# Supreme Court rules on test for compulsory electro-convulsive treatment: the bar for capacity to give informed consent is ‘rightly a low one’

**Case note: PBU & NJE v Mental Health Tribunal [2018] VSC 564 (1 November 2018)**

## Summary

The Supreme Court has found that the Victorian Civil and Administrative Tribunal (VCAT) committed an error of law in its interpretation and application of the capacity test in s 68 of the *Mental Health Act 2014* (Vic) (MH Act).

Proper application of the test requires only that a person be able to understand, remember and use or weigh relevant information, and communicate a decision regarding whether to have such treatment in general terms. Careful consideration in detail of the advantages and disadvantages of the treatment is not required. The test is whether a person is **capable** of the weighing exercise, not whether they actually do so. The fact that a person does not agree with their mental health diagnosis, or makes a decision that could be considered unwise, is not, in itself, enough to demonstrate that they lack capacity to make decisions about their medical treatment.

## Background

Section 96 of the MH Act sets out the powers of the Mental Health Tribunal in an ECT application.

Before an application for ECT can be granted, the Tribunal must be satisfied 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.

### PBU

PBU agreed he had a mental illness but not that he had treatment-resistant schizophrenia, as maintained by his doctors. In February 2017, a course of electro-convulsive treatment (ECT) was authorised by the Mental Health Tribunal. PBU regained capacity and refused further ECT and the final treatment was not given. Subsequently, PBU’s treating team made two further applications to the Mental Health Tribunal for ECT. The first of these, in March 2017 was refused. However, the second application, in April 2017, was granted. PBU applied for a review in VCAT and the orders were stayed.

The test for capacity to give informed consent to treatment under the MH Act is found in s 68(1). VCAT found that while PBU could understand the information he was given about ECT (the first limb of the capacity test), he lacked capacity to give or refuse informed consent because he disagreed with the diagnosis of his treating team. VCAT stated at [80]:

…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.

The Tribunal did not specify which of the remaining three limbs of the capacity test were not met.

VCAT found that there was no less restrictive option available for PBU’s treatment as maintaining the current treatment regime was not likely to lead to improvement. VCAT considered that maintaining the current treatment regime therefore did not meet the definition of ‘treatment’ in s 6, which requires that treatment remedy or reduce the ill effects of mental illness. The order for compulsory ECT was affirmed.

### NJE

NJE had been treated for schizophrenia by mental health services for some years, sometimes as a voluntary patient and sometimes as a compulsory patient. At the time of her initial ECT hearing, she instructed that she preferred to remain in hospital and continue to receive depot injection and other prescribed medication, rather than have ECT. NJE felt that ECT would interfere with her psychic capabilities. She did not believe she had any form of mental illness.

VCAT found that ECT provided the best chance of addressing the symptoms of NJE’s schizophrenia. In applying the capacity test, 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. VCAT found that she had not carefully considered the advantages and disadvantages of ECT because she didn’t believe it applied to her. VCAT found that she lacked the capacity to give informed consent and that, other than ECT, there was no less restrictive way for her to be treated. The order for compulsory ECT was affirmed.

## Reasons for decision

### Capacity test

Bell J held that VCAT had misapplied the first limb of the test for determining if compulsory ECT could be given to plaintiffs PBU and NJE. This limb, set out in s 96(1)(a)(i), requires that a person can only be given compulsory ECT if they lack capacity to give informed consent, as defined in s 68(1) of the MH Act.

Regarding PBU, his Honour stated that VCAT erred in finding that because PBU did not agree with his diagnosis, and was said to lack insight, that he lacked capacity to give or withhold informed consent to ECT. Whether a person lacks insight or holds delusional beliefs is not determinative and only one factor to be weighed in assessing capacity. He stated at [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 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.

Bell J further observed that a requirement for insight or ‘appreciation’ of information had deliberately been left out of both the MH Act and its parent legislation, the *Mental Capacity Act* *2005* (UK).

Regarding NJE, his Honour found that VCAT had set the bar for capacity too high. He considered the common law test of capacity and the parent UK legislation before stating at [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.

His Honour also stated at [206]:

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.

Bell J also endorsed the approach adopted by VCAT regarding the standard of proof applicable to findings of capacity. In applying the test in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336, VCAT stated at [33]:

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.

### No less restrictive treatment test

The second limb of the test for whether compulsory ECT can be ordered requires an assessment of whether there is a less restrictive form of treatment (s 96(1)(a)(ii)). PBU and NJE submitted that ‘treatment’ for the purpose of s 96(1)(a)(ii) is the same treatment that is considered necessary for compulsory treatment to be imposed in the first place under s 5(b) of the MH Act. Section 5(b) states that treatment must be necessary to prevent either serious deterioration in a person’s mental or physical health, or serious harm to that person or another person. Bell J rejected this submission, finding that the wording of s 96 did not import that definition into the section.

However, in obiter, his Honour did find that an assessment of what constitutes less restrictive treatment must take a person’s views and preferences into account regardless of whether that person is found to lack capacity to give informed consent under s 96(1)(a)(i). He stated at [101]:

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.

Section 96 must be interpreted in line with the Victorian Charter, particularly regarding the right to self-determination, equality before the law, freedom from non-consensual medical treatment and personal inviolability, which Bell J considered central to the right to privacy. Therefore, maintaining an existing treatment regime may be less restrictive than subjecting a person to ECT. His Honour stated at [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).

### Victorian Charter of Human Rights and Responsibilities

In discussing the Charter, Bell J considered that the right to equality before the law, the right to be free of non-consensual medical treatment, the right to privacy and the right to health were all engaged.

In discussing the right to equality before the law, Bell J found that the right to be free from discrimination is particularly important for people with mental disabilities. The right to application of the law without discrimination and the right to protection from discrimination were highlighted. He stressed that the MH Act cannot be applied in a way that amounts to discrimination on these bases.

In discussing the right to privacy, Bell J observed that people with mental disabilities are vulnerable to interference in their lives. As such, two aspects of privacy are particularly salient to them. These are the right to self-determination and the right to personal inviolability, which also encompasses the right to be free of non-consensual medical treatment.

His Honour also considered that the right to be free from non-consensual treatment and entitlement to health-related services are both elements of the right to health. His Honour stated at [104]:

…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 [104]

His Honour stressed that restrictions on human rights under the Charter must be demonstratively justified in accordance with the least infringement principle if they are to comply with the law.

## Orders

By the time of the hearing, both PBU and NJE had been released from hospital and were living in the community. ECT was no longer being sought by their treating doctors, so there was no need for remittal orders.

The Court quashed the orders of the Mental Health Tribunal and VCAT.

## Commentary

This decision has far-reaching implications for people at risk of compulsory ECT. Previously, the vast majority of ECT applications were granted by the Mental Health Tribunal. The decision makes it clear that if the general population are only required to satisfy a low threshold of capacity to make their own medical decisions, then it would be discriminatory to require those being treated under the MH Act to meet a higher one.

The decision underlines the ‘paradigm shift’ from paternal best-interests decision-making to a greater focus on self-determination intended by Parliament. The decision is useful not just for people in Mental Health Tribunal hearings, but also in direct negotiations with a person’s treating team regarding whether an ECT application should even be made. The decision has the potential to greatly reduce the numbers of people being subjected to ECT against their will.

This decision is available online at the Austlii website (<http://www6.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VSC/2018/564.html>).

Note: Victoria Legal Aid acted on behalf of the applicant at the hearing, with the assistance of Mr Emrys Nekvapil with Ms Anna Lord (14 and 15 August 2017, 26 April 2018) and Ms Jessie Taylor (8 June 2018)

*Case note prepared by Penelope Swales, Civil Lawyer, Victoria Legal Aid.*