

REJOINDER (RESPONSE TO ARTICLE BY CHRISTOPHER MAYLEA AND CHRISTOPHER RYAN)

MATTHEW CARROLL *

In 'Decision-Making Capacity and the Victorian Mental Health Tribunal' ¹ Drs Christopher Maylea and Christopher Ryan argue that the Victorian Mental Health Tribunal ('Tribunal') has an obligation to consider the assessment of a compulsory patient's decision-making capacity when determining whether or not to make a compulsory Treatment Order. Based on their interpretation of relevant legislation (the *Mental Health Act 2014* (Vic)) and a review of the Tribunal's published statements of reasons (that is, reasons for decision), the authors contend that the Tribunal makes an error by not meeting this positive obligation to take this matter into consideration.

This criticism is based on a fundamental misinterpretation of relevant law and a misunderstanding of the processes of the Tribunal. The authors failed to sufficiently recognise the distinctive features of the legislation that establishes the Tribunal and its processes. Their article also generates a misconception that by not focusing on their decision-making capacity, the perspectives of mental health consumers are not being considered as part of Tribunal hearings in Victoria.

The Tribunal welcomes scrutiny of its decisions and encourages investigation of its procedures and decision-making by actively co-operating with researchers and publishing de-identified statements of reasons. ² However, the published article misinterprets the relevant law and misrepresents decision-making by the Tribunal and must therefore be corrected.

INTERPRETATION OF THE MENTAL HEALTH ACT 2014 (VIC) (Austl)

As the authors acknowledge, some Australian jurisdictions have chosen to make decision-making capacity a central focus of the legislative criteria governing when a person can or cannot be compelled to receive treatment for a mental illness. After a lengthy, consultative review of the former *Mental Health Act 1986* (the former Mental Health Act'), Victoria chose not to do this. The Tribunal is very aware that this approach remains contested, and some stakeholders would have preferred an approach similar to that adopted elsewhere. For example, the West Australian *Mental Health Act 2014* (WA) expressly makes decision-making capacity a central consideration in determining

* Matthew Carroll is President of the Victorian Mental Health Tribunal.

¹ Christopher Maylea and Christopher James Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' [2017] *International Journal of Mental Health and Capacity Law* 87.

² Statements of reasons are prepared at the request of a party. In 2016-17, such requests were made in only 2.9 percent of conducted hearings. Statements of reasons are published on the AustLII website in accordance with the Tribunal's publication policy (<http://www.mht.vic.gov.au/statements-of-reasons/>) – Published statements of reasons account for an even smaller proportion of hearings. In 2016-17, 43.55 percent of statements of reasons were published, a figure that equates to 1.25 percent of the total hearings conducted by the Tribunal during that time period.

whether involuntary treatment orders can be made.³ However, like any other court or tribunal, the role of the Victorian Mental Health Tribunal is to interpret and apply the law as it is written, and not to reconfigure a clear legislative framework to introduce tests or provisions that were not included when the Victorian Parliament passed the Act.

The *Mental Health Act 2014* (Vic) ('the Act') is the legislation under which the Tribunal operates. Section 5 of the Act sets down four criteria that must be satisfied before a person can be the subject of a compulsory Treatment Order. In brief, these criteria specify that:

- (a) the person must have mental illness (section 5(a));
- (b) because of that mental illness the person must require immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to themselves or another person (section 5(b));
- (c) immediate treatment will be provided if an Order is made (section 5(c));
- (d) and there is no less restrictive means reasonably available to enable the person to receive the immediate treatment (section 5(d)).

None of these criteria include an assessment of a person's decision making capacity.

Nevertheless, the authors argue that the Tribunal must read into section 5 (and, in particular section 5(d), the 'least restrictive' criterion) a requirement to consider a person's decision-making capacity when deciding whether or not to make a compulsory Treatment Order. While their preferred approach to the conditions under which persons may receive compulsory mental health treatment is understandable, it is simply inconsistent with the language and structure of the Act as well as with the legal principles governing the interpretation of legislation.

Key principles of statutory interpretation in the context of the Act were recently addressed by the Supreme Court of Victoria. In *Daniels v Eastern Health* (*Daniels'* case) the Court identified four conditions that must be satisfied in order to read (or import) words into a statutory provision namely⁴:

- (a) the court must know the mischief with which the Act was dealing;
- (b) the court must be satisfied that by inadvertence Parliament has overlooked an eventuality which must be dealt with if the purpose of the Act is to be achieved;
- (c) the court must be able to state with certainty what words Parliament would have used to overcome the omission if its attention had been drawn to the defect; and
- (d) the modified construction (with the additional words) must be reasonably open and not be unnatural, incongruous or unreasonable and must be consistent with the statutory scheme.

Notably, the second and third conditions identified in *Daniels'* case make it inappropriate to adopt Maylea and Ryan's approach of importing a requirement of 'carefully considering' a person's decision-making capacity when determining whether

³ *Mental Health Act 2014* (WA) ss 25(1)(c), 25(2)(c).

⁴ *Daniels v Eastern Health* [2016] VSC 148 [11] (per McDonald J) quoting *Birmingham v Corrective Services Commission of New South Wales* (1988) 15 NSWLR 292, 299 (per McHugh JA) quoting *Wentworth Securities v Jones* [1980] AC 74, [105-6] (per Lord Diplock).

or not to make a compulsory Treatment Order.

Regarding the second condition, as previously noted, the Victorian Parliament did not include decision-making capacity as one of the criteria governing compulsory Treatment Orders, but this was not an inadvertent omission; instead, it expressly opted for a different formulation of the criteria for compulsory treatment. The deliberate nature of the omission of decision-making capacity as a criterion governing the making of compulsory Treatment Orders is demonstrated or reinforced by the fact that elsewhere the legislation includes provisions that do incorporate the consideration of decision-making capacity and/or the provision of informed consent:

Firstly

Decision-making capacity and the provision (or withholding) of informed consent must be considered in the context of the actual provision of treatment.⁵ Despite the contention of the authors these provisions do not bear upon the making of Treatment Orders by the Tribunal.

Secondly

When determining applications for an electroconvulsive treatment ('ECT') Order for an adult compulsory patient,⁶ the first question the Tribunal must consider is whether or not the person has capacity to give (or by implication withhold) informed consent for ECT.⁷ If the Tribunal decides a person has capacity it must refuse the application.⁸

Thirdly

In relation to the authorisation of neurosurgery for mental illness, the Tribunal cannot grant an application unless it is satisfied that the person who is to be treated has given informed consent in writing to the procedure.⁹

Fourthly

The Tribunal must consider decision-making capacity or the withholding of informed consent when determining applications concerning interstate transfer of treatment orders or interstate transfer orders.¹⁰

⁵ *Mental Health Act 2014* (Vic) ss 70, 71.

⁶ Decision-making capacity is also relevant to ECT applications beyond those concerning adult compulsory patients but this is the single largest group and the relevant point can be sufficiently illustrated by focusing on this cohort.

⁷ *Mental Health Act 2014* (Vic) s 96.

⁸ In 2016/17 the Tribunal refused 100 (14.5%) ECT applications, of those 41% were refused on the basis that the person had capacity to provide informed consent.

⁹ *Mental Health Act 2014* (Vic) s 102.

¹⁰ *Mental Health Act 2014* (Vic) ss 321, 323.

It is also relevant to note that the criteria for involuntary Treatment Orders enshrined in the former Mental Health Act did require consideration of a person's ability to consent to necessary treatment.¹¹ The particular approach in the former Mental Health Act was strongly criticised and was unlikely to have been replicated in the treatment criteria of a new Act. What is relevant for present purposes is that Parliament not only abandoned that approach, it also did not replace it with a differently formulated criterion regarding decision-making capacity. This, alongside Parliament's inclusion of specific provisions relating to decision-making capacity and/or informed consent elsewhere in the Act, demonstrates the absence of such an inclusion in the criteria governing compulsory Treatment Orders simply cannot be regarded as something that was inadvertently overlooked.

Additionally, the third condition identified in *Daniels'* case presents a further hurdle to the authors' suggestion that decision-making capacity be incorporated into the Tribunal's decision-making regarding compulsory Treatment Orders. As explained above, the Act is not silent in relation to decision-making capacity and informed consent – these concepts are incorporated in various parts of the Act. But where they are the Act employs very different formulations or approaches.¹² Consequently, it would be impossible to conclude with the requisite degree of certainty what words or approach Parliament would have employed if it were to include decision-making capacity within the criteria governing the making of compulsory Treatment Orders.

Thus, principles of statutory interpretation, including the implications of the *Charter of Human Rights and Responsibilities Act 2006* (Vic),¹³ do not support reading in decision-making capacity to section 5 of the Act as contended by the authors.

Consequently, it is unsurprising that the majority of Statements of Reasons published by the Tribunal which were examined by the authors did not refer to the 'decision-making capacity' of the person. In summary, this is not a relevant criterion listed in the Act nor is it legitimately imported by principles of statutory interpretation.

CONSIDERING THE VIEWS OF MENTAL HEALTH CONSUMERS

It is important to note that although the Act does not include decision-making capacity of the person as a requisite consideration for the making of compulsory Treatment Orders, the Act does not disregard the views and preferences of the person. Indeed,

¹¹ *Mental Health Act 1986* (Vic) s 8(d).

¹² For example, in some cases the Tribunal's task is to determine whether the person has given informed consent rather than whether they have capacity to give informed consent (noting that capacity to give informed consent is merely one of the requirements of informed consent (see — s 69(1)(a))). Examples of such sections include: s 102(2)(a) pertaining to the Tribunal's powers in respect of an application for neurosurgery for mental illness and s 96(2)(a)(i) relating to ECT applications involving young persons who have capacity to give informed consent. In other cases, the test the Tribunal must apply is drafted in terms of 'the person does not have capacity to give informed consent or does not consent...' Examples of such provisions are ss 321(4)(ii) and 323(4)(a)(ii) involving applications for interstate transfer for community patients and inpatients respectively.

¹³ See —*Daniel's* case, paras (7) and (8).

the Act requires the Tribunal, in its decision making, to consider the views and preferences of the person receiving treatment and those who support them.¹⁴ To meet this obligation the Tribunal is committed to conducting *solution-focused* hearings. The Tribunal's *Guide to Solution-Focused Hearings in the Mental Health Tribunal*¹⁵ is based on the work of Dr Michael King, a former West Australian and now Victorian Magistrate who has been instrumental in articulating a framework of practice for the specialist 'problem-solving' lists in Magistrates' Courts.¹⁶

A solution-focused approach recognises that a unique series of experiences and events precedes a person being a compulsory patient at a particular point in time, and if they are willing or wish to explain some of that, it is relevant and important for them to have the opportunity to do so. A solution-focused approach also challenges everyone to remember that compulsory treatment should never be regarded as an ongoing norm for any individual. Where possible there should be exploration of a pathway to less restriction and greater autonomy for individuals – including what voluntariness truly means in the context of each person's circumstances, taking into account that people should be allowed to make decisions that involve a degree of risk.¹⁷

An important clarification regarding solution-focused hearings is that the Tribunal is not to be regarded as the source of solutions. Rather a solution-focused approach facilitates a process that can provide an opportunity for those involved in hearings (mental health consumers, their support people and clinicians) to explore issues and potential strategies to address difficulties. In some cases it may simply be about timing – seizing an opportunity to discuss issues that hasn't presented itself before.

Two case studies illustrate this approach and how the views and preferences of mental health consumers are taken into account.

Rebecca* was distressed by the side-effects of her antipsychotic medication, in particular its impact on her artistic work; she was also concerned about the lack of a referral to a psychologist as part of her treatment plan, and that her clinical history contained incorrect information. Rebecca's treating team had asked the Tribunal to make a 12-month Community Treatment Order. Based on the discussion at the hearing where Rebecca and her treating team agreed on a strategy to address her concerns,

¹⁴ For instance, among other factors, s 55(2) requires the Tribunal, to the extent that is reasonable in the circumstances, to have regard to (a) 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; and (e) the views of the person's carer, if the Tribunal is satisfied that making the Order will directly affect the carer and the care relationship. Similar provisions requiring the Tribunal to have regard to the views of patients and carers are contained in ss 65(4), 93(2), 94(3), 281(4), 291(2), 321(3) and 323(3). (Many of these refer to obligations of the authorised psychiatrist but provisions specifying the Tribunal's powers make it clear that the Tribunal must also consider these factors)

¹⁵ The *Guide to Solution-Focused Hearings in the Mental Health Tribunal* is available on the Tribunal's website: www.mht.vic.gov.au/forms-and-publication/guidance-materials/

¹⁶ Dr King's *Solution-Focused Judging Bench Book* is available here: aija.org.au/wp-content/uploads/2017/07/Solution-Focused-Judging-Bench-Book.pdf.

¹⁷ *Mental Health Act 2014* (Vic) s 11(1)(d).

the Tribunal made a much shorter 12-week Order, as Rebecca should be able to be treated voluntarily if these issues were resolved.

Jacob's* treating team asked the Tribunal to make an Order that would require him to remain in hospital for at least another three weeks. Jacob was desperate to leave hospital for a number of reasons, including upcoming events that were of deep cultural significance to him and his family. The Tribunal hearing was the first occasion Jacob's mother and father had been available to participate in a meeting with Jacob and his treating team. The discussion that took place identified a collaborative strategy between Jacob, his family and treating team that meant the Tribunal made an Order that would allow Jacob to be treated while living at home (and participating in the cultural events) rather than staying in hospital.

The Victorian Mental Health Tribunal is able to work in such a way because it has been resourced at a level that allows it to conduct hearings where there is a reasonable amount of time to discuss the perspective of all participants. The Tribunal allocates at least one hour to each of its hearings whereas in many other jurisdictions, mental health tribunals will conduct up to three hearings in the same amount of time.

In addition, since the establishment of the Tribunal in 2014 it has worked closely with mental health consumers and carers on the design and development of its processes and procedures. Consumer and carer advisors have an influential role. A particularly significant initiative led by our consumer and carer Tribunal Advisory Group that will be rolled out in the second half of 2018 is a mechanism by which consumers and carers can provide feedback about the extent to which they did or did not feel listened to in the course of a Tribunal hearing.

CONCLUSION

It is entirely appropriate that ongoing policy-level discussion and debate occur concerning whether or not capacity should be the core issue that determines whether compulsory Treatment Orders can be made. Mental health law is neither fixed nor unchangeable but must evolve in response to changing expectations and our understanding of many factors, including international human rights law.

However, it is inappropriate to misinterpret the existing statutory framework in which a tribunal operates and to criticise a tribunal for failing to adopt a policy preference which cannot legitimately be imported into its governing legislation. Mental health law has a profound impact on people's lives. It is essential, therefore, that when research is published which addresses tribunal processes and decision-making that it is accurate and comprehensive.