legal interests as the grant of leave to intervene'.[8] In *Priest v West*, Maxwell P, Harper JA and Kyrou AJA set out the following principles by way of guidance in relation to the granting of such leave:[9]

> The court has a broad discretion to allow a person to appear as a friend of the court.[10] Where it is in the interests of justice to do so, the court can hear a friend of the court by allowing him or her to make oral submissions or to file written submissions, or to do both.[11] Only in an exceptional case will a friend of the court be permitted to adduce evidence or to raise a new issue or special defence.[12]
>
> The court's power to grant such leave is not limited to any particular individuals or organisations or to any particular types of cases or circumstances.[13] The individuals or organisations may include the holder of a non-governmental office,[14] a Minister of the Crown,[15] a public interest body,[16] or a professional organisation.[17]

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6 *Priest v West* (2011) 35 VR 225, 232–3 [30] (Maxwell P, Harper JA and Kyrou AJA) ('*Priest*').

7 *Roadshow Films Pty Ltd v iiNet Ltd* (2011) 248 CLR 37, 38–9 [2] (French CJ, Gummow, Hayne, Crennan and Kiefel JJ) ('*Roadshow Films*'), citing *Levy v Victoria* (1997) 189 CLR 579, 600–5 (Brennan CJ) ('*Levy*'); *Priest* (2011) 35 VR 225, 232 [29] (Maxwell P, Harper JA and Kyrou AJA).

8 *Roadshow Films* (2011) 248 CLR 37, 39 [3] (French CJ, Gummow, Hayne, Crennan and Kiefel JJ).

9 (2011) 35 VR 225, 233–4 [31]–[35].

10 *Levy* (1997) 189 CLR 579, 604; *Karam v Palmone Shoes Pty Ltd* [2010] VSCA 252 (29 September 2010) [3].

11 *United States Tobacco Co v Minister for Consumer Affairs* (1988) 20 FCR 520, 534 ('*United States Tobacco*'); *Levy* (1997) 189 CLR 579, 604–5; *Breen v Williams* (1994) 35 NSWLR 522, 532–3 ('*Breen*'); *Re BWV; Ex parte Gardner* (2003) 7 VR 487, 490–1 [12]–[17] ('*BWV*').

12 *Re Medical Assessment Panel; Ex parte Symons* (2003) 27 WAR 242, 250 [20].

13 *United States Tobacco* (1988) 20 FCR 520, 535.

14 See, eg, *BWV* (2003) 7 VR 487, 490 [16] (Catholic Archbishop of Melbourne); *R v Murphy* (1986) 5 NSWLR 18, 24–5 (President of the Senate).

15 For example, *Domaszewicz v State Coroner* (2004) 11 VR 237, 242 [20] (Attorney-General); *Y v Austin Health* (2005) 13 VR 363, 366 [11]–[12] (Attorney-General); *Zukanovic v Magistrates' Court of Victoria* [2011] VSC 141 (20 April 2011) [26] (Attorney-General).

16 *BWV* (2003) 7 VR 487, 490 [15]–[16] (Right to Life Australia Inc and Catholic Health Australia Inc);

> Ordinarily, the court will not grant such leave unless it is of the opinion that the person will be able to assist the court in a way that the court would not otherwise have been assisted.[18] Even when that criterion is satisfied, the court will need to be persuaded that the grant of leave will not result in additional costs to the parties, or delay in the proceeding, which would be disproportionate to the assistance expected to be derived.[19]
>
> Matters to be considered in determining whether to grant leave to a person to appear as a friend of the court include:
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> (a) whether the intervention is apt to assist the court in deciding the instant case;
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> (b) whether it is in the parties' interest to allow the intervention;
>
> (c) whether the intervention will occupy time unnecessarily;
>
> (d) whether the intervention will add inappropriately to the costs of the proceeding.[20]
>
> The assistance of a friend of the court may be indispensable if there would otherwise be no proper contradictor. That appears to have been the basis upon which the Victorian Attorney-General was granted leave to appear in *Re BWV; Ex parte Gardner*[21] and in *Domaszewicz v State Coroner*.[22]

40 Applying these principles in the present case, I grant leave to the Secretary in both proceedings to appear as *amicus curiae* (friend of the court). The legal issues raised in the appeals are complex and have considerable public importance, especially in relation to the interaction between the *Mental Health Act* and the Charter in the context of compulsory ECT and of assessing the capacity of persons with mental illness to give informed consent. Without participation by the Secretary, there would be no proper contradictor in either proceeding. By reason of the Secretary being responsible for the administration of the *Mental Health Act*, the Secretary has expertise in relation to the interpretation and application of that Act, and also its interaction with the Charter. The court has been substantially assisted by the

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Breen (1994) 35 NSWLR 522, 532–3 (Public Interest Advocacy Centre); *Levy* (1997) 189 CLR 579, 593 (Australian Press Council); *Commonwealth v Tasmania* (1983) 158 CLR 1, 50–1 (Tasmanian Wilderness Society); *National Australia Bank v Hokit Pty Ltd* (1996) 39 NSWLR 377, 380 (Consumers Federation of Australia) ('*Hokit*').

17 *Levy* (1997) 189 CLR 579, 593 (Media, Entertainment and Arts Alliance).

18 Ibid 604–5. See, eg, *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355, 359.

19 *Levy* (1997) 189 CLR 579, 604–5.

20 *Hokit* (1996) 39 NSWLR 377, 381.

21 (2003) 7 VR 487, 490 [13].

22 (2004) 11 VR 237, 242 [20].

Secretary's submissions. In the circumstances, the submissions have been indispensable.

Questions of law and grounds of appeal

41 Section 148(1)(b) of the *Victorian Civil and Administrative Tribunal Act* permits a party to appeal against an order of VCAT only on 'a question of law'. The jurisdiction of the court in such appeals is confined to the determination of a question of law.[23] Leave to appeal is required and here will be granted in both cases. Having regard to the issues raised in the appeals, this is plainly called for by the governing principles.[24]

42 Drawing upon questions of law specified in the proposed notices of appeal, PBU and NJE identified four common grounds of appeal. These were grounds 1, 2, 4 and 5 in the case of PBU (which corresponded to grounds 1, 2, 4 and 3 respectively in the case of NJE) as follows:

> 1. The Tribunal erred by failing to apply the test for 'capacity to give informed consent' in s 68(1) of the MH Act, but instead applying the different test whether PBU accepted the diagnosis for which ECT was proposed.
>
> 2. The Tribunal must have misunderstood ss 68(1) and 96(1)(a)(i) of the MH Act: on the facts as found, had it correctly understood s 68(1), the Tribunal could not have concluded that PBU '[did] not have the capacity to give informed consent' to ECT, within the meaning of s 96(1)(a)(i).
>
> …
>
> 4. Alternatively to Grounds 1 and 2, the Tribunal's reasons failed to comply with s 117 of the VCAT Act, or were otherwise inadequate, because they did not disclose how the Tribunal applied the test in s 68(1) of the MH Act to the facts as found such as to conclude that PBU '[did] not have the capacity to give informed consent' to ECT, within the meaning of s 96(1)(a)(i).

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23 *Roy Morgan Research Centre Pty Ltd v Commissioner of State Revenue* (2001) 207 CLR 72, 79 [15] (Gaudron, Gummow, Hayne and Callinan JJ).

24 See *Department of Premier and Cabinet v Hulls* [1999] 3 VR 331, 335-7 (Phillips JA, Tadgell and Batt JJA agreeing); *Myers v Medical Practitioners' Board of Victoria* (2007) 18 VR 48, 55-7 [28]-[31] (Warren CJ, Chernov JA and Bell AJA agreeing)

5. The Tribunal erred by concluding that continuing with the same treatment was not a 'less restrictive way for the patient to be treated' because it would 'amount to a failure to provide the treatment' required by s 72 of the MH Act, being treatment for the purposes identified in ss 6(1)(a) and 11(1)(b) of the MH Act, unconstrained by s 5(b).

43 In PBU, the following further ground of appeal was identified:

3. (a) Before making the Order, the Tribunal was required to consider what matter in s 68(1)(a), (b), (c) or (d) satisfied it that the criterion in s 96(1)(a)(i) was met. It failed to do so.

(b) The rights conferred by ss 8(2) and (3), 10(b) and (c), 13, 14(1), 15(1), 21(1) and 22(1) of the Charter were relevant in the decision made by the Tribunal. The Tribunal failed to give proper consideration to those rights, within the meaning of s 38(1) of the Charter, because it failed to consider, expressly or at all, each of the matters in ss 68 and 69 in determining that PBU '[did] not have the capacity to give informed consent' to ECT, within the meaning of s 96(1)(a)(i).

44 In NJE, the following further grounds of appeal were identified:

5. The Tribunal misconstrued and misapplied s 68(1)(c) of the MH Act by asking whether the Plaintiff could 'use *and* weigh' the information, when the correct test was whether the Plaintiff was not able to 'use *or* weigh' the information, and consequently the Tribunal failed to consider whether the Plaintiff was not able to do one, or the other, but not both.

6 Alternatively to ground 1, the Tribunal erred by directing itself that s 68(1)(c) 'requires a person to carefully consider the advantages and disadvantages of a situation or proposal before making a decision'.[25]

Determination of common ground 4 and ground 5 (NJE)

Common ground 4

45 Under common ground 4, PBU and NJE contend that VCAT erred in law by failing to comply with its obligation in s 117(1) of the *Victorian Civil and Administrative Tribunal Act* to give adequate reasons for decision. As a decision under s 96(1)(a)(i) of the *Mental Health Act* involves the application of the criteria specified in s 68(1)(a)–

[25] NJE was granted leave to add this ground.

(d), VCAT was required by s 117(5) of the *Victorian Civil and Administrative Tribunal Act* to include in its reasons its findings of fact in relation to each of these criteria, which it did not do. Reciting the evidence was not itself sufficient. The submissions acknowledged that VCAT's reasons for decision in the case of NJE were more specific in detail than its reasons in the case of PBU.

46 The Secretary submitted that VCAT was required to conduct the proceeding with as little formality and technicality, and as much speed, as possible (s 98(1)(d) of the *Victorian Civil and Administrative Tribunal Act*). Its primary obligation under s 117(1) and (5) was to give reasons disclosing the path of its reasoning, which it fulfilled. The evidence was not simply recited but was evaluated. The criteria in s 68(1)(a)–(d) of the *Mental Health Act* were identified and applied. It was not necessary for the consideration and analysis to be related to each and all of the specified criteria. The relevant factors were discussed and necessary findings were made.

47 The general principles were not in dispute and generally described in *Remanet Pty Ltd v Georgescu*.[26] Applying those principles, I do not accept the submissions made for PBU and NJE and accept the submissions made for the Secretary under this ground. The reasons for decision in both cases disclose the path of VCAT's reasoning and why it found that PBU and NJE lacked the capacity to give informed consent. Reading the reasons for decision fairly, in context and as a whole,[27] this conclusion can be readily comprehended and related to the findings made, although it was vitiated by errors of law that I will later examine.

48 Common ground 4 will therefore be rejected.

Ground 5 (NJE)

49 The submissions made for NJE under ground 5 were based on VCAT's reference to the criterion in s 68(1)(c) as being that the person had to be able to '*use and weigh*'

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26 [2017] VSC 367 (23 June 2017) [8] (Ierodiaconou AsJ).

27 *Shock Records Pty Ltd v Jones* [2006] VSCA 180 (7 September 2006) [85] (Bell AJA, Callaway and Ashley JJA agreeing); *Hesse Blind Roller Company Pty Ltd v Hamitoski* [2006] VSCA 121 (8 June 2006) [3] (Ashley JA), [19]–[22] (Redlich JA).

(italics in original in reasons for decision) the relevant information. The expressed criterion is actually that she be able to 'use *or* weigh' (italics added) the information.

50 It was submitted for NJE that it was sufficient under s 68(1)(c) for the person to be able to use *or* weigh the information. The two processes of cognition are different. 'Using' is broader than 'weighing', and either is sufficient. VCAT erred in law by adopting a more stringent test that addressed whether NJE had the ability to undertake both forms of cognition.

51 The Secretary submitted that VCAT correctly stated the terms of s 68(1)(c) earlier in its reasons. Read fairly as a whole, the reasons reveal that it correctly applied the test in that provision, despite substituting the word 'and' for the word 'or' in some places. These submissions should be accepted.

52 The words in s 68(1)(c) of the *Mental Health Act* are 'use *or* weigh' not 'use *and* weigh' (emphasis added), as in the parent provision in s 3(1)(c) of the *Mental Capacity Act 2005* (UK). The extrinsic materials do not assist in identifying the intended meaning of these words, which must be interpreted by reference to the actual language used, having regard to their purpose and context.[28]

53 I do not think these words express a single idea such that it does not matter whether one says 'use *or* weigh' or 'use *and* weigh'. Meaning must be given to each of the words. The verb 'use' relevantly means 'to employ for some purpose; to put into service; turn to account' and 'to avail oneself of; apply to one's own purposes'.[29] The verb 'weigh' relevantly means 'balance in the mind'.[30] I reject a meaning like '*carefully* balance in the mind' because the context is a provision that specifies a capacity test in which careful weighing is not required (see below).

54 The real question is whether the particle 'or' is used in the disjunctive or the conjunctive sense. I think the answer is that it is used in either or both senses

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28 *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue (Northern Territory)* (2009) 239 CLR 27, [4] (French CJ), [47] (Hayne, Heydon, Crennan and Kiefel JJ).

29 *Macquarie Dictionary* (Macquarie Dictionary Publishers, 7th ed, 2017) vol 2, 1653.

30 Ibid 1702.

depending on the circumstances. Certain information relevant to the decision is capable of being used; other information is capable of being weighed; and other information is capable of being both used and weighed. The expression 'use or weigh' requires the person to be capable of using or weighing information relevant to the decision depending upon the circumstances, particularly the nature, purpose and effect of the treatment decision and the nature and content of the information. Depending upon those circumstances, it may be necessary for the person to be capable of doing one or the other or both.

55 Because s 68(1)(c) has an application that depends upon the circumstances, it is perfectly natural to refer to the specified capability in terms of 'using or weighing' and 'using and weighing', as VCAT did. It will be seen below that some English judges have done the same thing in relation to the parent legislation. The important thing is that, having regard to the nature, purpose and effect of the treatment decision and the nature and content of the relevant information, VCAT properly determines whether the person is able to use or weigh the information.

56 In the case of NJE, VCAT approached the application of the test in s 68(1)(c) upon the basis that NJE had to be able to both use *and* weigh the information. In the circumstances, NJE had to be able to do so, indeed the relevant information could not be used without being weighed (but only to the low threshold of capacity that is stipulated (see below)). In applying the capacity test in s 68(1)(c), VCAT did not err in this respect, although it did in others.

57 Ground 5 (NJE) will therefore be rejected.

Determination of remaining grounds

58 Having regard to the way in which the appeals were run, the many substantive and subsidiary issues of law raised by the remaining grounds of appeal may fairly and adequately be stated as follows:

(1) Whether VCAT erred in law in interpreting and applying the 'capacity to give informed consent' test referred to in s 96(1)(a)(i) of the *Mental Health Act*.

(2) Whether VCAT erred in law in interpreting and applying the 'no less restrictive way for the patient to be treated' test specified in s 96(1)(a)(ii).

59 The legal issues raised under para (1) relate to common grounds 1 and 2, ground 3(a) (PBU) and ground 6 (NJE). The legal issues in para (2) relate to common ground 5. Determination of those legal issues will determine those grounds. It will not be necessary to determine any other grounds.

Issues arising under the Charter

60 In the appeals of both PBU and NJE, notices were served on the Attorney-General and the Victorian Equal Opportunity and Human Rights Commission under s 35(1)(a) of the Charter. These specified questions of law arising with respect to the application of the Charter to the operation of the *Mental Health Act* and the interpretation of the provisions of that Act in accordance with the Charter.

61 The notice served in the case of PBU specified the following questions arising under the Charter:

> 3. A question arises with respect to the interpretation of ss 68(1) and 96(1)(a)(i) of the *Mental Health Act 2014* (Vic) (the *Mental Health Act*) in accordance with s 32 of the Charter, read together with ss 8(2) and (3), 10(b) and (c), 13, 14(1), 15(1), 21(1) and/or 22(1) of the Charter. That question arises from the questions of law and grounds of appeal numbered 1, 2 and 3(a) in the Proposed Notice of Appeal.
>
> 4. A question arises with respect to the interpretation of s 96(1)(a)(ii) of the *Mental Health Act* in accordance with s 32 of the Charter, read together with ss 8(2) and (3), 10(b) and (c), 13, 14(1), 15(1), 21(1) and/or 22(1) of the Charter. That question arises from the question of law and ground of appeal numbered 5 in the Proposed Notice of Appeal.
>
> 5. A question of law arises that relates to the application of s 38(1) of the Charter to VCAT. That question arises from the question of law and ground of appeal numbered 3(b) in the Proposed Notice of Appeal.

The notice served in the case of NJE specified the same questions as specified in paras 3 and 4 of this notice, but in reference to grounds 1, 2 and 3 respectively of her notice of appeal. These issues arising under the Charter, as developed in oral submissions, will be addressed throughout this judgment.

62 I will begin with an overview of the *Mental Health Act*.

OVERVIEW OF *MENTAL HEALTH ACT*

Treatment of persons with mental illness

63 The central purpose of the *Mental Health Act* is to establish 'a legislative scheme for the assessment of persons who appear to have mental illness and for the treatment of persons with mental illness' (s 1(a)). As defined in s 4(1), 'mental illness' is a 'medical condition that is characterised by significant disturbance of thought, mood, perception or memory'. To ensure that persons are protected from discrimination in the application of the Act, a person is not considered to have a mental illness by reason only because they exhibit the behaviours or possess the attributes specified in s 4(2). Similar protections apply in relation to assessing capacity (s 68(2)(c), set out below).[31]

64 When the legislative conditions are satisfied, the person may be subjected to compulsory treatment[32] under a temporary treatment order (s 45) or a treatment order (s 52). The gateway to the application of these powers is kept by the 'treatment criteria' specified in s 5. These are that:

> (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

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31 The Charter affords additional protection against discriminatory application of the provisions: see below.

32 Under s 3(1), 'treatment' has the meaning given in s 6.

(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.

Neither a temporary treatment order (s 46(1)(b)) nor a treatment order (s 55(1)(a) and (b)) can be made with respect to a person to whom the treatment criteria do not apply.

65 The treatment criteria require that the person actually has a mental illness by reason of which immediate treatment of a particular kind is required, will be given and cannot reasonably be avoided. The treatment must be needed, indeed immediately needed. It must be needed for either of the specified purposes, which are to prevent not just any but a serious deterioration of the person's health and not just any but serious harm to the person or another person. A utility criterion requires that the treatment *will* be provided to the person under the order. No less restrictive means must be reasonably available to enable the person to receive the immediate treatment. As a safeguard, the treatment criteria are of continuing significance: where a temporary treatment order or a treatment order is made and an authorised psychiatrist determines that the criteria no longer apply to the person, the authorised psychiatrist must immediately revoke the order (s 61).

66 As regards the exercise of legal capacity, the main human rights of people with mental illness are the right to self-determination, to be free of non-consensual treatment and to personal inviolability (see below). Where the provisions of the *Mental Health Act* authorise compulsory medical treatment or other interference with those rights, it is intended that this be justified according to contemporary human rights standards, including the least infringement principle. The objectives in s 10[33] express this intention, as do the mental health principles in s 11(1).[34] All mental health service providers[35] and all persons performing any duty or function or

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33 See especially s 10(c).

34 See especially s 11(1)(e).

35 A mental health service provider is defined in s 3(1) to mean:

(a) a designated mental health service; or

exercising any powers under or in accordance with the Act are required to have regard to these principles (s 11(2) and (3)).

Objectives and principles

67 Reflecting the central purpose of the *Mental Health Act* (s 1(a)), the objectives in s 10 and the principles in s 11(1) seek to ensure that persons with mental illness have access to the treatment they need for their mental illness. As specified in s 11(f):

> (f) persons receiving mental health services should have their medical and other health needs, including any alcohol or other drug problems, recognised and responded to; …

Consistently with the right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, the objectives and principles emphasise enabling and supporting decision-making, and participation in decision-making, by the person (ss 10(d) and (g), 11(1)(c)), including the exercise of the dignity of risk (s 11(1)(d)). There is emphasis on respecting the views and preferences of the person in relation to decisions about their assessment, treatment and recovery (s 11(1)(c)). Together with the operative provisions of the *Mental Health Act*, the objectives and principles are intended to alter the balance of power between medical authority and persons having mental illness in the direction of respecting their inherent dignity and human rights.

Compulsory treatment

Assessment orders

68 Compulsory treatment of persons having mental illness depends upon them first being assessed for that treatment pursuant to an assessment order. The criteria for making an assessment order are directed at whether a person *appears to have* a mental illness and therefore *appears to need* immediate preventative treatment, whether the person can be assessed if an order is made and there is no less restrictive assessment

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(b) a publicly funded mental health community support service.

A designated mental health service is defined in that section to mean the specified hospitals and the Victorian Institute of Forensic Medicine.

option reasonably available (s 29). Certain procedures must be followed (see generally div 1 of pt 4) which do not here require examination.

69 If an assessment order is made in relation to a person, the treatment may be compulsorily given, and the person may also be taken to and detained in a hospital, pursuant to a temporary treatment order or a treatment order, where the conditions are satisfied (s 28). Temporary treatment orders are made by authorised psychiatrists (s 45(1)). Treatment orders are made by the MHT on the application of an authorised psychiatrist (ss 54(1) and 55(1)).

Temporary treatment orders

70 There are two kinds of temporary treatment orders: a community temporary treatment order, which authorises treatment of the person in the community; and an inpatient temporary treatment order, which authorises taking and detaining the person to and in a hospital for treatment (s 45(2) and (3)). Consistently with the principle of least restriction, an inpatient temporary treatment order can only be made if the authorised psychiatrist is satisfied that the treatment cannot occur within the community (s 48(3)). Temporary treatment orders have a normal duration of 28 days (s 51(1)). To protect the integrity of the temporary treatment process, the legislation separates it from the assessment process: a temporary treatment order can only be made by an authorised psychiatrist who did not make the relevant assessment order (s 47).

71 It is at the temporary treatment stage that a person having mental illness might first be compelled to undergo compulsory treatment and possible detention. Therefore, at this point, the legislation introduces certain foundational criteria, which are later drawn upon and developed, to govern decision-making in relation to these questions.

72 Under s 46(1), a temporary treatment order may be made if the authorised psychiatrist:

(aa) before examining the person, to the extent that is reasonable in the circumstances—

(i) has informed the person that the person will be examined by the authorised psychiatrist; and

(ii) has explained the purpose of this examination to the person; and

(a) has examined the person; and

(b) is satisfied that the treatment criteria apply to the person.

As specified in s 5 (see above), the treatment criteria are that the person *actually has* mental illness, that the person *actually needs* immediate treatment because of this illness and that the treatment will be provided if the order is made, and no less restrictive treatment option is available.

73 Under s 46(2)(a), when determining whether the treatment criteria apply to the person, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard (among other things) to:

(i) the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve.

Consistently with respect for the right to self-determination, to be free of non-consensual treatment and to personal inviolability of persons having mental illness, the legislation treats the person's views and preferences as mandatory relevant considerations in relation to whether a temporary treatment order should be made, despite the mental illness.[36] A view or preference is not excluded from consideration because the person has that illness, whether or not the view or preference is associated with it.

[36] The same considerations apply when determining whether to make a community temporary treatment order or an inpatient temporary treatment order (s 48(2)).

Treatment orders

74 As with the temporary treatment order, there are two kinds of treatment orders: a community treatment order, which authorises treatment of the person in the community; and an inpatient treatment order, which authorises taking and detaining him or her in a hospital (s 52(1)–(3)). The MHT can only make an inpatient treatment order if satisfied that the treatment of the person cannot occur in the community (s 55(3)). Treatment orders remain on foot for the period specified in the order, which must normally not exceed 12 months for a community treatment order and six months for an inpatient treatment order in the case of an adult person (s 57(1) and (2)).[37]

75 The MHT may make treatment orders on the application of an authorised psychiatrist who must first examine the person and be satisfied that the treatment criteria apply to the person (s 54(1)(a) and (b)). It can only make a treatment order after conducting a hearing and must satisfy itself independently that the treatment criteria apply to the person (s 55(1)(a)). Otherwise, the order to which the person is currently subject must be revoked (s 55(1)(b)). In exercising these powers, the MHT must take into account the person's views and preferences (among other things) (s 55(2)(a)).

Ensuring treatment for mental illness

76 Part 5 of the Act makes provision for the treatment of persons having mental illness. Treatment of persons having mental illness is predicated upon the fundamental principle expressed in s 72 that a person who is subject to a temporary treatment order or a treatment order 'is to be given treatment for his or her mental illness in accordance with the Act',[38] which reflects the prominence of the legislative purpose of ensuring access by persons with mental illness to health treatment (see further below). By the definition of 'treatment' in s 6(a) and other provisions of the Act, the treatment must be medically beneficial to the person, which necessarily involves the

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37 The maximum period is 3 months for both in the case of persons under the age of 18 years: s 57(2)(b).

38 Section 72 refers to a 'patient', which is defined in s 3(1) to include persons subject to such orders.

exercise of medical and like professional expertise. Treatment of the mental illness so that the person may recover health and wellbeing as far as possible is the primary focus of the Act. The framework in pt 5 is directed at ensuring that this treatment is provided having regard to the dignity and human rights of the person. Therefore, emphasis is placed upon the need to obtain informed consent for treatment from persons having the capacity to give it, and providing treatment without that consent only in strictly limited circumstances after consideration of whether no less restrictive treatment is available and the person's views and preferences.

Seeking, and presuming the capacity to give, informed consent

77 It would be discriminatory and a grave violation of human rights to regard a person having mental illness as lacking capacity to give informed consent merely because the person has that illness and the legislation does not operate upon this basis. Section 70(2) provides that anyone seeking the informed consent of another to treatment or medical treatment must presume that the other person has the capacity to give informed consent. This is the position under the common law (see below) and applies to an authorised psychiatrist who considers that a person needs treatment for mental illness. Before treatment or medical treatment is administered, 'the informed consent of the person must be sought' (s 70(1)), unless the person does not have the capacity to give that consent at the relevant time (s 70(3)).

78 If the treatment does not involve ECT or neurosurgery,[39] the authorised psychiatrist may make a compulsory treatment decision if satisfied that no less restrictive treatment option is available (s 71(3)), even if the person has capacity to give informed consent and refuses to give it. In so determining, the authorised psychiatrist must have regard (among other things) to:

> (a) the patient's views and preferences about treatment of his or her mental illness and any beneficial alternative treatments that are reasonably available and the reasons for those views and preferences,

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39 'Neurosurgery for mental illness' is defined in s 3(1) to mean various kinds of specified surgery and like internal treatment of the brain. Neurosurgery not for mental illness is not contemplated by the legislation.

> including any recovery outcomes that the patient would like to achieve.

79 If the treatment does involve ECT, the authorised psychiatrist cannot cause it to be administered but must apply to the MHT for that authorisation under s 93(1). The MHT (and VCAT on review) must grant the application if satisfied that the patient does not have the capacity to give informed consent (s 96(1)(a)(i)) and that there is no less restrictive way for the patient to be treated (s 96(1)(a)(ii)). The MHT cannot grant such an application if the person has capacity to give informed consent and refuses to give it (s 96(1)(b)).

80 It follows that, where a person who has capacity to give informed consent refuses to give it, the person may be subjected to compulsory treatment or medical treatment if the conditions are satisfied, unless it is ECT (or neurosurgery), in which case the person's decision to refuse to have the treatment must be absolutely respected. As informed consent for treatment and medical treatment must be sought unless the person does not have capacity to give it (s 70(3)), and ECT can only be compulsorily imposed upon a person who does not have the capacity to give informed consent (s 96(1)(a) and (b)), whether a person has this capacity is a critical consideration in relation to treatment that is ECT. That was the position of PBU and NJE before the MHT and VCAT in the present cases.

81 If the treatment involves neurosurgery for mental illness, the authorised psychiatrist can cause it to be administered (s 100(1)) but must first apply to the MHT for this authorisation (s 100(2)). The authorisation cannot be given unless the MHT is satisfied that that person has given informed consent in writing and the surgery will benefit the person (s 102(2)(a) and (b)).[40] Under s 69(1)(a), a person can only give informed consent if the person has the capacity to do so under s 68. Therefore, differently to ECT, neurosurgery cannot be compulsorily imposed upon a person who has refused to have it or lacks the capacity to give informed consent to it.

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40 Section 102(3) specifies considerations that must be taken into account.

82 Persons with mental disability have human rights that inform the interpretation and application of the relevant provisions of the *Mental Health Act*, consistently with its expressed purposes, objectives and principles (see above). To those rights I now turn.

HUMAN RIGHTS OF PERSONS WITH MENTAL DISABILITY

Universality and indivisibility of human rights

83 As human rights apply universally to all people equally, a person with mental disability has the same rights as other persons and, importantly for the present case, 'a person who lacks capacity has the same human rights as a person who does not lack capacity'.[41] Preambular para (c) of the *Convention on the Rights of Persons with Disabilities* ('CRPD') reaffirms both 'the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination.'[42] Drawing on the CRPD, Baroness Hale DPSC (Lord Neuberger, Lord Sumption and Lord Kerr JJSC agreeing) said in *Surrey County Council v P (SC(E))* that the universal character of human rights and the equal application of these rights to people with mental disabilities is 'founded on the inherent dignity of all human beings'.[43]

84 So it is with the Charter where, in the Preamble, the following principle (among others relevant) is stated:

> • Human rights belong to all people without discrimination, and the diversity of the people of Victoria enhances our community; …

Section 6(1) provides that '[a]ll persons have the human rights in Part 2', and 'person' is defined in s 3(1) to mean 'a human being'. Under the preambular

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41 *Cambridge University Hospitals NHS Foundation Trust v BF* [2016] EWCOP 26 (18 May 2016) [27] (MacDonald J), citing *Surrey County Council v P (SC(E))* [2014] AC 896, 919 [45] (Baroness Hale DPSC, Lord Neuberger PSC, Lord Sumption and Lord Kerr JJSC agreeing) ('*Surrey County Council*').

42 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) preambular para (c).

43 [2014] AC 896, 919 [45].

principles of the Charter, to which the operative provisions give effect, people with mental disability not only have human rights that are equal to all others but form part of the diversity that makes up and enhances the Victorian community.

85 It was not always so. There was once a time when people with mental disability were feared as lunatics, pitied as imbeciles and detained in rural asylums far away from public view and private conscience. Many were treated without respect or regard for the dignity of their humanity, for their right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, and for their need to access medical treatment. Too often their fate was one of discriminatory exclusion from vital aspects of personal, social and productive life, and continuing ill-health.

86 This description of the problem, which has been the subject of so much contemporary mental health reform, including the *Mental Health Act*, is apposite in the present case because it necessarily implies that, in human rights terms, neither civil and political rights nor economic, social and cultural rights can supply an adequate single solution. When it comes to deciding such questions as assessing capacity and providing compulsory treatment to persons with mental disability, a one-dimensional focus ignores the fact that human rights are not just universal but 'indivisible, interdependent and interrelated'. As a disability scholar has written of the CRPD, which is a treaty that specifies rights in both categories:

> Perhaps more than any other human rights treaty, the [CRPD] has demonstrated the falseness of the dichotomy between civil-political and social-economic rights. This chasm has to be closed at both ends. Just as some civil-political rights, such as the freedom of speech and expression, are meaningless without reasonable accommodation of the physical infrastructure; other social-economic rights, such as the right to health, become oppressive without informed consent and freedom of choice.[44]

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44 Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future' (2007) 34 *Syracuse Journal of International Law and Commerce* 429, 456-7; see also Penelope Weller, 'Health Law and Human Rights: Towards Equality and the Human Right to Health' in Ian Freckelton and Kerry Peterson (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 21–2.

87 The present cases raise for determination important legal issues about the interpretation and application of the capacity test and treatment assessment provisions of the *Mental Health Act* as informed by human rights specified in the Charter, especially the rights of self-determination, freedom from non-consensual medical treatment and personal inviolability, which are civil and political in character. But it would be artificial to confine the analysis to rights of that kind, and contrary to the purposes of the *Mental Health Act*.

88 Like everybody else, people with mental disability need reasonable health and access to medical treatment and health services as a pre-requisite for full and equal participation in life in all of its personal, social and productive dimensions. Our mental health legislation is directed at the fundamental purpose of ensuring that people with mental disability receive the health and other treatment they need. As this purpose[45] and its associated principles[46] also inform the interpretation and application[47] of the capacity and treatment assessment provisions of the *Mental Health Act*, these too need consideration (see below).

89 The obligations specified in the CRPD relate to both civil and political rights and economic, social and cultural rights, and give effect to the principle of universality and indivisibility of human rights reaffirmed in preambular para (c) (see above). The obligations have potential significance in relation to the interpretation and application of provisions of the *Mental Health Act*. As the Supreme Court of the United Kingdom[48] and the European Court of Human Rights[49] have recognised, the CRPD is part of the legal context in which the provisions of the *European Convention on Human Rights* are interpreted, particularly in relation to equality and discrimination issues (see below), as to which a 'European and worldwide consensus [exists] on the need to protect people with disabilities from discriminatory treatment

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45 *Mental Health Act* s 10(a).

46 Ibid s 11(1)(a), (b), (f).

47 Ibid s 11(2), (3).

48 *Surrey County Council* [2014] AC 896, 916–17 [36] (Baroness Hale DPSC, Lord Neuberger PSC, Lord Sumption and Lord Kerr JJSC agreeing).

49 *Glor v Switzerland* (European Court of Human Rights, Chamber, Application No 13444/04, 30 April 2009) [53] ('*Glor*'); *A-MV v Finland* (2018) 66 EHRR 22 [74] ('*A-MV*').

… towards full inclusion'.[50] In accordance with general principles of interpretation[51] and s 32(2) of the Charter, the provisions of the CRPD are relevant in the same way to understanding the meaning of human rights in the Charter, especially in relation to those issues. That might especially be so in relation to the emphasis in the CRPD on providing persons with disability access to the support they need to exercise their legal capacity and on respecting the rights, will and preferences of persons with disability when proportionate measures relating to the exercise of that capacity are necessary, subject to review and safeguards, as a last resort.[52] Various provisions of the *Mental Health Act* have been enacted with that emphasis in mind.

90 Certain issues of importance are raised by provisions of mental health legislation, such as the *Mental Health Act*, that enable substituted decisions to be made with respect to the compulsory treatment of persons with mental disability who have been found not to have capacity to give informed consent, as occurred with PBU and NJE. It is argued that such provisions are inherently discriminatory and contrary to the right to equality before the law and the right to have and exercise legal capacity. There is a great deal of contemporary scholarship on these issues,[53] much of it stimulated by publication of *General Comment No 1* on art 12 of the CRPD by the United Nations Committee on the Rights of Persons with Disabilities ('UNCRPD').[54] According to the Committee, full recognition of universal legal capacity (as specified in art 12(2)) requires 'State parties to … abolish denials of legal capacity that are

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50 European Court of Human Rights, Chamber, Application No 13444/04, 30 April 2009) [53], cited with approval in *Surrey County Council* [2014] AC 896, 916–17 [36] (Baroness Hale DPSC, Lord Neuberger PSC, Lord Sumption and Lord Kerr JJSC agreeing).

51 The authorities are collected and discussed in *Kaba v Director of Public Prosecutions* (2014) 44 VR 526, 566-73 [141]-[163] (Bell J) ('*Kaba*').

52 CRPD art 12(3)–(4).

53 See eg Rosemary Kayess and Phillip French, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *Human Rights Law Review* 1; Peter Barlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 *Modern Law Review* 752; Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014); Bernadette McSherry and Kay Wilson, 'The concept of capacity in Australian mental health law reform; going in the wrong direction?' (2015) 40 *International Journal of Law and Psychiatry* 60; Piers Gooding, *A New Era for Mental Health Law and Policy* (Cambridge University Press, 2017); and Anna Arstein-Kerslake, *Restoring Voice to People with Cognitive Disabilities* (Cambridge University Press, 2017).

54 UNCRPD, *General Comment No 1: Equal Recognition Before the Law (Art 12)*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014).

discriminatory on the basis of disability in purpose or effect'.[55] Taken literally, this would mean that State parties to the CRPD, such as Australia, would be obliged under international law to abolish all substituted decision-making regimes.

91 As set out in an interpretative declaration relating to the CRPD, Australia does not agree with the interpretation of art 12 adopted by UNCRPD. Australia's understanding is that

> that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards.[56]

Nor does the European Court of Human Rights[57] and the German Federal Constitutional Court[58] agree with this interpretation.

92 Neither PBU nor NJE, nor the Secretary, invited me to go into the particular issues raised by *General Comment No 1* of UNCRPD in the present case. Following the decision of *Kracke*[59] under the former legislation, the premise of the submissions made was that the *Mental Health Act* was not structurally incompatible with human rights because it authorised compulsory medical treatment (including ECT) for persons found not to have capacity to give informed consent to such treatment. Without challenging the compatibility of the substituted decision-making regime in that Act, it was submitted on behalf of PBU and NJE that the human rights in the Charter influenced — in the direction of self-determination, freedom from non-consensual treatment and personal inviolability — the interpretation and application

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55 Ibid [25].

56 *Convention on the Rights of Persons with Disabilities: Declarations and Reservations (Australia)*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

57 See *A-MV* (2018) 66 EHRR 22, 846 [90].

58 See *Bundesverfassunsgericht* (German Federal Constitutional Court) 1BVL 81/5, 26 July 2016 explained in *Bundesverfassunsgericht*, 'Limiting Coercive Medical Treatment to Persons under Custodianship Confined in Accommodations is Incompatible with the State's Duty of Protection (Press release, 59/2016, 29 August 2016) 2(d) <https://www.bundesverfassungsgericht.de/SharedDocs/Pressemitteilungen/EN/2016/bvg16-059.html>.

59 (2009) 29 VAR 1, 158 [784] (Bell J).

of its provisions relating to that treatment. The submissions on both sides went into those issues and this judgment will do so, but upon the same premise.

Right to health

93 There is a two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and personal health and wellbeing on the other. The relationship is highly pertinent for persons with mental disability because they are more vulnerable than most in these vital respects. Provisions of the *Mental Health Act* assume the existence of this relationship and draw it into the frame of reference in relation to mental health treatment and assessing capacity.

94 As relevant to persons with mental disability, the right to health has been recognised and developed within several human rights treaties,[60] especially the *International Covenant on Economic, Social and Cultural Rights* ('ICESCR')[61] and the CRPD.

95 Article 12(1) of ICESCR provides:

> The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[62]

Article 25 of the CRPD relevantly provides:

> States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:
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> (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

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60 Lisa Waddington and Bernadette McSherry, 'Exceptions and Exclusions: The Right to Informed Consent for Medical Treatment of People with Psychosocial Disabilities in Europe' (2016) 23 *European Journal of Health Law* 279, 281; see generally John Tobin, *The Right to Health in International Law* (Oxford University Press, 2012).

61 Opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

62 Ibid art 12(1).

> (b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
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> …
>
> (d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care; …[63]

As can be seen, the right in both ICESCR and CRPD is expressed in terms of 'the highest attainable standard' of health.

96 Neither ICESCR nor the CRPD defines 'health' as such. Speaking generally, Stavert and McGregor describe health by reference to the Constitution and reports of the World Health Organisation:[64]

> The World Health Organization … defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[65] It also interprets mental health broadly as 'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community'.[66]

Upon this basis, the authors describe health as a 'multi-faceted concept'.[67]

97 Stavert and McGregor also refer to guidance on the right to health in art 12(1) provided in *General Comment 14* of the United Nations Committee on Economic, Social and Cultural Rights:[68]

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63 CRPD art 25.

64 Jill Stavert and Rebecca McGregor, 'Domestic Legislation and International Human Rights Standards: The Case of Mental Health and Incapacity' (2018) 22 *The International Journal of Human Rights* 70, 72.

65 World Health Organization, *Constitution*, 45th ed, Supplement (October 2006, signed 22 July 1946, entered into force 7 April 1948) <http://www.who.int/governance/eb/who_constitution_en.pdf>.

66 World Health Organization, *Mental Health: Strengthening our Response* (30 March 2018) <www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>

67 Jill Stavert and Rebecca McGregor, 'Domestic Legislation and International Human Rights Standards: The Case of Mental Health and Incapacity' (2018) 22 *The International Journal of Human Rights* 70, 72.

68 Ibid.

> The UN Committee on Economic, Social and Cultural Rights in its General Comment 14 has interpreted the right to health as not a 'right to be healthy' but rather as a right that constitutes both freedoms and entitlements.[69] Freedoms include 'the right to control one's health and body … the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation'.[70] The entitlements conception is connected to the 'underlying determinants of health' which are defined as 'a wide range of socio-economic factors that promote conditions in which people can lead a healthy life',[71] including 'access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information …'[72] This has resulted in the right to health being concerned primarily with the provision of services, rather than viewing 'health' or the 'highest attainable standard of health' as the ultimate objective.[73]

Importantly for people with mental disability, the right to be free from non-consensual medical treatment and the entitlement to access health-related services are both elements of the right to health.

98 Section 9 of the Charter specifies a right not to be arbitrarily deprived of life.[74] This right encompasses a positive substantive obligation on the part of the State not to kill any person arbitrarily and to protect all persons from arbitrary death, and a positive procedural obligation to investigate death.[75] It is not suggested that PBU's and NJE's lives were endangered by reason of their mental illness or that ECT was necessary to prevent a risk of death.

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69 Committee on Economic, Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12)*, 22nd sess, UN Doc E/C12/2000/4, 11 August 2000, [8].

70 Ibid [8].

71 Ibid [4].

72 Ibid [11].

73 Jennifer Prah Ruger, 'Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' (2006) 18(2) *Yale Journal of Law and the Humanities* 273, 280.

74 See also *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 6(1) ('ICCPR'); CRPD art 10.

75 Sarah Joseph and Melissa Castan, *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary* (Oxford University Press, 2013, 3rd ed) 167, 176; *Telitsina v Russian Federation*, Human Rights Committee, Communication No. 888/1999, 80th sess, UN Doc CCPR/C/80/D/888/1999 (29 March 2004) [7.6]; *McCann v UK* (1995) 21 EHRR 97, [161]; *Kaya v Turkey* (1998) 28 EHRR 1, [105]; *McShane v UK* (2002) 35 EHRR 593, [93]; *LCB v United Kingdom* (1998) 27 EHRR 212, [36]; *R (L (A Patient)) v Secretary of State for Justice* [2008] 3 WLR 1325, 1333–7 [21]–[31]; *Commissioner of Police of the Metropolis v DSD* [2018] 2 WLR 895, 911 [48]; see also Human Rights Committee, *Draft General Comment 36: Right to Life (Art 6)*, UN Doc CCPR/C/GC/R36/Rev2 (1 April 2015) [16]–[18], [22]–[35].

99 Australia's obligation under international law is progressively to realise the multifaceted right to health as specified in art 12(1) of ICESCR and art 25 of the CRPD.[76] But it is not part of Australian domestic law until incorporated by legislation or otherwise.[77] The right to health is not legislated as such in the *Mental Health Act*. But its provisions have the central purpose of ensuring that people with mental disability have access to treatment for mental illness and attain a state of recovery and full participation in the life of the community. The provisions also have the purpose, supported by the Charter, of ensuring that the rights to self-determination, to be free of non-consensual medical treatment and to personal inviolability, although not absolute, are respected in treating mental ill-health and assessing capacity. The two purposes are connected.

100 As to ensuring access to mental health treatment, in the outline of the *Mental Health Act*, we saw that s 1(a) specifies that its first purpose is 'to provide a legislative scheme for the assessment of persons who appear to have mental illness and for the treatment of persons with mental illness'. Section 10(a) specifies that one of its objectives is 'to provide for the assessment of persons who appear to have mental illness and the treatment of persons who have mental illness'. Section 11(1) specifies that one of its principles is that 'persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life'. Part 5 establishes a regime pursuant to which persons with mental disability may be treated for their mental illness pursuant to the command in s 72 that: 'A patient is to be given treatment for his or her mental illness in accordance with this Act'.

101 As to respecting human rights, we also saw in the outline that the objective in s 10(c) is 'to protect the rights of persons receiving assessment and treatment' and that the principle in s 11(1)(e) is that 'persons receiving mental health services should have their rights, dignity and autonomy respected and promoted'. As fully discussed

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76 ICESCR art 2(1); CRPD art 4(2).

77 See the authorities cited in *Kaba* (2014) 44 VR 526, 566 [141] (Bell J).

below, the compulsory treatment regime represents a paradigm shift from best-interests paternalism to the least-restrictive kind of treatment, which draws upon elementary human rights concepts. Where reasonable, the views and preferences of the patient, supported if necessary, must be considered. The treatment decision is not to be based upon purely medical grounds but, where appropriate, is to encompass holistic consideration of patients in their entire personal and social setting. The regime gives effect to the support and participation objective (s 10(d)) and principle (s 11(1)(d)), which reflect the right to self-determination, to be free of non-consensual medical treatment and to personal inviolability.

102 The two-way connection between self-determination and health underpins the contemporary concept of 'recovery' which, in several ways, is implemented in the legislation. A positive objective is promoting the 'recovery of persons who have mental illness' (s 10(f)). Positively promoting 'recovery and full participation in community life' is an important element of the mental health principles (s 11(b); see also s 11(c)). The patient's intended 'recovery outcomes' are one element of the views and preferences that must be taken into account when assessing whether there is a less restrictive way to treat the patient, including in relation to ECT (s 93(2)(a) and s 96(1)(b)).

103 In the mental health context, 'recovery' is a term of art.[78] It reflects a contemporary understanding of 'health' that is broad — one that requires the social and personal circumstances of the person to be considered and one that is not focused exclusively on preventing and curing illness or disease as such. It emphasises the significance of respecting and promoting patients' self-determination over time and ensuring that patients avoid dependency and institutionalisation. As explained by the Minister for Health in the second reading speech relating to the Mental Health Bill 2014 (Vic):

> Recovery is often described as a journey rather than an outcome. The term 'recovery' in the mental health context does not necessarily mean that the

[78] See Victorian Department of Health, 'Recovery-Oriented Practice: Literature Review' (Literature Review, September 2011); Victorian Department of Health, 'Framework for Recovery-Oriented Practice' (August 2011) 2−3.

> person no longer has mental illness or is no longer experiencing any symptoms of mental illness. Instead, recovery in mental health encompasses the often fluctuating nature of mental illness where some people will not have a recurrence of mental illness, others will have some further episodes and some will experience repeated episodes of illness over time.
>
> Recovery is about maximising individual choice, autonomy, opportunity and well-being during a person's life and accordingly is a self-defined process that is highly individual.[79]

This explanation is obviously influenced by the multifaceted nature of the human right to health (see above). The concept of recovery has implications for the way in which risk management and health promotion are balanced in mental health-care decision-making.[80]

104 In conclusion, the central purpose of the *Mental Health Act* is to ensure that a person with mental illness has access to needed treatment and in various ways it promotes the right to health of the patient, broadly understood, more generally. Just as health as a subject of human rights is a multifaceted concept that has positive and negative (protective) elements, so the concept of health in the *Mental Health Act* is broad and recognises the two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and the person's health on the other. Mental health treatment decision-making is not a simple best-interests trade-off between the person's autonomy and health because health is a broad concept that relates to the whole person of which the person's autonomy, while not absolute, is a constitutive element.

Charter rights engaged

Rights engaged generally

105 A human right is engaged under the Charter when a statutory provision or other law or the conduct or decision of a public authority interferes with or limits the enjoyment or exercise of a specified right by the person. It is a different question

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79 Victoria, *Parliamentary Debates,* Legislative Assembly, 20 February 2014, 471 (Mary Wooldridge, Minister for Mental Health).

80 Andrew Carroll and Bernadette McSherry, 'Making defensible decisions in the era of recovery and rights' (2018) 26(5) *Australian Psychiatry* 474, 475.

whether the interference or limitation constitutes a violation of the right, which involves justification considerations (see s 7(2)).[81] To determine whether a right is engaged, it is necessary to ascertain and understand, without reference to those considerations, the meaning and content of the right in a purposive way by reference to the values and interests that it represents and protects.[82]

106 Under s 96(1)(a)(i) of the *Mental Health Act*, a determination may be made that a person with mental illness does not have the capacity to give informed consent to ECT. Subject to it being the least restrictive way for the patient to be treated (s 96(1)(a)(ii)), the patient may thereby be compulsorily subjected to that treatment without their consent.

107 The Secretary submitted that no human right in the Charter is engaged by an assessment of capacity under the provisions of s 68(1) because this is one of two conditions that must both be satisfied under s 96(1)(a) before a person can be subjected to compulsory ECT. To the contrary, an assessment under s 68(1) that a person does not have the capacity to give informed consent is both the foundation of the system for compulsorily imposing ECT upon patients and an interference with the person's human rights as such. It has the immediate consequence of compelling the person to be assessed for ECT under s 96(1)(a)(ii) when the person would otherwise be free of that assessment. More importantly, it takes away the person's fundamental right to refuse that treatment, which in and of itself constitutes an immediate injury to their individual dignity.[83] Because human rights protect a person's fundamental interest in self-determination, freedom from non-consensual medical treatment and personal inviolability, laws and decisions that limit the exercise of legal capacity engage the application of the rights that protect those

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81 See *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647, 683 [102]–[103] (Riordan J), citing *Kracke* (2009) 29 VAR 1, 27 [67] (Bell J).

82 The authorities are collected in *McDonald v Legal Services Commissioner (No 2)* [2017] VSC 89 (14 December 2017) [21] (Bell J) ('*McDonald*').

83 See *Starson v Swayze* [2003] 1 SCR 722, 759 (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ) ('*Starson*').

interests. As was recently decided by the European Court of Human Rights in the context of persons with mental disability:

> The Court has previously held that deprivation of legal capacity constitutes a serious interference with a person's private life.[84] The Court sees no reason to conclude otherwise in the present cases.[85]

108 It is not a purely formal step to recognise that a human right is engaged as if it warranted a mere salute in passing to some more important destination. Once the scope of an applicable right is properly ascertained and understood by reference to its undying purposes and values, the right 'delineate[s] the boundaries of the protective arena within which all individuals equally may live free, fulfilling and dignified lives'.[86] Public authorities must respect these boundaries (s 38(1)) unless the contrary is demonstrably justified (s 7(2)) or legally demanded (s 38(2)). The boundaries cannot be properly respected if the meaning and content of the right are not actually ascertained and understood.

109 One relevant example of the way in which human rights delineate the boundaries of the protective arena is the right to privacy, which enshrines the values of self-determination and personal inviolability (see below). Understanding the meaning and scope of this right influences the way in which persons with mental disability are assessed in relation to decision-making capacity. As Richards, McFarlane and Lewison LJJ held in *York City Council v C*:

> there is a space between an unwise decision and one which an individual does not have the mental capacity to take … [and] it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual's autonomy operates.[87]

Under the *Mental Health Act*, this space is preserved by interpreting and applying the capacity test in s 68(1)–(2) compatibly with the rights in the Charter, as was plainly intended by the legislature. In doing so, it is 'important to ensure that people with a

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84 See *Matter v Slovakia* (2001) 31 EHRR 32, 801 [68]; *Shtukaturov v Russia* (2012) 54 EHRR 27, 980–1 [83]; *Lashin v Russia* (European Court of Human Rights, Chamber, Application No 33117/02, 22 January 2013) [77].

85 *Shakulina v Russia* (European Court of Human Rights, Third Section, Application No 24688/05 and 5 others, 5 June 2018) [52].

86 *McDonald* [2017] VSC 89 (14 December 2017) [21] (Bell J).

87 [2014] 2 WLR 1, 19 [54] ('*York City Council*').

disability are not — by the very fact of their disability — deprived of the range of reasonable outcomes that are available to others'.[88] In this judgment, I return to this fundamental idea again and again.

110 The central issues in the present case relate to the interpretation and application of the capacity test referred to in s 96(1)(a)(i) and the no less restrictive treatment test specified in s 96(1)(a)(ii) of the *Mental Health Act,* and related provisions. The purpose of these provisions is to specify a standard for determining when a person with mental illness has the capacity to give informed consent to or refuse ECT treatment and to ensure that persons without that capacity are given that treatment when clinically warranted and it is the least restrictive way for the person to be treated, after taking the person's views and preferences into account. A determination of incapacity potentially interferes with or limits the enjoyment or exercise of a number of rights in the Charter. Among these are:

- the right to equality before the law;[89]
- the right not to be treated in a cruel, inhuman or degrading way;[90]
- the right not to be subjected to any treatment, including medical treatment, without full, free and informed consent;[91]
- the right not to have their privacy unlawfully or arbitrarily interfered with;[92]
- the right to liberty and security of the person;[93] and
- when deprived of liberty, the right to be treated with humanity and respect for the inherent dignity of the human person.[94]

111 While these several rights are potentially engaged in relation to those central issues, it is sufficient here to focus on the right to equality before the law, the right to be free of non-consensual medical treatment and the right to privacy, which are engaged.

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88 *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60 (28 September 2015) [12] (Peter Jackson J).
89 Charter s 8(3); see also the cognate rights in ICCPR art 26 and CRPD art 5(1).
90 Charter s 10(b); ICCPR art 7; CRPD art 15(1).
91 Charter s 10(c); ICCPR art 7; CRPD art 15(1).
92 Charter s 13(a); ICCPR art 17(1); CRPD art 22(1).
93 Charter s 21(1); ICCPR art 9(1); CRPD art 14(1).
94 Charter s 22(1); ICCPR art 10(1).

Equality before the law

112 The human right to equality before the law – the keystone in the protective arch of the human rights framework – is specified in s 8(3) of the Charter in the following terms:

> Every person is equal before the law and is entitled to the equal protection of the law without discrimination and has the right to equal and effective protection against discrimination.

113 As discussed in *Re Lifestyle Communities Ltd (No 3)*[95] and *Matsoukatidou v Yarra Ranges City Council*,[96] the fundamental purpose of the right to equality before the law is to protect the inherent and universal dignity of human persons. This right is particularly important for persons with mental disability because they are especially vulnerable to discriminatory ill-treatment, stigmatisation and personal disempowerment. In the discussion of the importance of protecting the dignity of persons with mental disability in *PJB v Melbourne Health* ('*Patrick's Case*'),[97] emphasis was placed upon the following seminal statement of Brennan J in *Secretary, Department of Health and Community Services v JWB and SMB* ('*Marion's Case*'):

> Human dignity is a value common to our municipal law and to international instruments relating to human rights. The law will protect equally the dignity of the hale and hearty and the dignity of the weak and lame; of the frail baby and of the frail aged; of the intellectually able and of the *intellectually disabled*… Our law admits of no discrimination against the weak and disadvantaged in their human dignity. Intellectual disability justifies no impairment of human dignity, no invasion of the right to personal integrity.[98]

114 As explained in *Matsoukatidou*,[99] the right to equality before the law in s 8(3) has three elements:

- the right to *equality before the law*, which is based on the concept of formal equality in law;

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95 (2009) 31 VAR 286, 310–14 [105]–[119] (Bell J) ('*Lifestyle Nominees (No 3)*').
96 (2017) 51 VR 624, 635–44 [36]–[61] (Bell J) ('*Matsoukatidou*').
97 (2011) 39 VR 373, 382–3 [31]–[32] (Bell J).
98 (1992) 175 CLR 218, 266 (footnotes omitted) (emphasis added).
99 (2017) 51 VR 624, 657–8 [104]–[106].

- the right to *equal protection of the law without discrimination* as defined in the *Equal Opportunity Act 1995* (Vic), which is based on the concept of substantive equality in law and fact; and

- the right to *equal and effective protection against discrimination* as defined in the *Equal Opportunity Act*, which is also based on the concept of substantive equality in law and fact.

It is the second and third elements that are relevant here.

115 Of the scope of the second element of this right, in *Matsoukatidou* it was said:

> The second element is the right to equal protection of the law without discrimination as defined in the *Equal Opportunity Act*, which is based on the concept of substantive equality in law and in fact. This requires that (in content) the law ensures that people are protected against discrimination in substance. This element of the right may require that the substantive law include positive adjustments and accommodations so that some parties are treated differently to other parties in order to ensure that they have equal protection of the law.[100] As this right is concerned with the content of the law in terms of (substantive) equality rather than the operation and administration of the law, it will be the third element that is more relevant in relation to the conduct of hearings and procedures followed by courts and tribunals.[101]

116 Of the scope of the third element, it was said:

> The third element is the right to equal and effective protection against discrimination as defined in the *Equal Opportunity Act*, which is also based on the concept of substantive equality in law and in fact. This goes beyond requiring that the law (in content) be equal in substance to requiring that, in the operation and administration of the law, people have equal and effective protection against discrimination. This element of the right may require that, in the conduct of hearings and procedures followed by courts and tribunals, positive adjustments and accommodations are made so that some parties are treated differently to other parties in order to ensure that they have equal and effective protection of the law.[102] It is this element of the right that is most relevant in the present case.[103]

117 Although the right to equality before the law in s 8(3) of the Charter was modelled on art 26 of the *International Covenant on Civil and Political Rights*, there are certain

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100 *Victorian Police Toll Enforcement v Taha* (2013) 49 VR 1, 70–1 [210]; *Lifestyle Communities (No 3)* (2009) 31 VAR 286, 317 [137]–[138], 340 [257] (Bell J).

101 (2017) 51 VR 624, 657 [105] (Bell J).

102 *Lifestyle Communities (No 3)* (2009) 31 VAR 286, 317–18 [139]–[141], 340 [257] (Bell J).

103 *Matsoukatidou* (2017) 51 VR 624, 657–8 [106] (Bell J).

differences between the two,[104] especially the limiting of the right in s 8(3) to discrimination as defined in the *Equal Opportunity Act*. However, because 'impairment', including 'a mental or psychological disease or disorder', is an attribute under ss 3(1) and 6 that comes within the definition of discrimination in ss 7(1) and 9(1) of the *Equal Opportunity Act*, the present case comes within s 8(3) of the Charter despite the limitation.

118 The second and third elements of the right to equality before the law in s 8(3) are engaged where a determination is made under ss 68(1) and 96(1)(a)(i) of the *Mental Health Act* that a patient does not have capacity to give informed consent to medical treatment. As we have seen, subject to it being the least restrictive way for the patient to be treated (s 96(1)(a)(ii)), the patient may thereby be coercively subjected to ECT. I do not need to emphasise what that treatment is. The determination takes away from the patient the right to refuse. The patient may only be subjected to this assessment and treatment by reason of having the mental illness that brings the patient within the regime of the legislation (see ss 4 and 5) when people without that illness are free of both. It is the substantive content (the second element) and the substantive operation and administration (the third element) of the provisions of s 8(3) that produce this discriminatory result. By way of comparison, it is the same with the analogous provisions of the *Guardianship and Administration Act 1986* (Vic) discussed in *Patrick's Case*.[105] To be compatible with patients' human rights, the provisions producing this human-rights limiting result, and particularly the capacity test in s 68(1), must, in content and application, be demonstrably justified (s 7(2)).

119 The CRPD, to which Australia is a party, speaks directly to the subject of the exercise of legal capacity by persons with mental disabilities. As explained in art 1, its purpose is:

> to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

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104 See further *Re Lifestyle Communities Ltd (No 3)* (2009) 31 VAR 286, 322 [162]–[165] (Bell J).

105 (2011) 39 VR 373, 385 [43]–[45] (Bell J).

> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[106]

PBU and NJE contend that VCAT's interpretation and application of the capacity test constitutes a discriminatory barrier to the exercise of their self-determination. VCAT's decisions are based on the proposition, contested in these proceedings, that they lack capacity to consent or refuse ECT in consequence of their disability.

120 As here relevant, art 12 of the CRPD in relation to equality before the law provides:

> 1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
>
> 2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
>
> 3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
>
> 4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.[107]

These historic provisions operate under international law (see above) to require the equal capacity of persons with mental disability to enjoy legal capacity is recognised (art 12(2)), that these persons are given access to needed support for the exercise of that capacity (art 12(3)) and that measures relating to the exercise of that capacity are subject to a safeguard regime (art 12(4)). I approach the issues for determination in these appeals with these provisions in mind.

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106 CRPD art 1.

107 Ibid art 12.

121 Equality is a powerful principle in relation to the interpretation and application of the capacity assessment criteria in s 68(1), as it is in relation to the content and application of the test of capacity at common law (see below). In various ways that will be considered in the next section of this judgment, the provisions must be interpreted and applied so as to ensure that the rights to self-determination, to be free of non-consensual medical treatment and to personal inviolability of people with mental disability are protected just as much as persons without that disability.

Freedom from non-consensual medical treatment

122 The right to be free of non-consensual medical treatment is specified in s 10(c) of the Charter thus:

> A person must not be—
>
> …
>
> (c) subjected to medical … treatment without his or her full, free and informed consent.

123 In *Kracke*, the following remarks were made about the general nature and purpose of this right:[108]

> 'Personal autonomy is a value that informs much of the common law.'[109] An example is that, when the common law is considering the duty of a doctor to warn a patient about the possible adverse effects of medical treatment, the starting point is 'the paramount consideration that a person is entitled to make his own decisions about his life'.[110] That should be the starting point under s 10(c) of the Charter. Forcing a person of full mental capacity to have unwanted medical treatment is a serious affront to their personal dignity and autonomy in itself.[111] The fact the treatment may be medically warranted is not at this stage the point. Remember, we are dealing here with people who, though mentally ill, still have full legal capacity [or are presumed to have that capacity]. The right to refuse unwanted treatment respects the person's freedom to choose what should happen to them, which is an aspect of their individual personality, dignity and autonomy.
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> The right is especially important in the context of treating someone for mental illness. People can be extremely sensitive about taking the powerful drugs that are often prescribed. However medically necessary they may be, the

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108 (2009) 29 VAR 1, 121–2 [569]–[570] (Bell J).

109 *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 248 [88] (Gummow, Hayne and Heydon JJ).

110 *F v R* (1983) 33 SASR 189, 193 (King CJ); applied in *Rogers v Whitaker* (1992) 175 CLR 479, 487 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

111 *Starson* [2003] 1 SCR 722, 760 (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ).

> drugs can cause alterations to mood, behaviour and body weight, as well as personal appearance, which can be very distressing. As [was submitted], such drugs can affect the very 'reality' in which a person lives. Section 10(c) of the Charter recognises the importance of this right to refuse, because it respects the personal dignity and autonomy of people with mental illness.

As the present case involves the compulsory performance of ECT upon PBU and NJE, these remarks are particularly apposite.

Privacy

124 The right to privacy is specified in s 13 of the Charter thus:

> A person has the right—
>
> (a) not to have his or her privacy, family, home or correspondence unlawfully or arbitrarily interfered with; and
> (b) not to have his or her reputation unlawfully attacked.

As can be seen, s 13(a) includes a right not to have one's privacy unlawfully or arbitrarily interfered with. The concept of arbitrariness is the specialised human rights concept which requires consideration of the proportionality of the interference.[112] The inclusion of internal limitations (lawfulness and arbitrariness) does not reduce the substantive meaning of the right in s 13(a) but forms part of analysing whether any interference is justified.[113]

125 People with mental disabilities are vulnerable to interference in their lives and meet barriers that 'may hinder their full and effective participation in society on an equal basis with others'.[114] Within the complete framework of human rights, civil and political as well as economic and social, a purpose of the right to privacy is to protect them from that interference and facilitate that participation. In *Kracke*[115] and *Director of Housing v Sudi*,[116] this role is discussed by reference to the leading authorities relating to the nature and purpose of the right. On the basis of that discussion, the

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112 *Patrick's Case* (2011) 39 VR 373, 395 [85] (Bell J).
113 *McDonald* [2017] VSC 89 (14 December 2017) [36] (Bell J).
114 CRPD art 1.
115 (2009) 29 VAR 1, 124–31 [589]–[620] (Bell J).
116 (2010) 33 VAR 139, 145 [29] (Bell J) ('*Sudi*').

general nature and purpose of the right to privacy was identified in *Kracke* as follows:

> The purpose of the right to privacy is to protect people from unjustified interference with their personal and social individuality and identity. It protects the individual's interest in the freedom of their personal and social sphere in the broad sense. This encompasses their right to individual identity (including sexual identity) and personal development, to establish and develop meaningful social relations and to physical and psychological integrity, including personal security and mental stability.
>
> The fundamental values which the right to privacy expresses are the physical and psychological integrity, the individual and social identity and the autonomy and inherent dignity of the person.[117]

In the latter case of *Sudi*, the scope of the several elements of s 13(a) was identified as follows:

> The rights to privacy, family, home and correspondence in s 13(a) are of fundamental importance to the scheme of the *Charter of Human Rights and Responsibilities Act*. Their purpose is to protect and enhance the liberty of the person — the existence, autonomy, security and well-being of every individual in their own private sphere. The rights ensure people can develop individually, socially and spiritually in that sphere, which provides the civil foundation for their effective participation in democratic society. They protect those attributes which are private to all individuals, that domain which may be called their home, the intimate relations which they have in their family and that capacity for communication (by whatever means) with others which is their correspondence, each of which is indispensable for their personal actuation, freedom of expression and social engagement.[118]

126 More recent decisions of international courts have endorsed this understanding of the values and interests protected by the right to privacy. For example, in *A-MV v Finland*, the European Court of Human Rights described the nature of the right (in art 8 of the *European Convention on Human Rights*) as follows:[119]

> The Court observes that the present case concerns primarily the private life aspect of art 8 rather than the family life aspect. Article 8 'secure[s] to the individual a sphere within which he can freely pursue the development and fulfilment of his personality'.[120] Article 8 concerns rights of central importance to the individual's identity, self-determination, physical and moral integrity,

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117 (2009) 29 VAR 1, 131 [619]–[620] (Bell J).

118 (2010) 33 VAR 139, 145 [29].

119 (2018) 66 EHRR 22, [76]; see also *Shakulina v Russia* (European Court of Human Rights, Third Section, Application No 24688/05 and 5 others, 5 June 2018) [52], in the passage set out above.

120 See *Bruggemann v Germany* (1981) 3 EHRR 244, 252 [55]; *Shtukaturov v Russia* (2012) 54 EHRR 27, 980–1 [83] (*'Shtukaturov'*).

> maintenance of relationships with others and a settled and secure place in the community.[121]

127 It may therefore be said that the right to privacy in s 13(c) of the Charter has two related dimensions of direct relevance to people with mental disability in the capacity context. The first is *self-determination*, which is a value of fundamental importance that relates to the universal capacity of persons equally to determine who they are, how they will live their lives and what should be done to them. A disability scholar explains that self-determination is related to the foundational democratic value of liberty, which applies equally to everyone:

> Individual liberty is prioritized on the understanding that part of what brings meaning to life is the freedom extended to all individuals to search for their personal realisation of the 'good life'[122] — which is different for every individual and only achievable if their liberty is respected.[123]

Of course, the right is not absolute and may be limited where this is justified according to the strict human rights standard (see s 7(2)). But the starting point is that people with mental disability have the same right of self-determination as everybody else. As the exercise of self-determination requires personal autonomy, the right to privacy protects that as well, and the two terms are frequently used interchangeably in the human rights context. Self-determination is a bedrock value that is also protected by other rights in the Charter.[124]

128 The second dimension is *personal inviolability*, which is a value of equal importance that relates to the freedom of all persons not to be subjected to physical or psychological interference, including medical treatment, without consent. This too is a right that is not absolute and may be limited when so justified. But the starting point is that people with mental disability have the same right to personal

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121 See *Connors v United Kingdom* (2005) 40 EHRR 9, 216–17 [82]; *Pretty v United Kingdom* (2002) 35 EHRR 1; *Goodwin v United Kingdom* (2002) 35 EHRR 18, 476 [90]; mutatis mutandis, *Gillow v United Kingdom* (1989) 11 EHRR 335, 352 [55].

122 Viktor Frankl argues that meaning in life comes from searching for and finding a purpose, and then actively imagining and achieving that purpose: Viktor E Frankl, *Man's Search for Meaning* (Beacon Press, 2006).

123 Anna Arstein-Kerslake, *Restoring Voice to People with Cognitive Disabilities* (Cambridge University Press, 2017) 93.

124 See, eg, ss 10(c), 14(1), 15(1)–(2).

inviolability as everybody else. Personal inviolability is also a bedrock value that is protected by other rights in the Charter.[125]

VCAT's obligations as a public authority under the Charter

129 In the present cases, it was necessary for VCAT (and the MHT) to determine whether an application should be granted for PBU and NJE to be given ECT. This required it to interpret and apply the 'capacity to give informed consent' test referred to in s 96(1)(a)(i) and the 'no less restrictive way' test specified in s 96(1)(a)(ii) (and the related provisions of ss 68 and 69). According to the general principles discussed in *Kracke*[126] relating to the *Mental Health Act 1986* (Vic), which were accepted in these proceedings, when doing so VCAT (and the MHT) is a public authority under s 38(1) of the Charter. It thereby performs the important institutional role of helping to ensure the human rights of people having mental illness, which is a purpose of the Charter[127] and also an objective[128] and principle[129] of the *Mental Health Act*.

130 VCAT performs this role by complying with its obligation under s 38(1) to act in ways that are compatible with the human rights of those people, and to make decisions that give proper consideration to those rights, unless it cannot reasonably so act or decide because of a contrary law (s 38(2)). As Parliament intended that the *Mental Health Act* be applied (as well as interpreted) compatibly with the Charter, issues under s 38(2) do not arise. Rather, the proper performance by VCAT of its obligations as a public authority under s 38(1) of the Charter gives effect to that intention.

131 VCAT also performs this role by interpreting the provisions of the *Mental Health Act* in accordance with the rule in s 32(1) of the Charter, which requires legislation to be interpreted in a way that is compatible with human rights, so far as possible consistently with their purpose. This is a strong principle of purposive

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125 See, eg, ss 10(b), 21(1), 22(1).
126 (2009) 29 VAR 1, 68–71 [283]–[299], 73 [309], [312] (Bell J).
127 Section 1(2).
128 Section 10(c).
129 Section 11(1)(e).

interpretation, not a principle of remedial interpretation, the content of which has been discussed in the authorities[130] and does not here call for consideration. As Parliament clearly intended that the *Mental Health Act* be interpreted (and applied) compatibly with human rights, proper interpretation of its provisions so far as possible consistently with the Charter is necessary to ensure that this intention is realised.

132 Taking these human rights into account, I now turn to the test in s 68(1) for determining when a person has capacity to give informed consent.

CAPACITY TO GIVE INFORMED CONSENT

Statutory provisions

133 Section 68(1) specifies a standard for determining whether someone has the capacity to give informed consent[131] and s 68(2) specifies principles that provide guidance when doing so.

134 Section 68(1) provides:

> (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
>
> (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.

It is to be noted that this standard is directed mainly at whether the person has certain abilities (not whether the person has actually chosen to exercise them) (paras (b), (c) and (d)), although para (a) is expressed differently (see further below).

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130 See *Slaveksi v Smith* (2012) 34 VR 206, 215 [24] (Warren CJ, Nettle and Redlich JJA); *Nigro v Secretary, Department of Justice* (2013) 41 VR 359, 383 [85] (Redlich, Osborn and Priest JJA).

131 'Capacity to give informed consent' is defined in s 3(1) to have the meaning given in s 68, so this provision governs the determination of that question in all cases under the *Mental Health Act*.

135 Section 68(2) provides:

> (2) The following principles are intended to provide guidance to any person who is required to determine whether or not a person has the capacity to give informed consent under this Act—
>
> (a) a person's capacity to give informed consent is specific to the decision that the person is to make;
>
> (b) a person's capacity to give informed consent may change over time;
>
> (c) it should not be assumed that a person does not have the capacity to give informed consent based only on his or her age, appearance, condition or an aspect of his or her behaviour;
>
> (d) a determination that a person does not have capacity to give informed consent should not be made only because the person makes a decision that could be considered to be unwise;
>
> (e) when assessing a person's capacity to give informed consent, reasonable steps should be taken to conduct the assessment at a time at, and in an environment in, which the person's capacity to give informed consent can be assessed most accurately.

136 The interpretation and application of these provisions are informed by well-accepted principles of both the common law and human rights regarding capacity. These will now be examined, in the course of which certain issues of statutory interpretation that were raised will be determined.

Principles of common law and human rights regarding capacity

Self-determination and personal autonomy

137 Self-determination is a fundamental value that is protected by the human right to privacy, among other rights (see above). It is also well-established in the common law. In *Airedale NHS Trust v Bland*, Lord Goff held that 'the principle of self-determination requires that respect must be given to the wishes of [a] patient' to consent to or refuse medical treatment.[132] In doing so, his Lordship referred[133] to the illuminating judgment of Hoffmann LJ in the Court of Appeal, which drew attention

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132 [1993] AC 789, 864 ('*Airedale NHS Trust*'); see also *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 92 [17] (McDougall J) ('*Hunter*').

133 *Airedale NHS Trust* [1993] AC 789, 864.

to the close connection between 'respect for the individual human being and in particular for his right to choose how he should live his own life' and 'respect for the dignity of the individual human being' which is 'an intrinsic value'.[134]

138 The close connection between self-determination and human dignity explains the importance of self-determination to the individual personally. So important to the individual personally is it that Robins, Catzman and Carthy JJA in *Malette v Shulman* held:

> Individual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, and not enhance, the value of life.[135]

In *Heart of England NHS Foundation Trust v JB*,[136] Peter Jackson J, after referring to the significance of a person's 'own system of values' when deciding whether to consent to or refuse medical treatment, said '[t]he freedom to choose for oneself is a part of what it means to be a human being'.[137]

139 The principle of self-determination is at risk when decisions about capacity are being made, including in relation to people with mental disability. While a person may need access to medical treatment, a person having capacity can decide to refuse the treatment even if it is medically necessary (see below). If medical treatment is compulsorily administered to the person because the person's capacity for self-determination is incorrectly not recognised or denied, this 'severely infringe[s] upon [the] person's right to self-determination', because '[t]he right to refuse unwanted medical treatment is fundamental to a person's dignity or autonomy'.[138] For the individual, capacity decisions therefore involve very high stakes.

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134 Ibid 826; see also *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84, 91 [24] (Martin CJ) ('*Brightwater Care Group*').

135 (1990) 67 DLR (4th) 321, 334 (Ontario Court of Appeal) ('*Malette*'); see also *Hunter* (2009) 74 NSWLR 88, 92 [16] (McDougall J).

136 [2014] EWHC 342 (COP) (17 February 2014) ('*Heart of England NHS Foundation Trust*').

137 Ibid [1].

138 *Starson* [2003] 1 SCR 722, 759 (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ).

Personal inviolability and the civil/criminal law

140 Personal inviolability too is a fundamental value that is protected by the human right to privacy, among others (see above). It too is a fundamental principle of the common law. Thus, in *Collins v Wilcock*, Robert Goff LJ said that '[t]he fundamental principle, plain and incontestable, is that every person's body is inviolate'.[139] In *Marion's Case*, Mason CJ, Dawson, Toohey and Gaudron JJ referred to the 'fundamental right to personal inviolability existing in the common law'.[140]

141 Under principles discussed by William Blackstone,[141] the common law does not draw distinctions between degrees of violence. Therefore the merest touching of a person is unlawful unless justified,[142] and the position is the same under the human right to privacy.[143] Vindication of human dignity is the purpose of the common law in this respect. It follows that, except in cases of emergency,[144] to administer medical treatment to a person's body without the person's consent, if the person has the capacity to give consent, is a civil and criminal assault or battery.[145] This, explained Mason CJ, Dawson, Toohey and Gaudron JJ in *Marion's Case*:[146]

> reflects the principle of personal inviolability echoed in the well-known words of Cardozo J in *Schloendorff v Society of New York Hospital*:[147]
>
> > 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault'.

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139 [1984] 1 WLR 1172, 1177 ('*Collins*'), cited with approval in *Re F (Medical Patient: Sterilisation)* [1990] 2 AC 1, 11–12 (Lord Donaldson MR).

140 (1992) 175 CLR 218, 253; see also 265–6 (Brennan J).

141 William Blackstone, *Commentaries on the Laws of England* (The University of Chicago Press, facsimile of first edition 1765–69, first published 1968, 1979 ed) vol 3, 120 ff.

142 *Collins* [1984] 1 WLR 1172, 1177 (Robert Goff LJ); *Marion's Case* (1992) 175 CLR 218, 233 (Mason CJ, Dawson, Toohey and Gaudron JJ), 265–6 (Brennan J), 310 (McHugh J).

143 *Storck v Germany* [2005] ECHR 406, [151]–[152].

144 On the scope of this doctrine, see *Hunter* (2009) 74 NSWLR 88, 95 [31]–[34] (McDougall J); *Malette* (1990) 67 DLR (4th) 321, 328–9 (Robins, Catzman and Carthy JJA).

145 *Marion's Case* (1992) 175 CLR 218, 234, 253–4 (Mason CJ, Dawson, Toohey and Gaudron JJ), 265–6 (Brennan J), 309–10 (McHugh J); *Re MB (Medical Treatment)* [1997] 2 FLR 426, 432 (Butler-Sloss, Saville and Ward LJJ) ('*Re MB*'); *Aintree University Hospitals NHS Foundation Trust v James* [2014] AC 591, 600–1 [19]–[20] (Baroness Hale DPSC, Lord Neuberger PSC, Lord Clarke, Lord Carnwath and Lord Hughes JJSC agreeing) ('*Aintree University Hospitals*').

146 (1992) 175 CLR 218, 234; see also 310 (McHugh J).

147 (1914) 105 NE 92, 93.

Making the connection between self-determination and personal inviolability, in *R (B) v Dr SS* Charles J held emphatically that

> the right to integrity of the person and the right to self-determination are fundamental human rights … Medical treatment is always an interference with the first of these rights, the right to integrity of the person, and constitutes an unlawful assault and battery in the absence of some lawful justification for it …[148]

142 Putting aside emergency cases, it is the consent of the patient that makes the medical intervention lawful when it would otherwise be unlawful.[149] In *Re T (Adult: Refusal of Treatment)*, Lord Donaldson MR (Butler-Sloss and Staughton LJJ agreeing) said that a person who is capable of exercising a choice '*must* consent if medical treatment of him is to be lawful'.[150] The application of this principle is graphically illustrated by the judgment of the Ontario Court of Appeal in *Malette*.[151] An award of damages against a doctor was upheld because he committed the tort of battery by treating an unconscious but capacitous patient without his consent when his lack of consent had been made manifest.[152] It was no justification that, without the treatment, the patient's life would have been threatened.

Presumption of capacity to give informed consent

143 The 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. Moreover, as was said in *Goddard Elliott v Fritsch*,[153] '[t]his foundational principle of the common law is also an international human right[154] which, in Victoria, is protected by the [Charter].'[155] All (adult) persons are therefore presumed to have the

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148 [2005] EWHC 1936 (Admin) (8 September 2005) [35(i)].

149 *Brightwater Care Group* (2009) 40 WAR 84, 91 [25] (Martin CJ), referring to *Marion's Case* (1992) 175 CLR 218, 233 (Mason CJ, Dawson, Toohey and Gaudron JJ) and *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

150 [1993] Fam 95, 102 ('*Re T*').

151 (1990) 67 DLR (4th) 321.

152 Ibid 326 (Robins, Catzman and Carthy JJA).

153 [2012] VSC 87 (14 March 2012) [545] (Bell J) ('*Goddard Elliot*').

154 Article 16 of the ICCPR provides: 'Everyone shall have the right to recognition everywhere as a person before the law'; see Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (Norbert Paul Engel Verlag, first published 1993, 2005 ed) 369 ff.

155 Section 8(1) provides: 'Every person has the right to recognition as a person before the law'.

inherent capacity to exercise the right to self-determination (unless the contrary is established). Lord Donaldson MR (Butler-Sloss LJ agreeing) so held in *Re T*: 'The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity, but it is a presumption which can be rebutted'.[156]

144 The presumption of capacity applies generally so as to include, for example, the capacity (of adults) to enter legal relations,[157] to be party to legal proceedings[158] and to consent to or refuse medical treatment.[159] The general principle that is applied is that every person is presumed to have the inherent and equal capacity to exercise the right to self-determination in these particular contexts, among others (unless the contrary is established).

145 The application of the principle that all persons are presumed to have the inherent and equal capacity to exercise their right to self-determination (unless the contrary is established) is not affected by the personal attributes of the individual (except in the special case of children). Humanity, not status, is the qualifying indicia: because recognition of legal personality is universal, the presumption applies to all persons equally regardless of gender, race, ethnicity or state of mental health, among other potential attributes. In particular, a person does not lose the benefit of the presumption of capacity upon the basis of their status as a person with a mental disability, under the *Mental Health Act* or otherwise. It applies equally to the person despite that status. Under human rights law, without compelling justification, it would be contrary to the principle of equality before the law[160] for it to be otherwise.

146 It follows that, in relation to the medical treatment of a person with a mental disability, the starting point at common law is that the person, like everyone else, 'is presumed to have the capacity to consent to or refuse medical treatment unless and until that presumption is rebutted'. Those words of Butler-Sloss, Saville and

156 [1993] Fam 95, 112.
157 *Masterman-Lister v Brutton & Co* [2003] 1 WLR 1511, 1533 [57]–[58], 1538–9 [73]–[74] (Chadwick LJ).
158 *Goddard Elliott* [2012] VSC 87 (14 March 2012) [545]–[547] (Bell J).
159 *Re MB* [1997] 2 FLR 426, 436 (Butler-Sloss, Saville and Ward LJJ).
160 See, eg, Charter s 8(3).

Ward LJJ in *Re MB (Medical Treatment)*[161] have been oft-cited and approved.[162] This is an example of the application of the general non-discriminatory principle that all adult persons, regardless of status, are presumed to have the capacity to exercise the right to self-determination (unless it is rebutted). So it is under the Charter.

147 In relation to capacity to give informed consent to treatment or medical treatment under the *Mental Health Act*, s 70(2) codifies this common law presumption thus:

> The person seeking the informed consent of another person to a treatment or medical treatment must presume that the other person has the capacity to give informed consent.

The MHT and VCAT correctly proceeded upon this basis in the current cases.

Capacity is decision-specific, can fluctuate and may be enhanced with support

148 Under s 69(1)(a), to give informed consent, the person must have capacity to give that consent. This requirement is expressed in that provision in terms of 'the treatment or medical treatment proposed'. The test of capacity in s 68(1)(a)–(d) is expressed in terms of 'the decision'. A principle guiding the assessment is that 'a person's capacity to give informed consent is specific to the decision that the person is to make' (s 68(2)(a)). This mirrors the common law, which presumes that everyone (including a person with mental disability) has legal capacity unless this is rebutted in relation to the matter or transaction in question (see above). Capacity is 'issue-specific' for all people.[163] As has been held, '[a] person may be perfectly capable of taking some decisions but not others'.[164]

149 A person's capacity to give informed consent may fluctuate in response to variations in the person's health and circumstances. As has also been held, '[a] person may be perfectly capable of taking the decision at some times and in some circumstances but

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161 (1997) 2 FLR 426, 436.

162 See, eg, *R (B) v Dr SS* [2005] EWHC 1936 (Admin) (8 September 2005) [38(i)] (Charles J); *Hunter* (2009) 74 NSWLR 88, 93 [23] (McDougall J); *Bridgewater Care Group (Inc) v Rossiter* (2009) 40 WAR 84, 90–1 [23] (Martin CJ).

163 *Re S* [2010] 1 WLR 1082, 1094 [53] (Judge Hazel Marshall QC).

164 *Re N* [2017] 2 WLR 1011, 1022 [25] (Baroness Hale DPSC, Lord Wilson, Lord Reed, Lord Carnwath, Lord Hughes JJSC).

not in others.[165]' This is recognised in s 68(2)(b), which provides that 'a person's capacity to give informed consent may change over time'.

150 Contemporary disability law emphasises the fundamental importance of relationships, context and support for the effective exercise of legal capacity by persons with mental disability in relation to medical treatment and other matters.[166] Provisions of the *Mental Health Act* recognise this. I refer, for example, to the objective in s 10(d), the principles in s 11(c) and (e), the right to communicate in s 15(1),[167] the role of nominated persons in s 23 and, particularly, the principle specified in s 68(2)(e), which is:

> (e) when assessing a person's capacity to give informed consent, reasonable steps should be taken to conduct the assessment at a time at, and in an environment in, which the person's capacity to give informed consent can be assessed most accurately.

Giving effect to these objectives, principles and rights may be positively necessary as accommodations for ensuring that, in respect of the capacity assessment, the person is treated equally before the law as required by s 8(3) (see above).

151 The test of capacity at common law is applied upon the basis that a person may be able to exercise legal capacity 'with the help of others'.[168] If the court is of the view that the person may be able to exercise that capacity with that help but it was not given, this can be taken into account when determining whether the presumption of capacity has been rebutted. Section 1(3) of the *Mental Capacity Act* goes even further. It states this principle: 'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success'.

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165 Ibid.

166 CRPD art 12(3); the kind of support that might be appropriate is discussed in UNCRPD, *General Comment No 1: Equal Recognition Before the Law (Art 12)*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) [17] (I am not endorsing the last phrase in the second line); on the rationale for this emphasis, see Mary Donnelly, *Healthcare Decision-Making and the Law* (Cambridge University Press, 2010) 108–14; see also Lucy Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80.

167 It is restrictable: see s 16(1).

168 *Koch* (1997) 33 OR (3d) 485, 521–2 [20] (Quinn J).

152 Section 68(2) of our *Mental Health Act* does not deal with the matter in this way. It does not state this strong principle. But the principles recognise the issue-specific, fluctuating and context-dependent nature of exercising the capacity to give informed consent (see above). Other general provisions applying to assessing capacity underline the importance in that connection of enabling participation by and support of the patient, and relevant relationships (see above). Whether and what kind of support has been given to the patient may therefore be relevant when determining, under s 68(1), whether the presumption of capacity in s 70(2) has been rebutted, as under the common law.

Functional test of capacity to give informed consent

153 As set out above, s 68(1)(a)–(d) of the *Mental Health Act* provides that a person has capacity to give informed consent if the person understands the information relevant to the decision, is able to remember and use or weigh that information and is able to communicate their decision.

154 Baroness Hale (Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing) explained in *R v Cooper* that:

> Three broad approaches could be discerned in the existing law and literature [in relation to assessing capacity]: the 'status', the 'outcome' and the 'functional' approaches.[169]

The 'status approach':

> excluded all people with a particular characteristic from a particular decision, irrespective of their actual capacity to make it at the time …[170]

The 'outcome approach':

> focused on the final content of the decision: a decision which is inconsistent with conventional values or with which the assessor disagreed might be classified as incompetent.[171]

The 'functional' approach:

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169 [2009] 1 WLR 1786, 1789 [12] ('*Cooper*').
170 Ibid.
171 Ibid 1790–1 [13].

> asked whether, at the time the decision had to be made, the person could understand its nature and effects.[172]

The test adopted in s 3(1) of the *Mental Capacity Act 2005* (UK)[173] on which s 68(1) of the *Mental Health Act* is based reflects the functional approach, as it is conventionally described. It may be that the test is better described as reflecting a capabilities approach because it refers to the capability of the person cognitively to function in the specified domains, but I will refer to it in the conventional manner.

155 Baroness Hale DPSC (Lord Wilson, Lord Reed, Lord Carnwath and Lord Hughes JJSC agreeing) explained in *Re N (An Adult)*[174] that the functional test in s 3(1) of the *Mental Capacity Act* was adopted as a result of recommendations made by the Law Commission after a process of consultation and consideration that lasted in excess of a decade. The test was derived from the one applied by the common law to determine whether a person has (for example) the capacity to enter into legal relations, and which applies to all persons in respect of whom the issue arises, whether the person has a mental disability or not.

156 Of that common law test, Munby J stated in *Sheffield City Council v E & S*:

> [t]he general rule of English law, whatever the context, is that the test of capacity is the ability (whether or not one chooses to exercise it) to understand the nature and quality of the transaction.[175]

His Honour went on to say:

> the same basic principle applies whether the question is as to capacity to enter into a contract, to execute a deed, to marry, to make a will, to conduct litigation, to consent to a decree of divorce, or to consent to medical treatment.[176]

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172 Ibid 1790 [13].

173 Section 3(1) relevantly provides that:

> a person is unable to make a decision for himself if he is unable —
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means).

174 [2017] 2 WLR 1011, 1020 [20].

175 [2005] Fam 326, 332 [19] ('*Sheffield City Council*'), approved in *York City Council* [2014] 2 WLR 1, 13–14 [28] (McFarlane LJ, Lewison and Richards LJJ agreeing).

176 [2005] Fam 326, 332 [19].

It is the same with the capacity of a person to instruct a legal practitioner.[177]

157 Before the *Mental Capacity Act* was passed, this common law test of capacity was applied in the context of the proposed compulsory medical treatment of persons with mental disability in such cases as *Re C (Adult: Refusal of Treatment)*,[178] *Re MB*[179] and *NHS Trust v T (Adult Patient: Refusal of Treatment)*,[180] and ultimately was endorsed by the House of Lords in *Cooper*.[181] In *Re MB*, the test so applied was stated thus:

> 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: (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.[182]

158 There was interaction between the development of the common law test as ultimately applied in *Re MB* (and other cases) and the reform process, for that test was 'closely modelled' on the one proposed in 1995 by the Law Commission.[183] It was the test in that form that ultimately came to be expressed in s 3(1) of the *Mental Capacity Act* and, with the one exception now to be discussed, it was that test that came to be expressed in s 68(1) of the *Mental Health Act*.

159 Under the *Mental Capacity Act*, the test in s 3(1)(a) is whether the person 'is unable — to understand the information relevant to the decision'. Being *capable* of understanding the information relevant to a decision is different to *actually* understanding this information.[184] Decisions under s 3(1)(a) of the *Mental Capacity*

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177 *Goddard Elliott* [2012] VSC 87 (14 March 2012) [555] (Bell J).
178 [1994] 1 WLR 290, 292 (Thorpe J) ('*Re C*').
179 [1997] 2 FLR 426, 437 (Butler-Sloss, Saville and Ward LJJ).
180 [2005] 1 All ER 387, 403–5 [53]–[54] (Charles J).
181 [2009] 1 WLR 1786, 1793 [24] (Baroness Hale, Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing).
182 [1997] 2 FLR 426, 437 (Butler-Sloss, Saville and Ward LJJ).
183 *R (Wilkinson) v Broadmoor Hospital Authority* [2002] 1 WLR 419, 443 [66] (Hale LJ) ('*Wilkinson*').
184 *R (B) v Dr SS* [2005] EWHC 86 (Admin) (31 January 2005) [87] (Silber J); *Re Koch* (1997) 33 OR (3d) 485, 521 [13] (Quinn J).

Act repeatedly stress the 'unable' aspect.[185] The question under s 3(1)(a) of the *Mental Capacity Act* 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.

160 By contrast, under the *Mental Health Act*, the test in s 68(1)(a) is whether the person 'understands the information he or she is given that is relevant to the decision'. The ordinary and natural meaning of the word 'understand' is 'perceive the meaning of', 'grasp the idea of' or 'comprehend'.[186] In that provision, I think the level of understanding intended is only a general kind of understanding that relates to the nature, purpose and effect of the treatment (see further below).

161 Differently to paras (b), (c) and (d), the domain of the test in para (a) is expressed in terms of the person's actual understanding of the information given as relevant to the decision, not in terms of the person's ability in that regard. It is not clear why this was made to be so. The extrinsic materials do not assist. The provision is anomalous in this respect. It is not consistent with: the general principles that apply to testing capacity as herein discussed; the like element of the common law test (see below); other recent Victorian capacity provisions that appear to have been modelled on s 68;[187] the parent *Mental Capacity Act* (s 3(1)(a)); the Mental Health Bill Exposure Draft 2010 (Vic) (cl 3); and mental health legislation in other States and the Territories.[188]

162 The terms of s 68(1)(a) make the test more onerous in this respect than the common law test of capacity, the parent legislation in the United Kingdom and the Australian

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185 See, eg, *King's College Hospital NHS Foundation Trust v C & V* [2015] EWCOP 80 (30 November 2015) [31] ff (MacDonald J) ('*King's College Hospital NHS Foundation Trust*').

186 *Macquarie Dictionary* (Macquarie Dictionary Publishers, 7th ed, 2017) vol 2, 1632.

187 *Medical Treatment Planning and Decisions Act 2016* (Vic) s 4 ('is able to … understand'); *Voluntary Assisted Dying Act 2017* (Vic) s 4 ('is able to … understand'); Guardianship and Administration Bill 2018 (Vic) cl 5 ('is able … to understand').

188 *Mental Health Act 2016* (Qld) s 14 ('is capable of understanding'); *Mental Health Act 2014* (WA) s 15 ('has the capacity to … understand'); *Mental Health Act 2009* (SA) s 5A ('is not capable of … understanding'); *Mental Health Act 2013* (Tas) s 7 ('is unable to … understand'); *Mental Health Act 2015* (ACT) s 7 ('can … understand'); *Mental Health and Related Services Act 2014* (NT) s 7 ('is capable of understanding'). The NSW Act does not contain a capacity test.

legislation to which I have referred. The Secretary defended s 68(1)(a) as being consistent with the purposes, objectives and principles of the *Mental Health Act* but I am not at all confident that I can accept that submission. Nonetheless, I do not think that it can be interpreted differently because the plain and ordinary meaning of the words used is clear and unambiguous, and I accept the Secretary's submission to that extent. MHT and VCAT applied s 68(1)(a) upon this basis, and both found as facts that PBU and NJE respectively satisfied this element of the test. Whether s 68(1)(a) in its present form is incompatible with the Charter, particularly having regard to the right to equality before law in s 8(3), was not explored in these proceedings.

163 It is to be noted that s 68(1) of the *Mental Health Act* does not specify a diagnostic test. The issue addressed is not whether the person is suffering from a mental impairment or whether the person's decision-making capacity is impaired in any of the respects specified in paras (a)–(d). Section 68(1) only applies to a person with a mental illness (s 5(a)), the diagnostic test for which is specified in s 4(1). Section 68(1) specifies a functional test in terms of the person's understanding and ability to remember, use or weigh and communicate in the particular respects. The question is whether the person has the relevant understanding and abilities, not whether the person's cognitive functioning is impaired in these respects. The *Mental Health Act* operates upon the presumption that, like everyone else, a person with impaired decision-making capacity has the capacity to give informed consent (until the contrary is established) (s 70(2)). It is the same under the parent legislation.[189] So in, *Re C*, it was held that a patient did not lack capacity in relation to a proposed foot amputation '[a]lthough his general capacity is impaired by schizophrenia'.[190] Therefore, a finding that a person has impaired cognitive functioning in these respects would not necessarily answer the question whether the person lacks the

189 *King's College Hospital NHS Foundation Trust* [2015] EWCOP 80 (30 November 2015) [31]; *Re C* [1994] 1 WLR 290, 295 (Thorpe J).

190 [1994] 1 WLR 290, 295 (Thorpe J), interpreting s 3(1) of the *Mental Capacity Act*.

relevant understanding and abilities, nor demonstrate that the statutory test had been properly considered and applied.

Unwise or unreasonable decisions and the dignity of risk

164 The rejection of the 'outcome' approach in favour of the 'functional' approach when the capacity standard was formulated is associated with the principle that a person is not to be treated as lacking capacity by reason of making a decision that could be considered to be objectively unwise (s 1(4) of the *Mental Capacity Act* and ss 11(1)(d) and 68(2)(d) of the *Mental Health Act*). This principle recognises the dignity of risk. As Quinn J in *Re Koch* said:

> It is mental capacity and not wisdom that is the subject of the [capacity legislation]. The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.[191]

165 Thus, by reason of the primacy of individual self-determination, the decision of a person (including someone with mental disability) able to make a decision must be respected, however unreasonable it may seem to others. This principle informs the legal relationship between doctor and patient, as explained by Lord Templeman in *Sidaway v Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital*:

> Where the patient's health and future are at stake, the patient must make the final decision. The patient is free to decide whether or not to submit to treatment recommended by the doctor … if the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject the advice for reasons which are rational, or irrational, or for no reason. The duty of the doctor in these circumstances, subject to his overriding duty to have regard to the best interests of the patient, is to provide the patient with information which will enable the patient to make a balanced judgment *if the patient chooses to make a balanced judgment*.[192]

In *Malette*, Robins, Catzman and Carthy JJA explained the relationship in the same way:

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191 (1997) 33 OR (3d) 485, 521 [17], approved in *Starson* [2003] 1 SCR 722, 759 (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ).

192 [1985] 1 AC 871, 904 (emphasis added) ('*Sidaway*'); see also *Airedale NHS Trust* [1993] AC 789, 864 (Lord Goff).

> The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment … for this freedom to be meaningful, people must have the right to make choices that accord with their own values *regardless of how unwise or foolish those choices may appear to others* …[193]

166 When it comes to assessing whether a person (whether mentally disabled or not) has the capacity to consent to or refuse medical treatment, the same principle applies. As Lord Donaldson MR (Butler-Sloss LJ agreeing) stated in *Re T*:

> [The] right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent …[194]

Butler-Sloss LJ added:

> A decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well-considered.[195]

This approach has been followed by courts of high authority in England[196] and has been approved in superior courts in Australia.[197]

167 It has been said that capacity assessments are inherently risky, uncertain and 'epistemologically fallible',[198] 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,

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193 (1990) 67 DLR (4th) 321, 328 (footnotes omitted) (emphasis added).

194 [1993] Fam 95, 102.

195 Ibid 116.

196 See, eg, *Airedale NHS Trust* [1993] AC 789, 864 (Lord Goff): decisions made 'however unreasonably'; *Re N* [2017] 2 WLR 1011, 1024 [34] (Baroness Hale DPSC, Lord Wilson, Lord Reed, Lord Carnwath and Lord Hughes JJSC agreeing): 'Of course, a person who has the capacity to make a decision for himself may do so for a good reason, a bad reason or no reason at all'.

197 *Brightwater Care Group* (2009) 40 WAR 84, 91 [27] (Martin CJ); *Hunter* (2009) 74 NSWLR 88, 91 [10] (McDougall J).

198 Mary Donnelly, *Healthcare Decision-Making and the Law* (Cambridge University Press, 2010) 116.

especially where treatment for grievous ill-health, or even the person's life, is at stake.[199] It has been described as the 'protection imperative'.[200]

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 ahead of the outcome approach in the design of the English capacity legislation, as now reflected in s 68(1) of our *Mental Health Act*. Baroness Hale (Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing) pointed out in *Cooper* that the outcome approach was rejected because, in the words of the Law Commission, it 'penalises individuality and demands conformity at the expense of personal autonomy'.[201] 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.[202]

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.[203]

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199 *PH v A Local Authority* [2011] EWCOP 1704 (30 June 2011) [16(iii)] (Baker J) ('*PH*').

200 *A University Hospital NHS Trust v CA* [2016] EWCOP 51 (8 December 2016) [19(8)] (Baker J); see also *PH* [2011] EWCOP 1704 (30 June 2011) [16(iii)] (Baker J).

201 [2009] 1 WLR 1786, 1790 [13], citing Law Commission, *Mental Incapacity* (Law Com No. 231, House of Commons Papers, Session 1995, 189) (London: HMSO) 33 [3.4].

202 *Starson* [2003] 1 SCR 722, 759 (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ); *King's College Hospital NHS Foundation Trust* [2015] EWCOP 80 (30 November 2015) (MacDonald J), citing *Cooper* [2009] 1 WLR 1786, 1790 [13] (Baroness Hale, Lord Hope, Lord Rodger, Lord Brown and Lord Mance); *York City Council* [2014] 2 WLR 1, 19–20 [53]–[57] (McFarlane LJ).

203 See further Emily Jackson, 'From "Doctor Knows Best" to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions about Their Medical Treatment' (2018) 81(2) *Modern Law Review* 247, 263–4.

170 Despite the irrelevance of the outcome of the decision to the assessment of the person's capacity, the tendency to make that assessment by reference to the person's (so-called objectively reasonable) best interests is strong, so much so that the courts have frequently stressed the need to guard against it. *York City Council*[204] was a case in which a wife with learning difficulties wanted to resume cohabitation with her sex-offending husband upon his release from prison. Refusing to intervene, McFarlane LJ (Richards LJ agreeing) held:

> There may be many women who are seen to be in relationships with men regarded by professionals as predatory sexual offenders. The Court of Protection does not have jurisdiction to act to 'protect' these women if they do not lack the mental capacity to decide whether or not to be, or continue to be, in such a relationship. The individual's decision may be said to be 'against the better judgment' of the woman concerned, but the point is that, unless they lack mental capacity to make that judgment, it is against *their* better judgment. It is a judgment that they are entitled to make.[205]

171 In *Heart of England NHS Foundation Trust*,[206] the issue was whether a person with a mental disability had the capacity to refuse to consent to an amputation of the leg below the knee. Finding that the person had that capacity despite his mental illness, Peter Jackson J stated that best interests considerations must not be allowed to dominate capacity assessments:

> The temptation to base a judgment of a person's capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity. Any tendency in this direction risks infringing the rights of that group of persons who, though vulnerable, are capable of making their own decisions. Many who suffer from mental illness are well able to make decisions about their medical treatment, and it is important not to make unjustified assumptions to the contrary.[207]

172 This statement was cited with approval and applied by MacDonald J in *King's College Hospital NHS Foundation Trust v C & V*[208] in a case involving a decision by a highly

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204 [2014] 2 WLR 1.
205 Ibid 19 [53].
206 [2014] EWHC 342 (COP) (17 February 2014) (Peter Jackson J).
207 Ibid [7].
208 [2015] EWCOP 80 (30 November 2015) [28] (MacDonald J).

eccentric individual to refuse life-saving medical treatment. As the Secretary submitted in the present case, the following statement by MacDonald J in that case applies equally to the interpretation and application of s 68(1)(c) of our *Mental Capacity Act:*

> a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to [the relevant] information in making the decision in question and chosen to attach no weight to that information in the decision making process.[209]

The judgment of MacDonald J, and those of Peter Jackson J in *Heart of England NHS Foundation Trust*[210] and *Wye Valley NHS Trust v B*[211] and the plurality in *Starson v Swayze,*[212] all concerned with highly eccentric individuals, are notable for applying the capacity test in a way that is criteria-focused, evidence-based, patient-centred and non-judgmental.

Threshold of capacity and non-discrimination

173 The functional criteria in s 68(1)(a)–(d) of the *Mental Health Act* refer to the understanding of the person and the person's ability to remember and use or weigh the relevant information and communicate a decision. An important issue arises in the case of NJE as to *how well* the person needs to be able to so understand and function. The issue is closely connected with the need to respect the human rights of persons with mental disability by avoiding discriminatory application of the capacity test. As I have repeatedly said, more should not be expected of them, explicitly or implicitly, than ordinary patients.

174 A doctor needs to ensure that a patient has sufficient information to be able to give consent to medical treatment. It is sufficient for the doctor to ensure that the patient 'is informed in broad terms of the nature of the procedure which is intended'.[213]

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209 Ibid [38].
210 [2014] EWHC 342 (COP) (17 February 2014).
211 [2015] EWCOP 60 (28 September 2015).
212 [2003] 1 SCR 722 (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ) ('*Starson*').
213 *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ); see also *Re T* [1993] Fam 95, 115 (Lord Donaldson LJ, Butler-Sloss LJ agreeing).

That is because, to have capacity to consent, the patient is only expected to be able to understand, remember and use or weigh the relevant information, and communicate a decision, in those broad terms (see further above).

175 As we have seen, the capacity test that is specified in s 3(1) of the *Mental Capacity Act* and s 68(1) of our *Mental Health Act* is derived from this common law test of capacity. The test as stated in *Re MB*[214] reflects the Law Commission's recommendations at the time and came to be adopted in s 3(1) of the *Mental Capacity Act*. Of that test, Hale LJ said in *R (Wilkinson) v Broadmoor Hospital Authority*:

> Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify.[215]

176 As this statement indicates, the capacity threshold is a 'low one' because it would otherwise be over-inclusive: it would include in the class of persons *not* having capacity many persons who *are* able to understand, remember and use or weigh the relevant information, and communicate a decision, in general terms having regard to the nature, purpose and effect of the treatment. It is better that these persons be able to satisfy a low threshold of capacity and exercise their right to consent to or refuse medical treatment than to have a high threshold of capacity that they could not satisfy, even if this might result in some non-consensual medical treatment.

177 The courts are acutely conscious of the danger of the capacity test being applied in a manner that discriminates against people with mental disability. The issue arose in *Sheffield City Council*[216] in relation to the capacity to marry of a woman aged 21 years having the mental functioning of a girl aged 13 years. When answering several preliminary questions, Munby J said:

> There are many people in our society who may be of limited or borderline capacity but whose lives are immensely enriched by marriage. You must be careful not to set the test of capacity to marry too high, lest it operate as an

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214 [1997] 2 FLR 426, 437 (Butler-Sloss, Saville and Ward LJJ).

215 [2002] 1 WLR 419, 446 [80]; see also *R (B) v Dr SS* [2005] EWHC 86 (Admin) (31 January 2005) [24] (Silber J).

216 [2005] Fam 326 (2 December 2004) (Munby J).

> unfair, unnecessary and indeed discriminatory bar against the mentally disabled.[217]

This statement was cited with approval in *PH v A Local Authority*[218] in a case under the *Mental Capacity Act*. Baker J said:

> Although [the observation of Munby J] concerned the capacity to marry, … it should be applied to other questions of capacity. In other words, courts must guard against imposing too high a test of capacity to decide issues such as residence because to do so would run the risk of discriminating against persons suffering from a mental disability. In my judgment, the carefully-drafted detailed positions of the 2005 Act … are consistent with this approach.[219]

178 A capacity test applying to people with mental disability is plain-bread discriminatory on that ground if the standard of functioning required of those persons is greater than the relatively low standard required of people generally. As we have seen, the general capacity standard of the common law requires only that the person, whether mentally disabled or not, is able to understand the general nature, purpose and effect of the medical treatment, transaction or proceeding in question. Section 3(1) of the *Mental Capacity Act* is interpreted and applied in the same way, as should be s 68(1) of our *Mental Health Act*.

179 The issue was further considered in *R (B) v Dr SS*[220] in relation to the capacity test stated in *Re MB*[221] by Butler-Sloss, Saville and Ward LJJ (see above). Silber J held in *R (B) v Dr SS* that this test

> does not … require the patient to be able to use [the information] or weigh it in the balance *to a particular standard.* Thus, a patient might be regarded as having capacity if he could understand, retain, use and weigh in the balance this information but could reject it for any rational but undisclosed reason.[222]

His Honour went on to say:

> Thus a patient could be regarded as having capacity to decide if he wishes to have treatment even though … he lacked insight or understanding of his

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217 Ibid [144].
218 [2011] EWCOP 1704 (30 June 2011) (Baker J).
219 Ibid [16(xi)].
220 [2005] EWHC 86 (Admin) (31 January 2005) (Silber J).
221 [1997] 2 FLR 426.
222 [2005] EWHC 86 (Admin) (31 January 2005) [20].

> problems, which insight might have to be addressed by medication. He could similarly be considered to have capacity not because he was shown to have capacity but because the evidence of, for example, his confused mind, did not go quite far enough to rebut the presumption of capacity.[223]

Referring to the judgment of Hale LJ in *Wilkinson*, Silber J concluded:

> All these factors show why the threshold of capacity is low and explain why a patient who reaches the threshold of capacity should not, as Hale LJ indicated, be regarded as being able to make a balanced and rational decision …[224]

180 The issue was considered again in *LBL v RYJ and VJ*[225] in relation to whether a person with mental disability aged 18 years had capacity to make decisions relating to his daily life. The judgment of Macur J was also informed by non-discrimination principles. Her Honour interpreted s 3(1) so as not to

> place greater demands upon VJ than others of her chronological age/commensurate maturity and unchallenged capacity.[226]

Accordingly, she held that it was

> unnecessary that [the person] should be able to give weight to every consideration that would otherwise be utilised in formulating a decision objectively in her 'best interests' … The test in s 3 is to the effect that the person under review must comprehend and weigh the salient details relevant to the decision to be made.[227]

181 This approach is well established. For example, following the judgment of Macur J in *LBL*, MacDonald J decided in *King's College Hospital NHS Foundation Trust* that, under s 3(1)(c) of the *Mental Capacity Act*:

> It is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient features … Even though a person may be unable to use and weigh some information relevant to the decision in question, they may nonetheless be able to use and weigh other elements sufficiently to be able to make a capacitous decision …[228]

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223 Ibid [89]. To like effect it was decided in *Re SB* that a person with bipolar disorder had capacity to consent to a late-term abortion even though '[s]he herself denies illness' and the evidence established that this 'is often a feature of her type of illness': [2015] EWHC 1417 (COP) [15] (Holman J).

224 [2005] EWHC 86 (Admin) (31 January 2005) [90].

225 [2010] EWHC 2664 (Fam) (22 September 2010) (Macur J)('*LBL*').

226 Ibid [58].

227 Ibid.

228 [2015] EWCOP 80 (30 November 2015) [37] (footnotes omitted).

Another example is *University Hospital NHS Trust*. After following the judgment of Macur J in *LBL*, Baker J held that it was sufficient if the person 'comprehends and weighs the salient details relevant to the decision'.[229]

182 As this analysis makes clear, the issue is not whether the person can function to the standard of being able to make a balanced and rational decision. To repeat, Butler-Sloss LJ stated in *Re T* that '[a] decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well-considered'.[230] This is not expected of people who are not mentally disabled and it is not expected of people who are mentally disabled. Under s 68(1)(a)–(d) of the *Mental Health Act*, the question is whether the person understands and is able to remember and use or weigh the relevant information, and communicate a decision, in terms of the general nature, purpose and effect of the treatment, not whether the person can make a sensible, rational or well-considered decision.

Belief and insight in respect of the illness and need for treatment

183 As we have seen, the capacity test in s 68(1) of the *Mental Health Act* is derived from s 3(1) of the *Mental Capacity Act 2005* (UK). The criteria in both refer to a person being able to 'use or weigh' (para (c)) the relevant information. There is no express belief or appreciation element. An important issue arises in the case of both PBU and NJE in relation to relevance of the state of the person's belief and insight in respect of the illness and need for treatment.

184 In the long process of consideration and consultation that occurred prior to the enactment of the *Mental Capacity Act*,[231] there were suggestions that the new legislation should adopt a test that included whether the person had the ability to 'appreciate' the information.[232] Consideration was also given to codifying the test

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229 [2016] EWCOP 51 (8 December 2016) [19(5)] (footnotes omitted).
230 [1993] Fam 95, 116.
231 Described in *Re N* [2017] 2 WLR 1011, 1020 [20] (Baroness Hale DPSC).
232 Law Commission, *Mental Incapacity* (Law Com No. 231, House of Commons Papers, Session 1995, 189) (London: HMSO) 38 [3.16].

applied by Thorpe J in *Re C*.[233] His Honour held that a person's decision-making capacity at common law depended upon: 'first, comprehending and retaining treatment information, second, *believing it* and, third, weighing it in the balance to arrive at a choice' (emphasis added).[234]

185 The Law Commission rejected these suggestions. It considered that the requirement for the person to be able to 'understand' and 'use' the relevant information covered cases where 'the person concerned can understand information [but] the effects of a mental disability prevented him or her from using the information in a decision-making process'.[235]

186 As enacted, s 3(1) of the UK *Mental Capacity Act* deliberately did not include any element based on the person appreciating or believing the diagnosis of their mental illness. It specifies that the person has to be able to 'use or weigh [the] information as part of the process of making the decision'. This is the test adopted in *Re MB*[236] by Butler-Sloss, Saville and Ward LJJ which, as we have seen, was itself modelled on earlier proposals of the Law Commission.[237] Giving judgment for the court, Butler-Sloss LJ stated that a person lacked capacity when unable to 'comprehend and retain' the relevant information and to 'use the information and weigh it in the balance as part of the process of arriving at a decision'.[238]

187 Decisions of courts under the *Mental Capacity Act* have noted the absence of any belief or insight criterion in s 3(1).[239] However, it is understood that the capacity test requires more than understanding because some people are prevented by their illness from using the information in the decision-making process. The issue whether a person believes or has insight into the diagnosis of their mental illness and

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233 [1994] 1 WLR 290.
234 Ibid 295.
235 Law Commission, *Mental Incapacity* (Law Com No. 231, House of Commons Papers, Session 1995, 189) (London: HMSO) 38–9 [3.17].
236 (1997) 2 FLR 426.
237 *Wilkinson* [2002] 1 WLR 419, 443 [66] (Hale LJ).
238 Ibid 437.
239 See, eg, *Local Authority X v MM and KM* [2007] EWHC 2003 (Fam) (21 August 2007) [81] (Munby J) ('*Local Authority X*').

need for treatment is considered to be part of determining whether they are able to use or weigh the relevant information.[240] I discuss the authorities in more detail below.

188 When issued as an exposure draft, s 64 of the Mental Health Bill 2010 (Vic) contained criteria for the making of an assessment order. Paragraph (d) of these criteria referred to the person being able to understand, retain, 'use, weigh or *appreciate*' (sub-para (iii)) (emphasis added) the information relevant to the decision and communicate the decision.[241] In the consultation process relating to that exposure draft, the Victorian Government received submissions noting that the 'appreciate' element was not in s 3(1) of the *Mental Capacity Act* and recommended that it be deleted.[242] In particular, the Law Institute of Victoria and the Mental Health Legal Centre Inc submitted (in identical language) that the term 'appreciate' was 'unnecessary, subjective and implies a value judgment on the manner in which a person should weigh the information in arriving at a decision'.[243] These submissions were accepted in the language as enacted in s 68(1)(a)–(d), which deliberately did not include any element based on appreciating (or believing) the relevant information. This does not make the state of a person's belief or insight in respect of the illness or need for treatment completely irrelevant to the issue of capacity.

189 In *Re C*, Thorpe J stated the capacity test in terms that seemed to require, as a normative criterion, that the person not simply be capable of understanding but also was in the state of actually 'believing' the treatment information.[244] On one view, this means that a person who does not subjectively accept the diagnosis of the person's illness or has no insight into it or the need for treatment lacks capacity in respect of the treatment decision. This is to treat belief or insight in respect of the

240 Ibid [81]–[82] (Munby J) and authorities discussed therein.
241 See also ss 70(d) and 71(d) in relation to inpatient treatment orders and community treatment orders.
242 See, eg, Law Institute of Victoria, Submission No 75 to Mental Health Act Review Team, 10 December 2010, 15; Mental Health Legal Centre, Submission to the Exposure Draft Mental Health Bill 2010, February 2011, 19.
243 Ibid.
244 [1994] 1 WLR 290, 292.

diagnosis and treatment as a criterion of capacity (a normative consideration) and not just as a factual consideration.

190 It is extremely unlikely that Thorpe J intended this consideration to operate in this way. After a patient-centred analysis of the facts of the case, his Honour found that the patient, who had chronic paranoid schizophrenia, *did* have capacity to refuse a foot amputation, despite the likely dire consequences. His Honour held:

> Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses. Indeed, I am satisfied that he has understood and retained the relevant treatment information, that *in his own way* he believes it, and that in the same fashion he has arrived at a clear choice.[245]

Thus Thorpe J appears to have approached the matter by considering the extent to which the person could weigh or use the information. In other words, his Honour has taken belief and insight in respect of the diagnosis and treatment into account not as a criterion (a normative consideration) but as a factual consideration.

191 In the cases following *Re C*, whether and how much the person believed or had insight into the illness and the need for the treatment has been treated as a relevant factual consideration, not as a criterion as such. For example, in *Re MB*, Butler-Sloss, Saville and Ward LJJ approved the statement of Thorpe J in *Re C* for this guarded proposition:

> If … 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.[246]

The court held that the person did not have capacity to refuse to consent to a Caesarean section for the birth of her child only because her thinking was totally dominated by her phobic fear of needles.[247]

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245 Ibid 295 (emphasis added).

246 [1997] 2 FLR 426, 437 [4(b)].

247 Ibid 438; approved in *Cooper* [2009] 1 WLR 1786, 1794 (Baroness Hale, Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing).

192 There have been several other cases in which courts have concluded, as a fact, that a person's delusional beliefs have deprived the person of the capacity to use or weigh the treatment information. These include *R (N) v Dr M* (person with chronic paranoid psychosis refusing to consent to depot medication for severely delusional reasons),[248] *NHS Trust v T (Adult Patient: Refusal of Treatment)* (person with borderline personality disorder self-harming by cutting and blood-letting refusing blood transfusion because 'I believe my blood is evil'),[249] *Trust A & B v H* (schizophrenic and delusional woman with cancer needing removal of tumour and hysterectomy refusing surgery to preserve her child-bearing capacity whilst denying she already had a husband and children),[250] and *Wye Valley NHS Trust v B* (person with schizoaffective disorder with psychotic symptoms refusing lifesaving foot amputation because 'Lord says it's no' in auditory hallucinations).[251]

193 The reasoning in these cases is perhaps well-illustrated by the following passage from the judgment of Sir Mark Potter P in *Trust A*:

> A person lacks capacity if some impairment or disturbance of mental functioning renders that person unable to make a decision whether to consent or refuse treatment. Such an inability occurs when either the patient is unable to comprehend and retain the material relevant to the decision, especially the likely consequences of having or not having the treatment in question, or where the patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision. In this respect a compulsive disorder or phobia may prevent the patient's decision from being a true one, particularly if conditioned by some obsessional belief or feeling which so distorts the judgment as to render the decision invalid.[252]

In other words, the issue of 'belief is subsumed in the more general requirements of understanding and of ability to use and weigh information'.[253] A person who lacks insight may, not must, be lacking in capacity.

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248 [2002] EWHC 1911 (Admin) (24 September 2002) [72] (Silber J).

249 [2005] 1 All ER 387, 390 [8] (Charles J) ('*NHS Trust*'); approved in *Cooper* [2009] 1 WLR 1786, 1793–4 [25] (Baroness Hale, Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing).

250 [2006] EWHC 1230 (Fam) (25 May 2006) [13] (Potter P) ('*Trust A*'); a similar case is *Cambridge University Hospitals NHS Foundation v BF* [2016] EWCOP 26 (18 May 2016) [51] (MacDonald J).

251 [2015] EWCOP 60 (28 September 2015) [34(2)] (Peter Jackson J).

252 [2006] EWHC 1230 (Fam) (10 May 2006) [22] (Sir Mark Potter P).

253 *Local Authority X* [2007] EWHC 2003 (Fam) (21 August 2007) [81] (Munby J).

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. As disability law scholars have written:

> A lack of insight may impact a person's ability to understand [or use or weigh] 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.[254] This, in combination with the requirement that a person only needs to understand information 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.[255]

195 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.[256] 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.

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254 Kate Diesfeld, 'Insight: Unpacking the Concept in Mental Health law' (2003) 10 *Psychiatry, Psychology and Law* 63; Yuval Melamed et al, 'Insight and Competence to Consent to Psychiatric Hospitalization' (1997) 16 *Medicine and Law* 721; TE Smith et al, 'Insight and recovery from psychosis in chronic schizophrenia and schizoaffective disorder patients' (2004) 38 *Journal of Psychiatric Research* 169.

255 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 and New Zealand Journal of Psychiatry* 324, 328.

256 See, eg, *Re SB v (A patient: Capacity to consent to termination)* [2013] EWHC 1417 (COP) (21 May 2013) [15] (Holman J); *Heart of England NHS Foundation Trust* [2014] EWHC 342 (COP) (17 February 2014) [9] (Peter Jackson J).

196 The decision of the Supreme Court of Canada in *Starson*[257] demonstrates that a person with mental disability lacking belief or insight in respect of the illness or need for treatment can have capacity to refuse treatment (see further above). 'Professor' Starson was a brilliant untrained physicist with bipolar disorder who was in psychiatric detention. He acknowledged he had mental problems but did not agree he was suffering from an illness or accept the need for medication. He refused medication because, in the past, it had significantly dulled his thinking and prevented him from working. He considered that the normalising effects of the medication 'would be worse than death'.[258] He was found to be lacking in capacity by the Consent and Capacity Board of Ontario.

197 Upholding the final appeal, the plurality of the Supreme Court of Canada stated:

> The enforced injection of mind-altering drugs against [Professor Starson's] will is highly offensive to his dignity and autonomy, and is to be avoided unless it is demonstrated that he lacked the capacity to make his own decision.[259]

It was held that the presence of a mental illness was not to be equated with incapacity, even for someone in psychiatric detention;[260] that Professor Starson had valid reasons for refusing medication (he 'preferred his altered state to what he viewed as the boredom of normalcy'[261]); and that the Board had placed primary importance upon what it thought was in his best interests, at the expense of failing adequately to consider whether '[he] had the capacity to make up his own mind as to whether he wanted medication or not'.[262]

198 In conclusion, it may be accepted that the presence of delusional thinking and irrational fears is '*capable* of depriving a person of capacity. The question is whether it does'.[263] So may it be accepted that lack of belief or insight in respect of a mental

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257 [2003] 1 SCR 722.
258 Ibid 770–1 [102] (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ).
259 Ibid 766 [91].
260 Ibid 760 [77].
261 Ibid 766 [92].
262 Ibid 754 [63].
263 *Cooper* [2009] 1 WLR 786, 1794 [28] (Baroness Hale, Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing); this conclusion was reached after an analysis that included consideration of *Re C*

illness or need for treatment may be capable of supporting a finding of incapacity. The question is whether it does. This means giving due consideration to a relevant fact, not (in effect) applying a determinative normative criterion.

Personal identity and the dignity of recognition

199 The principle of self-determination enables a person (including a person with mental disability) to exercise an individual choice to give or refuse consent to medical treatment. The choice is intensely personal because it is informed by the values, life experience and relationships of the individual. Some people make this choice as if it were the next note to sound in the song of their life. Choosing to consent to or refuse medical treatment is therefore a fundamental expression of the individual identity of the person and has an ontological dimension. When respect is afforded to the choice of the person to consent to or refuse medical treatment, the person is recognised for who they are. Respect of the choice is usually experienced as affirmation of the person's individual identity in the context of their own body and private life; rejection of the choice, however well-meaning and 'objectively reasonable', is frequently experienced as disaffirmation of the person's individual identity in that context. As written in a seminal article by David Feldman:

> Being subjected to treatment, especially invasive treatment, without one's consent is calculated to threaten one's sense of one's own worth and the feeling of being valued by others. How valuable can a person be, one might ask, if others are prepared to do things to him which remove from him any control over his own destiny? What could be less compatible with one's dignity than being treated as a person to whom such a thing might be done lawfully and properly?[264]

200 The position of even the most human-rights-respecting assessor of capacity is therefore acutely difficult. On the one hand, the person's health and even life may be at stake. On the other, the exercise of the right to consent to or refuse medical treatment is, besides everything else, a demand (or plea) to be personally understood, free of pre-judgment or stereotype. The person seeks recognition not

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[1994] 1 WLR 290, *Re MB* (1997) 2 FLR 426 and *NHS Trust* [2005] 1 All ER 387: at 1793 [24].

264 David Feldman, 'Human Dignity as a Legal Value: Part II' (2000) *Public Law* 61, 67–8.

just of the right to choose but also of the fundamental dignity of their humanity in respect of a decision that concerns who they are.[265]

201 The fundamental principles of self-determination, freedom from non-consensual medical treatment and personal inviolability, and the equally fundamental principles behind the right to health, are most respected by capacity assessments that are criteria-focussed, evidence-based, person-centred and non-judgmental. Such assessments engage with the demand (or plea) of the person to be understood for who they are, free of pre-judgment and stereotype, in the context of a decision about their own body and private life. I give as examples the assessment of MacDonald J in *King's College Hospital NHS Foundation Trust*,[266] in which it was found that the person did not lack capacity, and the assessment of Peter Jackson J in *Wye Valley NHS Trust*,[267] in which it was found that the person did lack capacity.

Establishing capacity

202 Both at common law and under s 70(2) of the *Mental Health Act*, a person is presumed to have capacity to give or refuse informed consent to medical treatment (see above). VCAT can only grant an application for approval of ECT if it is satisfied that the patient does not have that capacity (s 96(1)(a)(ii)), otherwise the application must be refused (s 96(1)(b)). According to generally accepted principles, no party in this administrative proceeding before VCAT bore a legal onus of proof but a practical onus rested upon the authorised psychiatrist, as the applicant, to present evidence and information sufficient to enable VCAT to attain that state of satisfaction.[268] That is especially so in the determination of applications for approval of ECT because, absent such evidence and information, the presumption of capacity in s 70(2) will not be rebutted.

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265 See further Emily Jackson, 'From "Doctor Knows Best" to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions about Their Medical Treatment' (2018) 81(2) *Modern Law Review* 247, 263–4.

266 [2015] EWCOP 80 (30 November 2015).

267 [2015] EWCOP 60 (28 September 2015).

268 *McDonald v Director-General of Social Security* (1984) 1 FCR 354, 358 (Woodward J), 365-6 (Northrop J), 369 (Jenkinson J), approved *Medical Practitioners' Board v McGoldrick* (1999) 15 VAR 462, 467-8 [20] (Buchanan JA, Tadgell and Phillips JJA agreeing) ; *Re PJR and Department of Justice* (2006) 25 VAR 336, 341 [17] (Morris P).

203 Deprivation of legal capacity constitutes a serious interference with a person's human rights (see above). As a safeguard against unjustified violation of those rights, the European Court of Human Rights held in *Herczegfalvy v Austria* that therapeutic necessity for the interference must be 'convincingly shown'.[269] This test is applied by courts in the United Kingdom when assessing capacity, both under the common law[270] and statutory mental health regimes.[271]

204 In the case of both PBU and NJE, VCAT approached the issue of whether it was satisfied that PBU and NJE did not have capacity to give informed consent by reference to the enhanced civil standard of proof described by Dixon J in *Briginshaw v Briginshaw*.[272] In the case of PBU, VCAT made the following remarks about that standard:

> The standard requires a tribunal to actually be persuaded that a fact in issue exists. It must consider the seriousness of the matter at hand and the gravity of the consequences flowing from a particular finding and determine whether the matters in issue have been proven to its reasonable satisfaction. That state of satisfaction is not likely to be reached based on uncertain proofs of evidence or whether findings are reached by drawing indirect inferences.

205 I consider that VCAT adopted the correct approach in this regard. I do not see any practical difference between the requirement that necessity for interfering with human rights be 'convincingly shown', on the one hand, and establishing that necessity according to the enhanced civil standard of proof described by Dixon J in *Briginshaw*, on the other. In both cases, a finding is made having regard to the gravity of that issue, namely the fundamental human rights of the person to self-determination, to be free of non-consensual treatment and to personal inviolability. This is also consistent with the requirement in s 7(2) of the Charter that reasonable limits on human rights be 'demonstrably justified'.

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269 [1992] 15 EHRR 437, 484 [82].

270 *Wilkinson* [2002] 1 WLR 419, 445 [77] (Hale LJ); *R (N) v M* [2003] 1 WLR 562, 568−9 [16]−[17] (Lord Phillips MR, Rix and Dyson LJJ).

271 *B v Dr SS* [2005] EWHC 86 (Admin) (31 January 2005) [96] (Silber J); *B v Dr SS* [2005] EWHC 1936 (Admin) (8 September 2005) [48] (Charles J).

272 (1938) 60 CLR 336, 362–3 ('*Briginshaw*').

Summary of principles

206 The abovementioned principles relating to assessing capacity to give informed consent under s 68(1)–(2) of the *Mental Health Act* may be summarised as follows:

(1) The primary purpose of the *Mental Health Act* is to ensure that people with mental illness, including those lacking the capacity to give informed consent, receive treatment for that illness (s 1(a); see also ss 10(a), 10(f), 11 and especially 72). But the legislative intention is that this is to be done in a manner that affords equal respect for their human rights and particularly their right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, as recognised in the Charter.

(2) Consistently with affording that respect and the position at common law for people generally, there is a (rebuttable) presumption that people with mental illness (as for people without that illness) have the capacity to give informed consent (s 70(2)). Capacity to give informed consent is issue-specific (s 68(2)(a)), can fluctuate (s 68(2)(b)) and may be enhanced with support, all of which may have significant implications for the capacity-assessing process and the ultimate determination.

(3) Reflecting the common law, the test of capacity in s 68(1) is primarily a functional one in which the question is whether the person has the ability to remember and use or weigh relevant information and communicate a decision, not whether the person has actually done so (paras (b), (c) and (d)). The purpose of the functional test (as distinct from a status or outcome-based test) is to ensure that, in relation to capacity to give informed consent, people with mental illness are afforded the same respect for their inherent dignity and autonomy-space as people not having that illness. In relation to s 68(1)(a), the question is whether the person understands the information.

(4) The capacity test must be applied in a non-discriminatory manner so as to ensure that people with mental illness are not deprived of their equal right to exercise legal capacity upon the basis of contestable value-judgments relating

to their illness, decisions or behaviour, rather than upon the basis of the neutral application of the statutory criteria (s 68(2)(c)). In short, the test is not to be applied so as to produce social conformity at the expense of personal autonomy.

(5) A person with mental illness is not to be found lacking the capacity to give informed consent simply by reason of making a decision that could be considered unwise (s 68(2)(d)), which recognises that self-determination is important for both dignity and health and that people with mental illness should have the same dignity of risk in relation to personal healthcare decision-making as other people. This reflects the two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and personal health and wellbeing on the other.

(6) Reflecting human rights consideration, the *Mental Health Act* rejects the best-interests paradigm for healthcare decision-making. Those assessing capacity under s 68(1)–(2) must vigilantly ensure that the assessment is evidence-based, patient-centred, criteria-focussed and non-judgmental, and not made to depend, implicitly or explicitly, upon identification of a so-called objectively reasonable outcome.

(7) The threshold of capacity in s 68(1)(a)–(d) is relatively low and requires only that the person understands and is able to remember and use or weigh the relevant information and communicate a decision in terms of the general nature, purpose and effect of the treatment. The threshold is not that the person understands the information sufficiently to make a rational or well-considered decision, is able make such a decision or has actually done so. The person does not need to have an understanding and possess those abilities in terms of the actual details of the proposed treatment but only the salient features.

(8) Acceptance of, belief in and insight into the diagnosis of illness and need for treatment varies significantly depending upon the person and the situation. It is not a normative criterion in s 68(1)(a)–(b). Depending upon the facts of the case, a person with mental illness may lack that insight or otherwise not accept or believe that the person has a mental illness or needs treatment yet may have the capacity to give informed consent when assessed under the statutory test. The opposite may be so.

(9) Lack of the capacity to give informed consent must be established according to the *Briginshaw* standard.

(10) The provisions of the *Mental Health Act* are predicated upon the central purpose of ensuring that persons with mental illness have access to and receive medical treatment, consistently with the person's right to health. Where, consistently with the above principles, it is established that the patient does not have the capacity to give informed consent and there is no less restrictive way for the patient to be treated, VCAT must grant an application for ECT (s 96(1)(a)) because, under the legislative scheme and subject to its safeguards, this is a necessary means of ensuring that the patient is given that treatment.

207 Before determining the grounds of appeal, I will deal with a discrete submission about the relationship between ss 68 and 69.

Distinguishing *capacity* to give from *giving* informed consent: ss 68 and 69

208 For a person to have 'capacity to give informed consent', s 68(1)(b) and (c) of the *Mental Health Act* requires the person have the ability to remember and use or weigh the 'information that is relevant to the decision'. Paragraph (a) refers to information that the patient 'is given' that is so relevant. Section 69(2) contains guiding principles for determining this question. Section 69(3) specifies when a person has been given a reasonable opportunity to make a decision. The definition of 'capacity to give informed consent' in s 3(1) refers to the meaning of that term in s 68.

209 It was submitted for PBU and NJE that the 'information that is relevant to the decision' under s 68(1)(a), (b) and (c) is the 'adequate information' that must be given to the patient under s 69(1)(b) and (2). I do not accept that submission. For the following reasons, *capacity* to give informed consent under s 68(1) is different to *giving* informed consent under s 69(1)–(3) and the information base is not necessarily the same, although it may overlap.

210 Section 69(1) specifies when a person gives informed consent:

> (1) For the purposes of treatment or medical treatment that is given in accordance with this Act, a person gives *informed consent* if the person—
>
> (a) has the capacity to give informed consent to the treatment or medical treatment proposed; and
>
> (b) has been given adequate information to enable the person to make an informed decision; and
>
> (c) has been given a reasonable opportunity to make the decision; and
>
> (d) has given consent freely without undue pressure or coercion by any other person; and
>
> (e) has not withdrawn consent or indicated any intention to withdraw consent.

It can be seen that, to give informed consent, the person has to have the capacity to do so with respect to the proposed treatment, not generally (para (a)). The words in italics call up the definition of 'informed consent' in s 3(1), which refers to the meaning of that term in s 69. 'Capacity to give informed consent' and 'informed consent' are separately specified in s 3(1).

211 Under s 69(2), a procedure must be followed before the person can be one who has been given adequate information to make an informed decision under s 69(1)(b):

> (2) For the purposes of subsection (1)(b), a person has been given adequate information to make an informed decision if the person has been given—
>
> (a) an explanation of the proposed treatment or medical treatment including—
>
> (i) the purpose of the treatment or medical treatment; and

(ii) the type, method and likely duration of the treatment or medical treatment; and

(b) an explanation of the advantages and disadvantages of the treatment or medical treatment, including information about the associated discomfort, risks and common or expected side effects of the treatment or medical treatment; and

(c) an explanation of any beneficial alternative treatments that are reasonably available, including any information about the advantages and disadvantages of these alternatives; and

(d) answers to any relevant questions that the person has asked; and

(e) any other relevant information that is likely to influence the decision of the person; and

(f) in the case of proposed treatment, a statement of rights relevant to his or her situation.

The information and other steps in the specified procedure are detailed and clearly directed at implementing the purposes of the objective in s 10(d) and the principle in s 11(1)(c) (among others) (see above).

212 Under s 69(3), a procedure must be followed before the person can be one who has been given a reasonable opportunity to make a decision under s 69(1)(c):

(3) For the purposes of subsection (1)(c), a person has been given a reasonable opportunity to make a decision if, in the circumstances, the person has been given a reasonable—

(a) period of time in which to consider the matters involved in the decision; and

(b) opportunity to discuss those matters with the registered medical practitioner or other health practitioner who is proposing the treatment or medical treatment; and

(c) amount of support to make the decision; and

(d) opportunity to obtain any other advice or assistance in relation to the decision.

This procedure is directed at implementing the participatory purposes in ss 10(d) and 11(1)(c) (among others). In this context, the requirement that the person be given a 'reasonable … amount of support to make a decision' is particularly

important because it reflects the emphasis on supported decision-making in the CRPD and contemporary disability rights law (see above).

213 As discussed above, to satisfy the requirements of s 68(1)(a), (b) and (c), the person needs to understand the information relevant to the decision and be able to use or weigh the information only in terms of the general nature, purpose and effect of the treatment. This is a low threshold. It is not necessary for the person to have a detailed understanding of the treatment or be able to make a well-considered decision. The function of the test of capacity in s 68(1) is to enable determination of whether the person has capacity to give informed consent according to that standard. To interpret the phrase 'the information that is relevant to the decision' in s 68(1)(a)–(c) by reference to the information that must be supplied and the opportunity that must be given under s 69(1)(b) and (2)–(3) would increase the threshold of capacity and not be consistent with the person's equal right to self-determination, to be free of non-consensual medical treatment and to personal inviolability.

214 By contrast, to satisfy the requirements of s 69(1)(b)–(e), the person must be given adequate information and a reasonable opportunity to make a decision, and have actually given free consent that has not been withdrawn. These requirements are directed at ensuring that a person with capacity to give informed consent is provided with information that is adequate, and an opportunity that is reasonable, for the purpose of exercising that capacity, and for giving that kind of consent freely without withdrawal, if the person choses to do so. Where these things are done and free consent is given without withdrawal, the requirements are satisfied.

215 The distinction between having the *capacity* to give informed consent and *giving* or *not giving* informed consent is consciously employed in the legislative scheme. For example, in s 71(1)(a)(i) and (ii), a distinction is drawn between a person not having the capacity to give informed consent and a person having that capacity but not giving it. With both categories of person, an authorised psychiatrist may make

treatment decisions where there is no less restrictive way for the patient to be treated (s 71(3)–(4)), as long as the treatment is not ECT or neurosurgery (s 71(1)(b)).

216 The distinction is critical in relation to ECT. Under the legislative scheme, an authorised psychiatrist may perform ECT on a patient who has capacity to give informed consent and who gives that consent (ss 70(1)–(3), 69(1)–(3), 92(1)(a)). A person who has that capacity can refuse to give that consent and this choice must be respected. The authorised psychiatrist can make application for ECT approval to VCAT (and the MHT) only in respect of a patient who does not have the capacity to give informed consent (ss 93(1)(a) and 96(1)(a)(i)).

217 The common law recognises the distinction between having the capacity to give consent for medical treatment and being given the opportunity to give informed consent for that treatment. As discussed above, if bodily treatment is not to be a civil or criminal assault, the doctor must seek and obtain the consent of the patient for the treatment (except in emergency cases). To give this consent, the patient must be able to understand in general terms the nature, purpose and effect of the treatment.[273] It is sufficient for the doctor to provide advice and information to the patient in those terms, which the patient can ignore if the patient wishes to do so.[274]

218 There is a separate and additional tortious duty upon a doctor under the law of negligence to put the patient in the position of being able to make an informed decision if the patient chooses to make an informed decision. The scope of this duty was identified in *Rogers v Whitaker*:

> The law [recognises] that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[275]

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273 *Reeves v The Queen* (2013) 88 ALJR 215, 221 [35] (French CJ, Crennan, Bell and Keane JJ).
274 *Sidaway* [1985] 1 AC 871, 904 (Lord Templeman).
275 (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

219 Pursuant to this duty, the doctor must provide 'relevant information and advice' to the patient.[276] The provision of this information and advice goes to whether the doctor has performed the tortious duty of putting the patient in the position of being able to give informed consent, where the patient chooses to make an informed decision, not to whether the patient has given consent at all such that the treatment is not a civil or criminal wrong. Where a doctor is sued in negligence for non-compliance with the duty, it would be a valid defence that the doctor had provided the necessary information and advice to the patient.

220 The purpose of ss 69(1)(b)–(c) and 69(2)–(3) is to facilitate and maximise effective participation by persons with mental illness in treatment decision-making, to support and enhance the exercise of the person's legal capacity and ultimately to give effect to the person's right to self-determination, to be free of non-consensual medical treatment and to personal inviolability. But, for a person with capacity to give informed consent under s 68(1), it is up to the person to choose how to proceed in the light of the information given and steps taken under s 69(2)–(3). Determination of capacity under s 68(1) is an anterior and independent question. The information bases may overlap, but the relevant information for the purposes of s 68(1) is not interpreted expansively to include that which is covered by s 69(2)–(3).

221 I now directly address the grounds of appeal.

DETERMINATION OF NO CAPACITY TO GIVE INFORMED CONSENT

Grounds of appeal

222 The authorised psychiatrists made applications under s 93(1) of the *Mental Health Act* that VCAT grant approval for PBU and NJE to be given ECT. Section 96(1) sets out VCAT's obligations in relation to such applications:

> (1) In relation to an application made under section 93, the Tribunal must—
>
> (a) grant the application if the Tribunal is satisfied that—

276 Ibid 489.

(i) the patient does not have the capacity to give informed consent; and

(ii) there is no less restrictive way for the patient to be treated; or

(b) refuse to grant the application if the Tribunal is not satisfied as to the matters referred to in paragraph (a).

223 The grounds of appeal relate to the way in which VCAT performed these obligations in determining that PBU and NJE did not have the capacity to give informed consent (para (a)) and that there was no less restrictive way for them to be treated (para (b)). In this part of the judgment, I will consider the grounds of appeal that relate to capacity to give informed consent (common grounds 1, 2 and 3(a) (PBU) and ground 6 (NJE): see above). In the next part of the judgment, I will consider the ground that relate to the no less restrictive treatment requirement (common ground 5).

Contentions of parties

224 The primary contention advanced on behalf of PBU and NJE was that, in both cases, VCAT erred in law when interpreting and applying s 68(1)(a)–(d) of the *Mental Health Act* by requiring the patient to accept or believe the diagnosis of their illness and need for treatment before they could be regarded as having the capacity to give informed consent. The submission was developed in various ways by reference to the language and purpose of the *Mental Health Act* and human rights considerations arising under the Charter. The Secretary accepted that it would be an error of law to interpret or apply the capacity test in this way and submitted that, in the case of PBU, VCAT did not necessarily do so and that, in the case of NJE, it did not do so.

225 In the case of NJE, it was additionally submitted that VCAT erred in law by directing itself that s 68(1)(c) required a person carefully to consider the advantages and disadvantages of a situation or proposal prior to making a decision. The Secretary accepted that it would be an error of law to interpret or apply that provision in this way and submitted that VCAT did not necessarily do so and, if it did, it may not have affected the outcome.

Belief of and insight into the diagnosis and need for treatment

226 Section 96(1)(a) required VCAT to determine whether it was satisfied that PBU and NJE did not have capacity to give informed consent, starting with the presumption in s 70(2) that they did. This responsibility took VCAT to the test in s 68(1)(a)–(d), which required it to determine whether or not PBU and NJE understood and were able to remember and use or weigh the relevant information and communicate a decision.

227 I discussed in the previous section a number of principles relating to the interpretation and application of the test of capacity in s 68(1)(a)–(d). One of these is that, to rebut the presumption of capacity, it is not sufficient to find that a person does not accept or believe the diagnosis that the person has a mental illness or that the person has no insight into the need for treatment. According to the statutory criteria, a person may not have that acceptance, belief or insight yet may have capacity to give an informed consent, although these matters may be factually relevant in the overall consideration. This is important if the capacity criteria and are to be applied in a manner that is non-discriminatory towards and respects the autonomy space of people with mental illness.

228 In the case of PBU, VCAT accepted the contention of the clinical director of the hospital that PBU did not have capacity because he did not accept the diagnosis of schizophrenia in relation to him (see above). VCAT determined that, 'where [PBU] did not accept the diagnosis for which the treatment was intended to be given', he 'did not have capacity to give informed consent'. This language suggests that VCAT considered that PBU's lack of acceptance of the diagnosis was tantamount to determinative.

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.

230 PBU's position was very similar to that of the person in question in *Starson*. There, the one-sided capacity assessment incorrectly focussed upon whether 'Professor' Starson did not accept the diagnosis and on what insight he did not have, without properly considering the relevance of what he did accept about his mental ill-health and the insight that he did have, and how this influenced his ability to understand and use or weigh relevant information.[277]

231 It is of the first importance that the test of capacity in s 68(1)(a)–(d) is applied in a way that does not discriminate against people with mental disability upon that ground, implicitly or explicitly. For anybody, mentally disabled or not, 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 (see above), and it is not under these provisions. As discussed, for a variety of reasons, people have deficiencies of belief, acceptance or insight in relation to the need for medical treatment that to others defy reality. Out of respect for the diversity of humanity and the dignity of risk, the capacity of people not having mental disability is not denied for that reason alone, and it would be discriminatory to deny people with mental disability the same respect. Giving that respect is consistent with ensuring the equal right of people with people with mental disability to self-determination, to freedom from non-consensual medical treatment and to personal inviolability.

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277 [2003] 1 SCR 722, 755 [67], 768 [95] (Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ).

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.

234 I accept the submissions of the Secretary that the reasons for decision of VCAT in the case of NJE reveal that it did not make an error of law of this kind. VCAT explicitly considered each of the criteria in s 68(1)(a)–(d). It found that NJE understood and had the ability to remember the relevant information and communicate a decision (see above). It found that NJE did not have the ability to use or weigh the information. Although some language in the reasons for decision suggests that this conclusion might have been based upon PBU's non-acceptance of the diagnosis, read fairly and as a whole, I think that this was treated as relevant, not determinative. The error of law that VCAT committed in the case of NJE related to the threshold of capacity.

Threshold of capacity and function-based capacity assessments

235 As we saw in the last section, the threshold of capacity in s 68(1)(a)–(d) is relatively low. It requires the person to have an understanding of and an ability to remember and use or weigh relevant information, and communicate a decision, in broad terms

as to the general nature, purpose and effect of the treatment. It does not require the person to have an ability to use or weigh relevant information in every detail but only as to the salient features and in those terms. The capacity test at common law is applied upon this basis and it would be discriminatory to expect people with mental disability to function or have an ability to function at a higher level than that.

236 Further, it is a fundamental principle of the common law, to which ss 11(1)(d) and 68(2)(d) of the *Mental Health Act* give expression, that a person with mental illness is not to be denied capacity only by reason of making a decision that some may consider to be unwise or irrational. People, whether having mental illness or not, have the freedom to choose whether to make a rational or balanced decision and, under s 68(1)(c), the question is whether the person has the ability to use or weigh relevant information, not whether the person is capable of making a rational and balanced decision or has actually done so. This principle contributes to ensuring respect for the human rights of all people, whether having mental disability or not, to self-determination, to be free of non-consensual medical treatment and to personal inviolability.

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 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.

239 Respect for the right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, and for the dignity of the person, underpin both the common law test of capacity and the criteria in s 68(1)(a)–(d). It is for this reason that a functional approach has been adopted to testing capacity, one that leaves a person with the freedom to choose whether to make a rational and balanced decision if the person chooses to do so. The criteria do not instantiate a best-interests or reasonable-outcome test and the capacity assessor must be careful not to allow the mandated functional assessment to degenerate into one (see above). In particular, the criterion in para (c) is whether the person has the ability to 'use or weigh' relevant information, not whether the person has actually done so, to a careful-consideration standard or at all. The test in para (c), so understood, is not the test that VCAT actually applied.

240 Respect for the right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, and for the dignity of the person, is also reflected in the relatively low threshold of capacity to which the test at common law and the provisions of s 68(1)(a)–(d) give effect. Many people, whether mentally disabled or not, lack the experience, knowledge and objectivity that is necessary for them to understand relevant information and to be able to make decisions relating to their own medical treatment in a detailed, rational and balanced way. But most people, whether mentally disabled or not, can understand relevant information and are able to make decisions in broad terms as to the general nature, purpose and effect of the treatment. The criterion in para (c) does not apply such that the person must be able to 'use or weigh' the relevant information to the standard of requiring the person 'to carefully consider the advantages and disadvantages of a situation or proposal before making the decision', as VCAT stated.

241 While the discussion by VCAT of NJE's circumstances is very sympathetic, it is heavily influenced by best-interest considerations. I refer in particular to VCAT's expression of 'concern' that NJE spends several nights per week without sleep because she is working with psychic healing powers. I take this to be a response to evidence that NJE was frequently active and awake during the night for that reason. VCAT did not expressly relate this expression of concern to any of the criteria in s 68(1)(a)–(d). But the only criterion in issue was para (c) ('use or weigh'), so it must have been related to that one.

242 A person may be frequently active and awake at night due to a desire to work with psychic healing powers. This may or may not help to support a finding that the person does not have the ability to use or weigh relevant information. 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. Even then, the person may be able to use or weigh relevant information in relation to ECT (and the subjective value of the belief or behaviour to the patient must count in determining whether there is no less restrictive way to treat the patient, having regard to the patient's views and preferences, where this is reasonable: see below). 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.

243 It was submitted for the Secretary that any mistake by VCAT in this respect did not affect the outcome because it was open to VCAT to conclude that s 68(1)(a) (the understanding domain) was not actually satisfied. NJE's understanding of relevant information was in issue in the case. VCAT expressly decided this issue in NJE's favour. The court will not go behind that determination.

244 In the case of NJE, ground of appeal 6 will be upheld.

DETERMINATION OF NO LESS RESTRICTIVE TREATMENT

Ground of appeal

245 I here consider the ground of appeal relating to VCAT's interpretation and application of s 96(1)(a)(ii) of the *Mental Health Act* and its related provisions (common ground 5).

246 This ground relates to the relevance of the purposes of the treatment criteria in s 5(b) to the approval of ECT under s 96(1)(a)(ii) where the person does not have the capacity to give informed consent. PBU and NJE contend that VCAT erred in not having regard to those purposes whereas the Secretary contends that the criteria were not mandatorily relevant.

Statutory provisions

247 As discussed in the overview of the *Mental Health Act*, the criteria in s 5 operate as a gateway which must be opened before a person having mental illness may be subjected to compulsory treatment under treatment orders (ss 45 and 52).[278] The relevant criteria are specified in s 5(b) which, to repeat, are that:

> (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; …

[278] Section 5 specifies criteria that must be satisfied 'for a person to be made subject to a [treatment order]'.

248 When an authorised psychiatrist is determining whether to make application for approval of ECT in respect of an adult patient, s 93(1)(b) requires the authorised psychiatrist to be satisfied that there is no less restrictive way for the patient to be treated. Section 93(2) sets out a number of matters that must be considered when so determining. It provides that:

> the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following —
>
> (a) the views and preferences of the patient in relation to electroconvulsive treatment and any beneficial alternative treatments that are reasonably available and the reasons for those views or preferences, including any recovery outcomes the patient would like to achieve;
>
> (b) the views and preferences of the patient expressed in his or her advance statement;
>
> (c) the views of the patient's nominated person;
>
> (d) the views of a guardian of the patient;
>
> (e) the views of a carer of the patient, if authorised psychiatrist is satisfied that the decision to perform a course of electroconvulsive treatment will directly affect the carer and the care relationship;
>
> (f) the likely consequences for the patient if the electroconvulsive treatment is not performed;
>
> (g) any second psychiatric opinion that has been obtained by the patient and given to the psychiatrist.

These matters must also be considered when VCAT is determining the same issue under ss 96(1)(a)(ii) and 93(3). Cognate matters are specified in s 71(4), which applies when an authorised psychiatrist is determining whether to give compulsory treatment (that is not ECT or neurosurgery) to a patient who has the capacity to give informed consent but who refuses to give that consent in relation to treatment (see s 71(1)(a)(ii)).

249 Determining under s 96(1)(a)(ii) (or s 71(3)) whether there is no less restrictive way for the patient to be treated engages the fundamental human rights principles to which reference has already been made (see above). It is part of a system under which the patient may be compulsorily subjected to ECT (or other treatment). I have

said enough already about the human rights issues that arise in this general context. I will confine myself here to analysing aspects of the operation of the no less restrictive treatment test that are here pertinent.

No less restrictive treatment test

A 'no less restrictive treatment' test; not a 'best interests' test

250 The test in s 96(1)(a)(ii) of the *Mental Health Act* is deliberately expressed in terms of whether there is no less restrictive way for the patient to be treated, not in terms of whether ECT is in the patient's best interests. This is an important human rights safeguard that applies to other compulsory treatment (see eg s 71(3)). Enactment of the no less restrictive treatment test, along with the requirement to take the views and preferences of the patient into account (see next) and the provisions that promote supported decision-making,[279] represents a paradigm shift in the design of the mental health legislation. It is a shift away from the paternal model of decision-making that applied under legacy mental health legislation, which permitted such treatment compulsorily if warranted in the patient's 'objective' best interests. It is a shift towards recognition of persons with mental disability as dignified rights-bearers, not welfare cases,[280] whether or not they have the capacity to give or refuse informed consent. It gives effect to the statutory purpose of ensuring that persons have access to needed treatment in a way that brings recognition of that dignity and respect for those rights into the frame of reference in mental health treatment decision-making.

251 The no less restrictive treatment test corresponds to one element of the proportionality requirement which human rights law applies to ensure that interference with the exercise or enjoyment of human rights only occurs when justified.[281] This requirement is specifically included in s 7(2)(e) of the Charter. In

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279 See, eg, ss 10(d), 11(1)(c).

280 See generally Piers Gooding, *A New Era for Mental Health Law and Policy: Supported Decision-Making and the UN Convention on the Rights of Persons with Disabilities* (Cambridge University Press, 2017) 128–31.

281 This is sufficiently explained for present purposes in *Kracke* (2009) 29 VAR 1, 33–41 [98]–[144] (Bell J).

the compulsory treatment regime of the *Mental Health Act,* the test may be understood as a safeguard for the purposes of art 12(4) of the CRPD. The purpose of the test, with other provisions, is to ensure that interference with the exercise of the human right of patients to self-determination, to be free of non-consensual medical treatment and to personal inviolability, which compulsory treatment causes (see above), is justified in human rights terms.

252 The no less restrictive treatment test is therefore intended to operate under the *Mental Health Act* in a quite different way to the former best-interests test. It involves a different conception of the relationship between medical authority and the patient: it is one that respects, to a much greater degree, the patient's right to self-determination, to be free of non-consensual medical treatment and to personal inviolability; one that is intended positively to promote patient participation and supported decision-making; and one that, in appropriate cases, incorporates recovery (and not simply cure) as an important therapeutic purpose in a holistic consideration of the person's health (broadly understood) (see above).

253 However, the provisions of the *Mental Health Act* are predicated upon the central purpose of ensuring that persons with mental illness have access to and receive needed medical treatment (see ss 1(a), 10(a), 10(f), 11 and especially 72). Where it is established that the patient does not have the capacity to give informed consent and there is no less restrictive way for the patient to be treated, VCAT must grant the application for ECT (s 96(1)(a)) because, under the legislative scheme and subject to its safeguards, this is a necessary means of ensuring that the patient is given that treatment and their right to health is respected.

Views and preferences of patient

254 Section 96(3) requires VCAT (and the MHT) to apply s 96(1)(a)(ii) having regard to the matters specified in s 93(2), to the extent that is reasonable in the circumstances. The first of these matters is the 'views and preferences' of the patient. The requirement applies even though the patient has been found to lack the capacity to give informed consent.

255 The views and preferences of the patient to be considered under s 93(2)(a) are several and may relate to: ECT as such; any beneficial alternative treatments that are reasonably available; the reasons for the patient's views and preferences relating to ECT and any such other treatments; and recovery options that the patient would like to achieve.

256 Not only must the decision to approve or refuse ECT be based on whether there is a less restrictive way for the patient to be treated (not what is in the person's best interests); the decision must be made after taking into account the patient's views and preferences in respect of these matters, even where the person lacks the capacity to give informed consent. Also informed by human rights considerations (see above), the mandatory requirement that the patient's views and preferences be considered (to the extent that is reasonable in the circumstances) also represents a paradigm shift in the legislative design. It is a paradigm shift away from depriving patients lacking that capacity of any effective role in determining what should happen to them towards respecting patients' inherent dignity and humanity and their never-lost right to self-determination, to be free of non-consensual medical treatment and to personal inviolability. This is a mechanism for implementing the policy of the *Mental Health Act*, expressed in both the objectives and the principles, that the rights, dignity and autonomy of persons receiving mental health services should be respected and promoted (see ss 10(c)–(d), 11(1)(c)–(d), (f)) (see further art 12(4) of the CRPD). Those giving practical effect to the requirement to take the patient's views and preferences into account (including VCAT and the MHT) must engage with those objectives and principles,[282] which emphasise patient participation and supported decision-making.[283] These remarks also apply in relation to the compulsory treatment of patients who do not lack the capacity to give informed consent. For the same reasons, there is a mandatory requirement to take their views and preferences into account when determining whether there is a less restrictive way for them to be treated (s 71(3)–(4)).

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282 See s 11(2)–(3).

283 See, eg, ss 10(d), 11(1)(c).

257 A predicate of the requirement to take the patient's views and preferences into account when assessing whether there is no less restrictive way for the patient to be treated is that determination of that question is not simply a medical matter. The statutory intention is that views and preferences reflecting the values, life experience and relationships of the patient in the 'wider sense, not just medical but social and psychological',[284] will be included in what may be described as a holistic consideration of the issue. This is closely connected to the two-way relationship that exists between self-determination and health, to the concept of 'recovery' which is recognised in various provisions, and to the emphasis in the legislative scheme upon enabling participation and supported decision-making (see above). Approaching the application of s 96(1)(a)(ii) in a way that focusses upon medical considerations to the exclusion of personal and social considerations, and doing so in a way that does not enable effective participation by or support of the patient where this is reasonable and possible, may therefore be too narrow in a particular case. As a patient's health, medical treatment and self-determination are interrelated, this can cut both ways: discriminatory denial of capacity and paternalistic medical treatment can undermine patients' dignity, autonomy and prospects of recovery in the long term; but, subject to safeguards, compulsory medical treatment may presently be necessary as a last resort to improve those prospects and contribute to the realisation of patient autonomy and self-actualisation.

258 That brings me to the decisions of VCAT in the two cases.

VCAT decisions in PBU and NJE applying s 96(1)(a)(ii)

259 In the applications before VCAT for approval of ECT, it was submitted on behalf of PBU and NJE that they did not need immediate treatment to prevent serious deterioration of mental or physical health or serious harm to them or another person (s 5(b)(i) and (ii)) and that maintaining the current treatment was a less restrictive

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284 *Aintree University Hospitals* [2014] AC 591, 607 [39] (Baroness Hale DPSC, Lord Neuberger PSC, Lord Clarke, Lord Carnwath and Lord Hughes JJSC agreeing) (referring to an analogous requirement when conducting a 'best interests' analysis under s 4 of the *Mental Capacity Act*); see also *Sheffield Teaching Hospitals NHS Foundation Trust* [2014] EWCOP 4 (22 May 2014) [55] (Hayden J).

way for them to be treated. VCAT rejected this submission and held that the treatment criteria in s 5(b) were not relevant to whether there was any less restrictive way for them to be treated under s 96(1)(a)(ii).

260 In the case of PBU, VCAT placed emphasis upon the need for the treatment to be beneficial:

> When considering whether there is no less restrictive way for the patient to be treated, the matters in section 93(2) must be considered. Relevant here, section 93(2)(a) requires me to consider PBU's views and preferences in respect of any *'beneficial'* alternative treatments. Taking into account the meaning of *'treatment'* under section 6, I read the reference to *'beneficial alternative treatments'* as a reference to treatments which alleviate the symptoms *and* reduce the ill effects of the person's mental illness. That is consistent also with mental health principle 11(1)(b) which refers to services which aim to bring about the best possible therapeutic outcomes. Section 93(2)(f) requires me to consider the likely consequences of ECT not being performed.
>
> The evidence before me supports a finding that PBU's mental health will not improve if he continues as is. I have difficulty with the contention that plateauing means that there should be no change where PBU is demonstrably very ill and unable to be discharged from hospital in his current condition. Continuing hallucinatory or like experiences are consistent with the evidence that PBU is very unwell despite his current treatment regime. On the evidence before me it seems to me that continuing in the same way amounts to an indefinite stay in hospital with limited leave options and no prospect for progression in health or life for PBU. I make those comments taking into account the fact that the diagnosis of treatment resistant schizophrenia has not been challenged by any medical evidence. I also take into account the fact that, under the MH Act, treatment is intended to remedy illness or alleviate symptoms and reduce ill effects of illness.

261 For PBU, the preferred and available alternative treatment was to continue the same medication and for the treating team to continue its efforts to engage with him and give weight to his views as to the proper diagnosis. VCAT acknowledged that preference.

262 VCAT made it clear that it was not deciding that maintaining the treatment status quo could never constitute a less restrictive way of treating the patient:

> Treatment under the MH Act is intended to remedy the person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness. The aim of providing a mental health service such as treatment is to bring about the best possible therapeutic outcomes and to promote recovery and full participation in community life.

> Looked at in this way, treatment that maintains the person (that is, avoids their mental health deteriorating) may not be sufficient. It may be sufficient treatment if it is part of a plan which is intended to lead to recovery by allowing time for consideration and discussion so the person may better participate in decision making. That is what the MHT seemed to have in mind in *NLK*. If, however, the maintenance of current treatment does not improve the person's mental health and is not part of a plan which will lead to improvement in a reasonable time, arguably it may not properly be regarded as treatment within the definition in section 6 or meet the section 72 imperative to provide treatment.

The case of *NLK* was one in which the MHT had decided that, in the factual circumstances, it was not satisfied that there was no less restrictive way to treat the patient:

> However, on balance the Tribunal was not satisfied there was no less restrictive way for NLK to be treated at the time of this hearing. It was noted in the report that a course of ECT would take some time to take effect, confirming that whatever is the next step in NLK's treatment, his recovery will not be rapid. In that context, and given his mental state was regarded as having plateaued, it seemed reasonable to take time to have further discussions with NLK and AA, pursue a second psychiatric opinion and make contact with NLK's private psychiatrist.[285]

263 In the case of NJE, VCAT (differently constituted) followed the decision in PBU that s 5(b) was not relevant to the application of s 96(1)(a)(ii), placing the same emphasis upon the need for the alternative treatment to be beneficial.

264 For NJE, the preferred and available alternative treatment was to remain in hospital and continue to receive depot and other prescribed medication. She feared that ECT would interfere with her psychic powers which, VCAT acknowledged, 'she values'.

Submissions in appeal proceedings

265 In these appeals, as before VCAT, it was argued for PBU and NJE that VCAT erred in law by failing to take into account the purposes specified in s 5(b) when deciding whether less restrictive means of treatment were available under s 96(1)(a)(ii). Therefore, when deciding whether ECT was the least restrictive means of treatment, it was necessary to consider whether the purpose of the treatment was to provide

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285 [2016] VMHT 19 (9 March 2016) 4(b) (Matthew Carroll, Legal Member; Dr S Carey, Psychiatrist Member; V Spillane, Community Member).

immediate treatment that the person needed to prevent or address serious deterioration in health or serious harm to the person or another (s 5(b)). It was not that, when deciding whether to approve ECT, the treatment criteria were [re]assessed under s 6 as a discrete step, but (as counsel put it) that 'you can't abandon serious deterioration as an object and move to complete alleviation of symptoms'. It was submitted that the issue was not really whether ECT and the alternative treatment were 'treatment' under s 6, but whether the treatment was directed at the protective purposes underlying the criteria in s 5(b).

266 In counsel's submissions, under s 96(1)(a)(ii) (read with s 93(2)), the question which VCAT should have addressed, but did not, was: 'Is ECT the less restrictive way that the person can be treated to address the harm in s 5(b)(i) and (ii)? Not to immediately prevent them, but to address them …'. The issue was not: 'Is [ECT] the best way of … getting the person out of hospital?' It was submitted that the treatment for mental illness that patients must be given 'in accordance with the Act' under s 72 was treatment for the purposes inherent in s 5(b)(i) and (ii). In counsel's submission, persons in the position of PBU and NJE as compulsory patients remained as such because of the continuing applicability of the treatment criteria in s 5.

267 Counsel emphasised that he was not submitting that all treatment of a patient under the *Mental Health Act* had to be directed at the purposes of s 5(b). It was rather that, when ECT was in question, these purposes were relevant when determining whether a less restrictive way was available to treat the patient under s 96(1)(a)(ii) (with s 93(2)). Compulsory treatment of the patient was justified because the treatment criteria in s 5 continued to apply and subsequent treatment should not be at odds with the purposes of those criteria.

268 To the determination of this issue I now turn.

Relevance of purposes of treatment criteria in s 5(b) to less restrictive treatment assessment

269 I accept the Secretary's submission that the assessment of whether there is a less restrictive way for the patient to be treated under s 96(1)(a)(ii) does not require consideration of the purposes of the treatment criteria in s 5(b). In both cases, VCAT correctly so decided. The requirement that a treatment be the least restrictive available does not mean that the patient is to be treated to a minimum threshold or receive minimal treatment to address or prevent serious deterioration of health or serious harm.

270 This conclusion is supported by the express language of ss 96(1)(a)(ii) and 93(2) to which VCAT must have regard under s 96(3)(a). These provisions are self-contained and there is simply nothing in the text to indicate that the purposes of s 5(b) operate as an influence upon the assessment that must be carried out. It is the same with s 71, where the issue arises in relation to a patient who has capacity to give informed consent but refuses to give it.

271 The function of s 5 in the statutory scheme is to specify gateway criteria that must be satisfied before a person can be 'subject to a Temporary Treatment Order or Treatment Order', to use the opening words of the provision. As we saw in the overview of the *Mental Health Act* (see above), temporary treatment orders (s 46(1)(b)) and treatment orders (s 55(1)(a)–(b)) can only be made in respect of persons who satisfy the treatment criteria specified in that section. Once the person becomes so subject, the person is liable to be treated voluntarily or involuntarily according to the operative provisions of the *Mental Health Act*. The treatment criteria in s 5 have continuing relevance as a safeguard against unwarranted compulsory treatment and thereby serve an important protective human rights function. For example, an authorised psychiatrist who determines that the treatment criteria do not apply to the person must immediately revoke the order (s 61). But the purposes of the criteria do not control the treatment that may be administered to a patient after entry to and before exit from the treatment system, which is regulated by other provisions.

272 Tying assessment of treatment under ss 96(1)(a)(ii) and 93(2) to the protective purposes of the treatment criteria in s 5 is inconsistent with ensuring that the patient is given treatment for mental illness, which s 72 positively requires, and more broadly with the patient's right to health. As we have seen, it is the first purpose of the *Mental Health Act* that persons with mental illness receive treatment for that illness (s 1(a)), which is also reflected in the objectives (see s 10(a)–(b), (f)) and principles (see s 11(1)(a)–(c)). The treatment that must be so provided is that which is the least restrictive way for the patient to be treated having regard to the medical and related needs, and (where it is reasonable in the circumstances) the views, preferences and recovery aspirations of the patient. Regard must also be had to the likely consequences if ECT (or other proposed treatment) is not performed (ss 93(2)(f) and 71(4)(h)). The treatment is not limited to that which is immediately necessary to address a serious deterioration in the person's mental or physical health or risk of serious self-harm or harm to another. I am not suggesting that, in particular circumstances, there might not be sound reasons under ss 96(1)(a)(ii) and 93(2) (not under s 5(b)) for taking into account what may or may not be necessary immediately to prevent or address a serious deterioration in the person's mental or physical health or a risk of serious harm to the person or another. But the assessment that must be carried out under those provisions is not controlled by those narrow purposes.

273 Tying assessment of treatment to the purposes of the treatment criteria is also completely inconsistent with the obligations of doctors, including doctors in hospitals, under the common law as it governs the doctor-patient relationship. The doctor has a positive duty to take reasonable care of the patient and this applies whether the patient has the capacity to consent to or refuse treatment or not. This is a duty to take reasonable care to provide treatment that is in the patient's best interests,[286] not merely to provide treatment for the purpose of preventing or

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286 *R (Burke) v General Medical Council* [2006] QB 273, 296–7 [32] (Lord Phillips MR, Waller and Wall LJJ), endorsing the analysis of Munby J in *R (Burke) v General Medical Council* [2005] QB 424, 454–5 [82]–[87].

managing an immediate deterioration in health or a risk of harm. The provisions of the *Mental Health Act* relating to treatment of patients for mental illness regulate aspects of the doctor-patient relationship in the mental health setting. For example, s 96(1)(a)(ii) (and s 71(4)) specifies a less restrictive treatment test in place of a best-interests test. But the purpose of doing so is to ensure the provision of treatment in a manner that respects the human rights of patients, not to reduce the standard of care that the doctor must provide to a level that is inconsistent with those rights. The issue arising under ss 96(1)(a)(ii) is whether, other than ECT, there is any less restrictive way for the patient to be treated for mental illness for the purpose of meeting the need of the patient for that treatment (broadly understood), taking into account the views and preferences of the patient and the other matters in s 93(2) (see above). This assessment is not constrained by the much narrower purposes of the treatment criteria in s 5, including para (b), which serve a different function in the statutory scheme.

274 There was an apprehension evident in the submissions made for PBU and NJE that, in the case of PBU, VCAT had cast a shadow of doubt over the legitimacy of the treatment status quo as a less restrictive treatment alternative under ss 96(1)(a)(ii) and 93(2). While there is emphasis in VCAT's reasons for decision on treatment needing to be positively beneficial in terms of s 6(a) (see above), I do not think VCAT intended to cast any such doubt. The maintenance of the treatment status quo might be a legitimate less restrictive way for the person to be treated under these provisions. Whether it is so is very much a question for evaluation in the individual circumstances of the case, having regard to the considerations in s 93(2) to the extent that is reasonable in the circumstances. As I have emphasised, this is not simply a medical question and may incorporate the statutory concept of recovery.

275 Common ground of appeal 5 will therefore be rejected.

CONCLUSION

276 Because ECT is the application of electric current to specific areas of a person's head to produce a generalised seizure, the *Mental Health Act* does not permit it to be

imposed upon a person having mental illness who has the capacity to give informed consent unless the person actually gives that consent. The statutory test for determining whether the person has that capacity is satisfied where the person understands and can remember and use or weigh relevant information and communicate a decision. I have determined in these appeals that VCAT misinterpreted and misapplied this test in ways that undermined PBU and NJE's human right to self-determination, to be free of non-consensual medical treatment and to personal inviolability which are protected by the *Charter of Human Rights and Responsibilities Act*.

277 PBU 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 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. VCAT determined that PBU could understand and remember relevant information and communicate a decision in relation to ECT but could not use or weigh that information. After finding that PBU lacked the capacity to given informed consent and that, other than ECT, there was no less restrictive way for him to be treated, it ordered that he be compulsorily subjected to a course of that treatment.

278 NJE suffered from treatment resistant schizophrenia for which she received voluntary and involuntary treatment in the community and in hospital. After several extended involuntary stays in hospital, she was placed on a community treatment order, but it was revoked and she was placed on an involuntary treatment order. She wanted to remain in hospital and continue to receive depot and other prescribed medication but VCAT found that ECT provided the best chance of addressing the symptoms of schizophrenia. As in the case of PBU, VCAT determined that NJE could understand and remember relevant information and communicate a decision in relation to ECT but could not use or weigh that

information. It found that she lacked the capacity to given 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.

279 In the case of PBU, the central error of law was that VCAT determined that he did not have the capacity to give informed consent because he did not accept or believe, or have insight into, the diagnosis of his mental illness. For various personal, social and medical reasons, it is not uncommon for persons having mental illness *and* persons not having mental illness to deny or diminish their illness and the need for treatment. In both cases, lack of acceptance, belief or insight may be relevant when determining whether a person has the capacity to give informed consent, but it is only one consideration. It would be discriminatory to treat this consideration as determinative in relation to people having mental illness when it is not determinative in relation to people not having mental illness. In fact, PBU did accept that he had a mental illness for which he needed non-ECT treatment, but VCAT gave this little weight.

280 In the case of NJE, the central error of law was that VCAT determined that she did not have the capacity to give informed consent because she had not actually given careful consideration to the advantages and disadvantages of ECT. To have the capacity to give informed consent, it is not required of persons having mental illness, nor of persons not having mental illness, that they give, or are able to give, careful consideration to the advantages and disadvantages of the treatment. It is not required that they make, or are able to make, a rational and balanced decision in relation to the decision. 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. Personal autonomy and the dignity of the individual are at stake. A person does not lack the capacity to give informed consent simply by making a decision that others consider to be unwise according to their individual values and situation. To impose upon persons having mental illness a higher

threshold of capacity, and to afford them less respect for personal autonomy and individual dignity, than people not having that illness, would be discriminatory.

281 People with mental illness are highly vulnerable to interference with the exercise of their human rights, especially their right to self-determination, to be free of non-consensual medical treatment and to personal inviolability. In that connection, the judgment discusses the relationship between the *Mental Health Act* and the *Charter of Human Rights and Responsibilities Act* with particular reference to the *Convention on the Rights of Persons with Disabilities*. There is emphasis upon both the right to health of persons having mental illness and their right to self-determination, to be free of non-consensual medical treatment and to personal inviolability. The reforms of the *Mental Health Act* enacted in 2014 represent a paradigm shift away from best-interests paternalism towards recognition of persons having mental illness as equal rights-bearers, not dependant welfare cases. The purpose of the statutory test for determining whether a person with mental illness has the capacity to give informed consent is not to produce social conformity at the expense of personal autonomy for those people. However, because persons with mental illness must have access to needed treatment, compulsory ECT may be imposed when the person is properly found to lack the capacity to give that consent, and another statutory condition is satisfied.

282 The other condition is that, when a person having mental illness lacks the capacity to give informed consent, compulsory medical treatment, including ECT, cannot be imposed unless there is no other less restrictive way for the person to be treated. But persons 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 in the new legislation. The operation of this safeguard is discussed in the judgment, especially the importance of supporting the person meaningfully to express their views and preferences. But I

have not accepted the submission made for PBU and NJE that compulsory treatment must be confined to the purpose of immediately preventing serious deterioration in the person's mental or physical health or serious harm to the person or another. This would be incompatible with the person's right to health and the primary purpose of the *Mental Health Act*, which is to ensure that people with mental illness have access to medical treatment that is needed, not just desperately needed.

283 VCAT determined that PBU and NJE lacked the capacity to give informed consent and were therefore liable to receive compulsory ECT. In doing so, it erred in law by interpreting and applying the capacity test in the *Mental Health Act* incompatibly with the human rights of PBU and NJE under the Charter. The appeals will therefore be upheld and VCAT's orders in both cases are to be quashed. In substitution for those orders, the court will order that the orders of the MHT that PBU and NJE be subjected to courses of ECT are quashed. As the court has been informed that PBU and NJE are now being treated in the community and compulsory ECT is no longer being sought, there is no need for remitter orders.