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Analysis of the Victorian Mental Health Tribunal's Engagement with Human Rights

Castan Centre Human Rights Clinic

Kudzai Muringani

Stephanie Nolan

Tae Fabricato

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EXECUTIVE SUMMARY

Compulsory mental health treatment is permitted in all Australian states and territories. The *Mental Health Act* 2014 (Vic) ('MHA') establishes the Mental Health Tribunal ('MHT'), an independent oversight body that is empowered to make compulsory Treatment Orders in Victoria.[1] Some of the core principles of the MHA include ensuring that consumers are supported to make and participate in decisions about their assessment, treatment, and recovery and protecting and promoting individuals' rights, dignity, and autonomy at all times.[2] The MHT is designed to provide oversight and guarantee that consumers' rights are being respected.

This report will examine recently published decisions of Victoria's MHT from a human rights law perspective to determine whether the MHT is sufficiently engaging with human rights when making their decisions. In particular, the MHT statements of reason are reviewed to determine whether the *Charter of Human Rights and Responsibilities Act* 2006 (Vic) ('the Charter') and/or the human rights principles outlined under s 11 of the MHA have been meaningfully engaged with.

The dominant trend that emerged from this analysis was that the MHT does not appear to be consistently documenting sufficient consideration of human rights when making their decisions to significantly restrict a consumer's human rights. The report proceeds to suggest recommendations to make the operation of the MHT more consistent with its purpose and domestic human rights law. These recommendations include:

- **Recommendation 1:** Embedding SDM in the MHT's decision making process.
- **Recommendation 2A:** Explicit consideration of rights in statements of reason.
- **Recommendation 2B:** Detailed and consumer focused reporting mechanisms.
- **Recommendation 3:** Ensuring effective review mechanisms.
- **Recommendation 4:** Facilitating training for those with decision-making power under the MHA.

[1] *Mental Health Act 2014* (Vic) ('*MHA*').

[2] Ibid s 10.

INTRODUCTION

The Victorian Mental Health Tribunal ('MHT') is established by the *Mental Health Act 2014* (Vic) ('MHA') and is designed to be an oversight body for consumer's subject to compulsory treatment.[3] This report analyses the MHT's engagement with essential human right principles and standards when making their decisions.

Compulsory treatment refers to medical treatment administered to a person regardless of their consent.[4] This inherently involves limitations to human rights.[5] Despite this, the MHT is empowered to make, revoke or vary compulsory Treatment Orders sought by mental health services, where certain legislative criteria is fulfilled.[6] Treatment Orders enable a consumer to either be compulsorily treated in the community or in a designated mental health service.[7]

While the MHT was introduced to assist in reducing compulsory treatment by providing a check and balance on clinician decisions, the Royal Commission into Victoria's Mental Health System's 2021 Report ('Royal Commission') recognised that compulsory treatment remains 'too high' and at times 'the default response' in Victoria.[8] This finding is in contradiction with the purpose of the MHA, which emphasises that compulsory treatment is a *last resort*, and voluntary treatment is to be preferred.[9]

Notably, this contradiction is also reflected in academic research that has found a disconnect between the mental health law in theory and consumer's lived experience of the law.[10] For example, although the MHT is designed to ensure that consumer's rights are promoted, many consumers have reported that they continue to feel controlled by clinicians.[11] Consequently, instead of

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[3] Aisha Macgregor, Michael Brown and Jill Staverty, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature' (2019) 27(4) *Health & Social Care in the Community* 494, 494.

[4] 'Compulsory Treatment Orders', *Victoria Legal Aid* (Web Page) <https://www.legalaid.vic.gov.au/find-legal-answers/mental-health-and-your-rights/compulsory-treatment-orders>.

[5] Simon Katterl and Chris Maylea, 'Keeping human rights in mind: Embedding the Victorian Charter of Human Rights into the public mental health system' (2021) 27(1) *Australian Journal of Human Rights* 58, 59 ('Keeping Human Rights in Mind').

[6] See *MHA* (n 1) s 5; s 92(1)(b), (2).

[7] Ibid s 52(3).

[8] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 364.

[9] *MHA* (n 1) ss 10-11.

[10] Katterl and Maylea, 'Keeping human rights in mind' (n 5) 69.

[11] Victoria Legal Aid, *Your Story, Your Say: Consumers' priority issues and solutions for the Royal Commission into Victoria's Mental Health System* (2020) 15 ('*Your Story, Your Say*').

experiencing the benefit of having their rights and preferences adhered to, consumers commonly report feeling subject to mere 'best interests decision making'.[12]

Best interest decision-making can be contrasted to Supported Decision Making ('SDM'), which invites clinicians to support consumers when making their own health decisions, rather than making decisions on their behalf.[13] From a human rights perspective, SDM is preferable to best interests or substituted decision-making. SDM has been identified as an important pillar of a rights-based approach. The *Convention on the Rights of People with Disabilities* ('CRPD') recognises SDM as a means by which people with disabilities can be directly involved in decisions that impact their lives, in line with the right to equality.[14]

The authors acknowledge that the Tribunal itself is inherently a substitute decision making body.[15] Importantly however, other legal mechanisms exist under the MHA that enable SDM, including a presumption of capacity, advance statements, nominated persons and the right to seek a second psychiatric opinion.[16] These mechanisms can be engaged with *prior to* hearings before the MHT. SDM can also occur throughout the MHT hearing process if, as a baseline, consumer's rights are actively promoted, considered, and weighed in decisions.

It is within this context that the following report analyses MHT decisions. The authors emphasise that in order to align with human rights and the purpose of the MHA, there needs to be evidence of meaningful facilitation of SDM both before the MHT process is initiated and, as far as possible, during the hearing process.

In light of this, it is paramount to assess whether the MHT has been sufficiently considering and giving weight to human rights limitations when making their decisions. Two predominant mechanisms exist that aim to promote a more human rights-based practice in the MHT; the human rights principles contained in s 11 of the MHA and rights contained in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('the Charter').

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[12] In MB Simmons and PM Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health' (2017) 34(4) *Irish Journal of Psychological Medicine* 275, 278-9 best-interests decision making by third parties is where one person substitutes their decision on behalf of another, ostensibly because it is in their 'best interest.'

[13] See ibid.

[14] *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 30 March 2008) art 12, 25 ('*CRPD*').

[15] Chris Maylea and Asher Hirsch, 'The Right to Refuse: The Victorian Mental Health Act 2014 and the Convention on the Rights of Persons with Disabilities' (2017) 42(2) *Alternative Law Journal* 149, 150.

[16] *MHA* (n 1) ss 68-71 (capacity and consent), ss 19-22 (advance statements), ss 23–27 (nominated persons) and ss 78-89 (second psychiatric opinion).

MHT's obligations in relation to these two mechanisms are as follows:

MHA Principles

The decisions of the MHT focus largely on the treatment criteria set out under the MHA (s 5).[17] However, when exercising any function or power under the MHA, the MHT must have regard to the mental health principles (s 11(3)).[18] These principles include that consumers should be provided mental health assessment and treatment 'in the least restrictive way possible' with voluntary assessment and treatment preferred,[19] and should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.[20]

The Charter

The MHA provisions are also required to be interpreted consistently with Charter rights 'so far as it is possible to do so consistently with their purpose'.[21] Additionally, as the MHT acts in an administrative capacity when reviewing compulsory Treatment Orders, and therefore acts as a 'public authority' within the meaning of the Charter.[22] Accordingly, it is unlawful for the MHT to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right.[23]

The MHA and the Charter

Case law from the Supreme Court supports an approach that fosters a higher level of engagement with the guiding principles and the provisions of the Charter. In *PJB* it was held that public authorities should, upon assessing that a right is engaged and limited, assess whether the limitation is reasonable and justified in the circumstance.[24] Further, *Castles* ruled that decision makers must provide evidence of the relevant Charter considerations in their reasoning and deliberations.[25] Thus, the decision maker is required to actively provide some evidence that they 'seriously turned their mind to the

[17] Ibid s 5.

[18] Ibid s 11(3).

[19] Ibid s11(1)(a).

[20] Ibid s11(1)(b).

[21] *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 32 ('*Charter*').

[22] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, [11] ('*PBU*').

[23] *Charter* (n 20) s 38.

[24] *PJB v Melbourne Health and Another (Patrick's Case)* [2011] VSC 327 [239]-[232] ('*PJB*').

[25] *Castles v Secretary of the Department of Justice* (2010) 28 VR 141 [186] ('*Castles*').

possible impact of the decision on a person's human rights and the implications thereof for the affected person, and that the countervailing interests or obligations were identified'.[26] It is within this framework that we adopted our analysis of the MHT decisions. If the MHT emulated *Castles* and explicitly documented their reasoning, this would provide clarification as to the extent to which they are engaging with human rights.

The report continues as follows:

- **Part 1** will consider the section 11 principles and the extent to which they have been engaged with during the MHT decision making process.
- **Part 2** will adopt a similar analysis to Part 1 in relation to rights under the Charter.
- **Part 3** contains recommendations to make the operation of the MHT more consistent with its purpose and human rights under legal frameworks in Victoria.

METHODOLOGY

The hearings of the MHT are of a closed nature.[27] Consequently, the published statements of reasons are the only insight available into the MHT's consideration of the mental health principles and Charter rights. It is important to note that not all statements of reason are made available to the public, with only a selection of cases published each year.

In order to analyse the MHT's recent engagement with human rights, 40 cases published over the last 12 months, between July 2020 to June 2021, were reviewed. This involved undertaking a thematic analysis of the decisions to identify patterns in the reported decision-making process.

Firstly, the MHT's deliberations were analysed qualitatively to determine the extent to which they considered principles and Charter rights. Secondly, a quantitative analysis was adopted to determine the frequency of such considerations. Overall, of the 40 cases analysed, 21 decisions went in the consumers favour, with the remaining 19 cases resulting in a compulsory treatment order; this reflects approximately a 50/50 percentage split. This is an interesting statistical finding juxtaposed against the statistics found in the Tribunal's annual review,[28] which indicates that between the months of June 2020 and July 2021, 7,225 treatment order hearings were held, of which 6679 (93%: 61% CTO and 32% ITO) of the hearings resulted in a Treatment Order being made with only 546 (7%) of the orders being revoked.[29] It is therefore important to recognise that the cases examined in this report do not represent all those that were brought before the MHT in the stipulated time period, and rather are a smaller sample made available to the public.

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[26]See ibid.

[27] *MHA* (n 1) s 193.

[28] Mental Health Tribunal, *Annual Report 20:21* (Report, August 2021) 13 <https://www.mht.vic.gov.au/annual-reports> ('*Annual Report*').

[29] Ibid 14.

In our analysis of human rights engagement, four cases were unable to be examined as Treatment Orders were revoked on the basis of the first treatment criterion being unfulfilled.[30] However, all 36 remaining statements of reasons enlivened human rights consideration and discussion. Statements of reason are described in this report as 'explicitly' addressing or engaging with human rights where they include a direct reference (by name) of relevant MHA principles, or Charter rights and an overt application of these principles and rights to the facts in the case. This is in contrast to statements of reason which referred to the above only in the abstract or did not evidence a consideration of a consumer's particular right at all. The ambiguity in these latter cases makes a rights analysis difficult and illustrates that it would be beneficial for the MHT to clearly state and substantively discuss the relevant rights that they must take into consideration.

PART 1: THE SECTION 11 PRINCIPLES

1.1 Obligations under Section 11

As mentioned prior, when exercising any function or power under the MHA, the MHT must have regard to the mental health principles (s 11(3)).[31] The principles are a key element of the framework under the MHA and operate as an essential safeguard to human rights. They articulate specific rights, applying equally for all people receiving mental health services regardless of age or status as either compulsory or voluntary under the MHA.[32] This section will focus on an analysis of the application of the guiding principles under section 11 of the MHA which include the following:

- The least restrictive method, with voluntary assessment and treatment preferred (s 11(1)(a));
- Services should be provided with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life (s 11(1)(b));
- Consumers should be involved in decisions and should be supported to make or participate in those decisions and their views and preferences should be respected (s 11(1)(c));
- Consumers should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk (s 11(1)(d));
- Their rights, dignity and autonomy should be respected and promoted (s 11(1)(e).[33]

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[30] In *AAP* [2020] VMHT 17; *CKH* [2020] VMHT 37; *DDQ* [2020] VMHT 21; *SUN* [2020] VMHT 23 a treatment order was not made because s 5(a) of the *MHA* was not met.

[31] *MHA* (n 1) s 11(3).

[32] 'Mental health principles and the rights of persons affected', *Victoria Legal Aid* (Web Page) <https://www.legalaid.vic.gov.au/information-for-lawyers/practice-resources/mental-health-law-practice-guide-for-lawyers/about-mental-health-act-2014-and-its-principles/mental-health-principles>.

[33] *MHA* (n 1) s 11(1)(a)-(e).

As noted, the current mental health system inherently involves limitations on human rights through practices such as involuntary treatment, detention, seclusion and restraint.[34] Accordingly, a deeper engagement with principles aimed at promoting a more rights-based approach to mental health, is essential.

In *PBU & NJE v Mental Health Tribunal*, Bell J highlighted the importance of the mental health principles at [67]:[35]

> Consistently with the right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, the [s.10] objectives and [s.11] principles emphasise enabling and supporting decision-making, and participation in decision-making, by the person (ss 10(d) and (g), 1(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.[36]

The following section will examine the general trends linked to some of the key principles provided for under s 11 of the MHA.

1.2.1 *Engagement with the Least Restrictive Method of Treatment*

Involuntary treatment involves a considerable deprivation of liberty. Consumers do not lose their rights by reason of mental illness and thus any restriction on these rights must be justified.[37]

Section 11(1)(a) states that persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment being preferred.[38] 'Least restrictive' means the infringement on an individual's rights is kept to a minimum. This includes the type of treatment a consumer receives, where the consumer is placed and any responses to a behavioural problem.

The requirement for the least restrictive option is also provided for under s 5 of the MHA, which, sets out the treatment criteria for a person to be made subject to an order:

- The person has mental illness; and
- Because the person has mental illness, the person needs immediate treatment to prevent:

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[34] Katterl and Maylea, 'Keeping human rights in mind' (n 5) 60.

[35] *PBU* (n 21) [67].

[36] Ibid.

[37] Ibid [66].

[38] *MHA* (n 1) s 11(1)(a).

- Serious deterioration in the person's mental or physical health; or
- Serious harm to the person or to another person; and

- The immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and
- There is no less restrictive means reasonably available to enable the person to receive the immediate treatment.[39]

1.2.2 *Engagement of least restrictive test in specific cases*

The principle requiring the least restrictive treatment is the most widely engaged across the cases, either expressly or by inference. This is to be expected due to the emphasis on this element in both sections 5 and 11 of the MHA. It appeared that in a number of the decisions the MHT's deliberations were directed towards determining whether or not there was any less restrictive means of treatment, to the neglect of other principles. Given that the discussion of the other principles was often limited to a single sentence, it is difficult to determine the extent to which the MHT grapples with the relevant human rights issues.

For example, in *FZT* the MHT granted an application for electroconvulsive treatment ('ECT') stating that 'there was no less restrictive way for [the consumer] to be treated at present'.[40] The summary of the decision went on to discuss why this was the case, noting the risks such as deterioration in the consumer's mental state.[41] As a result they concluded that medication alone was not sufficient.[42] Brief acknowledgement of the consumer's preferences and concerns were made stating, 'we understood your current treatment preferences as expressed at the hearing'.[43] However the discussion did not go beyond this, despite the fact that the consumer submitted they believed medication was enough to alleviate their symptoms, which would have at least warranted a discussion of the principle that permits a consumer to make decisions that involve a degree of risk.[44]

Additionally, in *OSH* the consumer had been subject to ECT against their will since 2018.[45] The consumer preferred medication and had found both counselling and therapy helpful.[46] However, the treating team stated that the consumer, 'had a wide spectrum of medication trials, and that ECT produces the best response'.[47] The MHT granted the application for ECT on the basis of the treating

[39] Ibid s 5(a)-(d).

[40] *FZT* [2021] VMHT 4, [17].

[41] Ibid.

[42] Ibid.

[43] Ibid.

[44] Ibid [7].

[45] *OSH* [2020] VMHT 38, [5].

[46] Ibid.

[47] Ibid [8].

team's submissions.[48] ECT was preferred in the circumstances over medication because medication was according to clinicians 'less effective'.[49] This was determined notwithstanding the statement in *PBU* which held that:

> where reasonable, the views and preferences of the consumer, 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 consumers in their entire personal and social setting.[50]

Cases like *OSH* gave the impression that the Tribunal placed great emphasis on the submissions of the treating team as opposed to the preferences of the consumer, essentially depriving them of a right to make decisions including those that involve a degree of risk. These may have been appropriate and lawful decisions. However, without documenting the balance between the various rights and the decision-making process, there is no means of knowing whether the MHT gave weight to other principles.

1.3 Engagement with Other Pertinent Section 11 Principles

For the purposes of this discussion, sections 11(1)(b), (c), (d) and (e) will be examined. These principles were relevant in all MHT decisions and it was common for them to be discussed collectively; conjointly referred to as 'the mental health principles.'[51] Overall, these principles aim to promote a rights-based foundation to the MHT's decisions.[52] They emphasise the importance of upholding the consumer's dignity, autonomy and rights, including their right to be respected and supported when participating in decisions relating to their own mental health.[53] Additionally, they are therapeutically focused and highlight that it is within the consumers right to make decisions about their assessment, treatment and recovery, including decisions that involve a degree of risk.[54] Importantly, these mental health principles strive to alter the balance of power between the medical authority and consumers in the direction of respecting consumer's human rights.[55]

1.3.1 General Trends in Cases

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[48] Ibid.

[49] Ibid [9].

[50] *PBU* (n 21) [101].

[51] See *AKU* [2020] VMHT 27; *AMX* [2020] VMHT 28; *OSR* [2020] VMHT 36; *PED* [2021] VMHT 8.

[52] Victoria, *Parliamentary Debates,* Legislative Assembly, 19 February 2014, 458 (Ms Woolridge, Minister for Mental Health) <https://www.parliament.vic.gov.au/images/stories/daily-hansard/Assembly_2014/Assembly_Daily_Extract_Thursday_20_February_2014_from_Book_2.pdf>.

[53] *MHA* (n 1) ss 11(1)(c), (e).

[54] Ibid ss 11(1)(b), (d).

[55] *PBU* (n 21) [67].

Overall, consistent with the general trend, the MHT's documented engagement with the principles was limited and varied. Despite these mental health principles being enlivened in every case, the MHT only explicitly applied them to the individual facts in 5 (of 19) cases where a Treatment Order was made,[56] and 11 (of 21) cases where a Treatment Order was not made.[57]

Notably, in 8 other cases where a Treatment Order was made, the MHT made no mention of their obligation to consider the principles or demonstrate evidence of considering the principles impliedly.[58] Rather, a Treatment Order was imposed, and rights were limited, in acceptance of the treating team's evidence without documenting consideration of the principles.

When the principles were considered impliedly this was through broad statements like 'the Tribunal took into account a range of factors, including your views about treatment'[59] and the Tribunal 'acknowledged that you would like to take control of your treatment.'[60] However, the MHT often failed to connect these statements to the particularities of the case and specifically document the reasons why consumer's views were overruled or not.

These observations are largely consistent with research that indicates that many consumers feel that MHT decisions are a rubber stamp for clinical decisions as opposed to an accountability measure to support their participation and protect their rights.[61]

1.3.2 Section 11 Principles Discussed in Specific Cases

There were some select cases where the MHT explicitly engaged with the principles and linked their discussion to the particular facts, albeit with limited elaboration.

For example, in *CGP* the MHT specifically engaged with matters relevant to sections 11(b), (c), (d) and (e).[62] The MHT found that despite a degree of risk, the negative impacts of continued detention in hospital outweighed the therapeutic benefits to a consumer who preferred community treatment and was willing to continue with their antipsychotic medication. Although the discussion was brief, the MHT explicitly balanced the principles with the treating team's submission.*

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[56] *AGD* [2020] VMHT 20; *AKU* [2020] VMHT 27; *AMX* [2020] VMHT 28; *CGP* [2020] VMHT 30; *IMK* [2021] VMHT 12.

[57] *BHI* [2020] VMHT 19; *CFQ* [2020] VMHT 24; *CIE* [2020] VMHT 34; *CPQ* [2021] VMHT 11; *DTM* [2020] VMHT 35; *EHI* [2020] VMHT 22; *KAL* [2020] VMHT 41; *LJV* [2020] VHMT 33; *OSR* [2020] VMHT 36; *PED* [2021] VHMT 8; *YDK* [2020] VMHT 18.

[58] *BVR* [2020] VMHT 16; *JJM* [2020] VHMT 29; *LDH* [2021] VMHT 14; *NKI* [2020] VMHT 26; *QGG* [2021] VMHT 9; S*XD* [2021] VHMT 6; *VBD* [2020] VMHT 25; *YQT* [2021] VHMT 1.

[59] *RGV* [2021] VHMT 2, [14].

[60] *BYG* [2020] VMHT 39, [15].

[61] Aisha Macgregor, Michael Brown and Jill Staverty, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A systematic review of the international literature' (2019) 27(4) *Health & Social Care in the Community* 494, 511; VLA, '*Your Story, Your Say*' (n 11) 15.

[62] *CGP* [2020] VHMT 30, [47]-[48].

This can be contrasted to the approach taken by the majority in *AKU*.[63] In this case, a Treatment Order was made despite the consumer indicating a willingness and desire to continue medication as a voluntary patient.[64] The majority did not document consideration of the principles whereas the dissenting community member did. The majority was concerned that the consumer would not voluntarily take their medication because they did not agree with all aspects of their diagnosis and treatment.[65] It was on this basis that the majority decided a Treatment Order was necessary. Notably however, the dissenting community member took into account 'the mental health principles that a person should be treated in the least restrictive way, and that people receiving mental health treatment should be able to make decisions regarding their treatment and recovery that involve a degree of risk.'[66] It was after balancing the need to consider the principles that they concluded a Treatment Order was not necessary.[67] The majority's lack of documentation as to why a departure from the principles was justified arguably gives the impression that they did not consider the principles, or respect the consumer's alternative view of their diagnosis and treatment, when making the Treatment Order. The inconsistency between the members' consideration of the principles makes it difficult to ascertain what weight MHT members, more broadly, are accustomed to giving the principles when making their decisions.

Additionally, of the cases reviewed, the case of *KAL* arguably documented the most detailed and explicit consideration of the principles and ultimately those principles constrained MHT's decision and a Treatment Order was revoked.[68] The MHT began by outlining their obligations to consider the principles and applied those principles to the specific fact scenario.[69] The MHT actively balanced the principles including the consumer's preferences, factors that mitigated their risk and the interest of holistic rather than clinical recovery, before ultimately finding that the consumer could be treated less restrictively.[70] Notably, despite being unique among the cases reviewed, this case was utilised in the MHT's annual report to demonstrate how principles are engaged with in the Tribunal.[71]

1.3.3 Section 11 Principles Conclusion

This above demonstrates that when the MHT fails to overtly document their consideration of the principles, a failure to give proper consideration to these principles and actively support consumer involvement may be inferred. It is acknowledged that MHT members may indeed have given some

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[63] *AKU* [2020] VMHT 27, [28]-[31].

[64] Ibid [9].

[65] Ibid [30].

[66] Ibid [32]-[35].

[67] Ibid.

[68] *KAL* [2020] VMHT 41.

[69] *KAL* [2020] VMHT 41 [16].

[70] *KAL* [2020] VMHT 41 [21].

[71] *Annual Report* (n 28) 23.

consideration to the principles in making their decision, the current documentation practices of the MHT do not evidence the actual level of engagement with the principles.

PART 2: THE CHARTER RIGHTS

2.1 Obligations under the Victorian Charter

This section will look at the MHT's engagement with the Charter and explore the extent to which consumer's human rights are being taken into account in MHT decision-making.[72]

As outlined in the Introduction, the MHT has two obligations under the Charter. Firstly, the Charter makes clear that laws should be interpreted, so far as is possible with those laws' purposes, in a manner that is compatible with Charter and international human rights, including the CRPD.[73] Secondly, as a public authority, the MHT must be capable of providing evidence that it has properly considered Charter rights in making its decision to grant or revoke a Treatment Order.[74]

The rights engaged on the facts of the cases included the right to privacy,[75] freedom from medical treatment without consent,[76] freedom of movement,[77] and right to liberty.[78] These are not the only rights relevant but have been identified as the most predominant.

2.2 General Trends in Cases

The MHT's statements of reason do not explicitly engage with the Charter rights in the requisite way, as they do not document analysis of the rights beyond a generic statement. This was evident in the 19 decisions where a Treatment Order was made against consumers' preferences. Only a generic statement was provided in these cases, stating that 'the Tribunal understands that the order limits your rights to privacy, liberty and freedom from medical treatment without consent, but

[72] *Charter* (n 20); *MHA* (n 1) s 5.

[73] *Charter* (n 20) s 32; *CRPD* (n 13).

[74] *Charter* (n 20) s 38(1).

[75] Ibid s 13.

[76] Ibid s 10(c).

[77] Ibid s 12.

[78] Ibid s 21.

because the treatment criteria have been met those limitations were reasonable and so allowed under the Charter'.[79]

The generality of the above statement makes it difficult to determine whether the MHT has given proper consideration to human rights in making decisions, and whether it is interpreting the treatment criteria in the most human rights-compliant manner. The approach reflects what has been identified in *Castles* as invoking the charter 'like a mantra',[80] which is a rubber stamp method that does not engage with Charter rights of each individual.

The general trend in Charter rights considerations is similar to that which has been highlighted in Part I. The limitation of rights arises in every decision, however the MHT does not explicitly provide the details that justify restriction in the particular case. It is acknowledged that the Charter rights overlap with s 11 principles. Therefore, consideration of the principles in some of the cases demonstrates that the MHT is amenable to considering Charter rights, even where they do not explicitly refer to them by name. Even so, there were 13 decisions where a compulsory order was made and neither the Charter rights or the principles were taken into account beyond the generic statement or an assessment of the least restrictive test.[81] This signifies a lack of engagement with the holistic factors for supported decision making and promoting dignity and autonomy.

The current approach does not sufficiently demonstrate movement away from 'best outcome' reasoning.[82] It would be beneficial for the MHT to state the Charter rights explicitly beyond the generic sentence. This would result in a more comprehensive rights-based approach, ensuring consistency and proper consideration. In doing so, compulsory treatment orders may become less of a default response.[83]

2.3 Charter Rights Engaged in Specific Cases

This section will look at some of the rights engaged in particular cases in order to assess how the MHT could consider Charter rights more actively.

Freedom from medical treatment without consent is immediately engaged on the facts in all cases whereby the treating team is making a Treatment Order that the consumer is contesting. It is

[79] *FZT* [2021] VMHT 4; LDH [2021] VMHT 14; *IMK* [2021] VMHT 12; *SXD* [2021] VMHT 6; *QGG* [2021] VMHT 9; *YQT* [2021] VMHT 1; *RGV* [2021] VMHT 2; *BVR* [2020] VMHT 16; *AGD* [2020] VMHT 20; *XNA* [2021] VMHT 32; *AKU* [2020] VMHT 27; *NKI* [2020] VMHT 26; *VBD* [2020] VMHT 25; *CGP* [2020] VMHT 30; *JJM* [2020] VMHT 29; *AMX* [2020] VMHT 28; *DNP* [2020] VMHT 42; *BYG* [2020] VMHT 39; *OSH* [2020] VMHT 38.

[80] *Castles* (n 25) [186].

[81] *FZT* [2021] VMHT 4; LDH [2021] VMHT 14; *IMK* [2021] VMHT 12; *SXD* [2021] VMHT 6; *RGV* [2021] VMHT 2; *YQT* [2021] VMHT 1; *BVR* [2020] VMHT 16; *XNA* [2021] VMHT 32; *AKU* [2020] VMHT 27; *NKI* [2020] VMHT 26; *VBD* [2020] VMHT 25; *JJM* [2020] VMHT 29; *OSH* [2020] VMHT 38.

[82] 'Best Interest' reasoning has been rejected by cases and commentaries including *PBU* (n 21) [167]-[168].

[83] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 13, 364.

notable that there were many cases where consumers made submissions about negative side effects or an objection to treatments, and the right was not deeply engaged within the statements of reason. This factual matrix arose in 9 of the cases and a decision was made against the consumer's wishes with no mention of the right, beyond the generic statement.[84]

YQT illustrates the lack of engagement with the right of freedom from medical treatment without consent. A Treatment Order was made despite the consumer's submission that it was important for them not to be subject to medical intervention.[85] The MHT's decision did not engage explicitly with the right, rather they gave weight to the evidence of the treating team that treatment was required to prevent serious deterioration in mental health. They accepted that there was no less restrictive way considering that the consumer would cease medical treatment if the Treatment Order was lifted. Interestingly, even when the consumer highlighted this right in their submission, no detailed documentation of a response in the MHT's decision was provided.

Conversely, in *DTM*, a consumer was successful in applying to have their Treatment Order revoked. In the MHT decision, consideration was given to the consumer's 'strong desire' to stop treatment which they believed was extremely 'harmful' to them.[86] This is an example where rights were taken into account and a contrast to decisions where consumers noted negative side effects that were not addressed. However, the discussion remained limited as the right was only discussed implicitly.

Additionally, freedom of movement is frequently engaged in many of the cases whereby compulsory orders are contemplated. It is particularly pertinent when an order limits the consumer's ability to partake in particular activities or when an Inpatient Treatment Order is made. Right to liberty is also particularly engaged when an Inpatient Treatment Order is made.[87]

In *AGD*, both rights were engaged as the consumer submitted that they wanted to continue treatment as a voluntary patient, they particularly wanted to live with their daughter temporarily and then move interstate.[88] The MHT gave weight to the treating team's submission that treatment could only occur in an inpatient environment and an ITO was made. The MHT considered the consumer's rights in the following way:

> The law says voluntary treatment is to be preferred. In your case it was also very important that you have a long history of voluntary treatment… Understandably you wanted to leave hospital and have rightly asked about options… But given the seriousness of this relapse and how complex and difficult

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[84] *FZT* [2021] VMHT 4; LDH [2021] VMHT 14; *IMK* [2021] VMHT 12; *SXD* [2021] VMHT 6; *RGV* [2021] VMHT 2 *BVR* [2020] VMHT 16; *XNA* [2021] VMHT 32; *VBD* [2020] VMHT 25; *OSH* [2020] VMHT 38.

[85] *YQT* [2021] VHMT 1, [2].

[86] *DTM* [2020] VMHT 35, [19].

[87] *Charter* (n 20) s 21.

[88] *AGD* [2020] VMHT 20, [11].

> it has been to begin to relieve your symptoms, the Tribunal decided the risks were too high for this approach to be a reasonable one at the time of your hearing.[89]

Thus, while the MHT considered voluntary options and decision making, explicit engagement with the relevant Charter rights could be more pervasive to ensure proper consideration of consumer rights.[90]

2.4 Charter Rights Conclusion

Overall, this report suggests that, although the MHT may have considered Charter rights in detail, there must be evidence of this consideration included in the published statements of reasons. It is only if this consideration is documented that one can accurately assess whether the MHT fulfilled its human rights obligations.

PART 3: RECOMMENDATIONS

The sections above identified issues such as a lack of SDM and documentation of engagement with human rights and principles in the MHT's decision making process. Relatedly, the Royal Commission discussed compulsory treatment as a default response in Victoria, and cited a lack of adherence to SDM practices and training.[91] It is acknowledged that the MHT faces difficulties due to existing in a highly demanded and under-resourced system.[92] However, the MHT's Royal Commission submission welcomed examination into its functions as part of the enquiry related to compulsory treatment, and what can be done to reduce it.[93] Thus the following key recommendations address the issues identified and would help strengthen existing provisions in the MHT and bring it in line with its purpose and human rights obligations.[94]

Recommendation One: Embed SDM in the MHT's decision making process

SDM mechanisms should be meaningfully considered by the MHT before making substitute decisions. The MHT should put into practice their recommendation that 'voluntary assessment and treatment, and respect for a person's views and preferences should be assumed and only displaced

[89] Ibid [18].

[90] *Charter* (n 20) s 38(1).

[91] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Summary and Recommendations 4; 91.

[92] Chris Maylea,'Tensions in the Work of Mental Health Tribunals' (2019) 150 (January-February) *Precedent* 13, 16.

[93] Mental Health Tribunal, *Further submission to Royal Commission into Victoria's Mental Health System* (August, 2020) 4 <https://www.mht.vic.gov.au/sites/default/files/documents/202009/MHT%20Second%20Royal%20Commission%20submission.pdf> ('*Further submission*').

[94] *MHA* (n 1) ss 68-71 (capacity and consent), ss 19-22 (advance statements), ss 23–7 (nominated persons), ss 78-89 (second psychiatric opinion).

where not possible'.[95] SDM should only be deemed 'not possible' when the MHT has actively balanced all Charter rights, principles and SDM mechanisms against the treating team's submissions. This approach should exist within a framework that reassures clinicians they will not be blamed or criticised for adopting a less risk averse approach.[96] As a result, personal recovery would be prioritised over clinical recovery,[97] which would enhance human rights compliance and contribute to a reduction in the rates of compulsory orders.

Recommendation Two A: Explicit consideration of rights

The MHT should demonstrate evidence of proper consideration of human rights, through explicit engagement with the s 11 principles, Charter rights and SDM practices.

One of the issues identified above is the difficulty in determining the extent to which rights and principles have been taken into account from the current method of documentation. Indeed in many cases, consideration of the principles and Charter rights is limited to a single sentence. There should therefore be a process for ascertaining this information, to better understand the cognitive decision-making process of the MHT members and the extent to which human rights are being considered. It is suggested that the MHT follow a model similar to the *Bare v IBAC* guidance test:[98]

- The decision maker should understand the rights affected;
- Seriously turn their mind to the possible impact on the consumer's human rights;
- Identify the countervailing interests and obligations and
- Balance these considerations against the treating team's submission.[99]

An outline of these steps is provided in Figure 1. The test has traditionally been used in relation to the proper consideration limb of the Charter,[100] however it may provide guidance for the optimum level of engagement required.

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[95] *Further submission* (n 89) 4.

[96] Ibid.

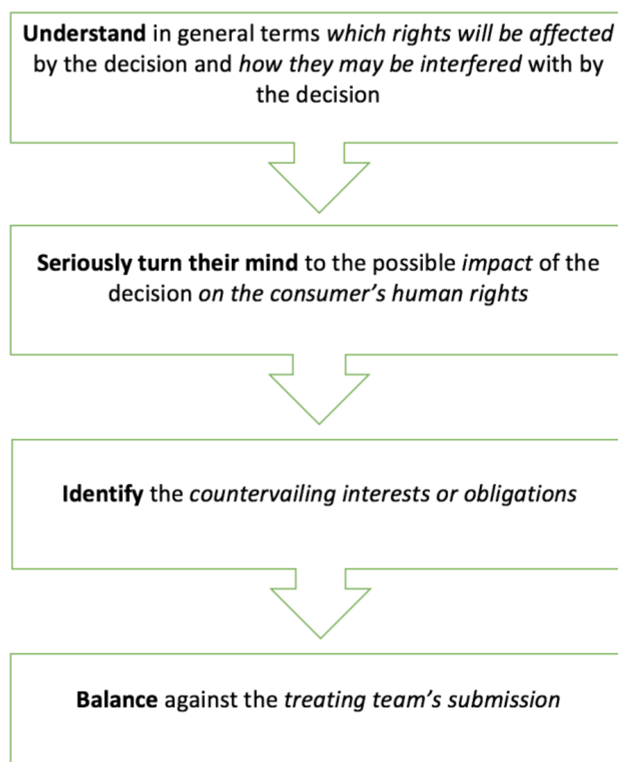
[97] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Summary and Recommendations 12.

[98] *Bare v Independent Broad-Based Anti Corruption Commission and Others* [2015] VSCA 197, 198 [218] (*'Bare v IBAC'*).

[99] Ibid.

[100] *Charter* (n 20) s 38.

Figure 1: Visual Representation of Recommendation 2A.



This figure is based on the Bare v IBAC guiding test. [101] The last step is adapted to the MHT context.

Recommendation Two B: Detailed and Consumer focused reporting mechanisms

All MHT hearings should be recorded to promote transparency, in line with Victorian Legal Aid's recommendation.[102] This is common practice in the NSW's equivalent MHT and the Victorian Civil and Administrative Tribunal ('VCAT').[103]Additionally, the process of publishing the recorded decisions should be consumer rather than MHT centred. Publication would be consent based as part of an opt in or opt out process. Where the consumer has consented, the documents would be sent to a subset or other body to ascertain whether the consumer's information can be sufficiently deidentified, in line with the right to privacy.[104] This process would be framed to address broader issues such as a lack of access to legal representation that may impact a consumer's ability to effectively participate.

[101] *Bare v IBAC* (n 92) 198 [218].

[102] Victorian Legal Aid, *Act for Change: A Mental Health and Wellbeing Act that realises the vision for change: Submission on the Mental Health and Wellbeing Act Update and Engagement Paper* (August 2021) 34.

[103] Ibid.

[104] *Charter* (n 20) s 13.

Recommendation Three: Ensuring effective review mechanisms

Oversight and review mechanisms need to be improved and be more available to consumers that have been subject to MHT decisions.

Although consumers have the right to have their decision reviewed by the VCAT,[105] this right is rarely used.[106] The review process should be made clear to every consumer. Further, improved recording and publishing of human rights considerations in decisions could also increase the use of review mechanisms.

Recommendation Four: Facilitating training for those with power under the MHA

There needs to be comprehensive, rights-based training for clinicians and mental health services that exercise power under the MHA.

The MHA has a strong emphasis on collaborative decision-making and clinicians play an important role in ensuring consumers are involved in decisions and aware of their rights.[107] While clinician handbooks and policies for recommending training exist, there is little evidence of these being comprehensively implemented.[108] Instead, it has been found that many clinicians have a lack of knowledge about their legal responsibilities, a lack of training and/or a continuing preference for best interest approaches.[109] Clinicians' increased understanding of human rights obligations may encourage SDM approaches between consumers and clinicians. Ultimately, this may encourage clinicians to provide treatment options more in line with human rights thereby providing alternatives that are less restrictive at MHT hearings and effectively reducing the need for compulsory treatment more generally.

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[105] *MHA* (n 1) s 201.

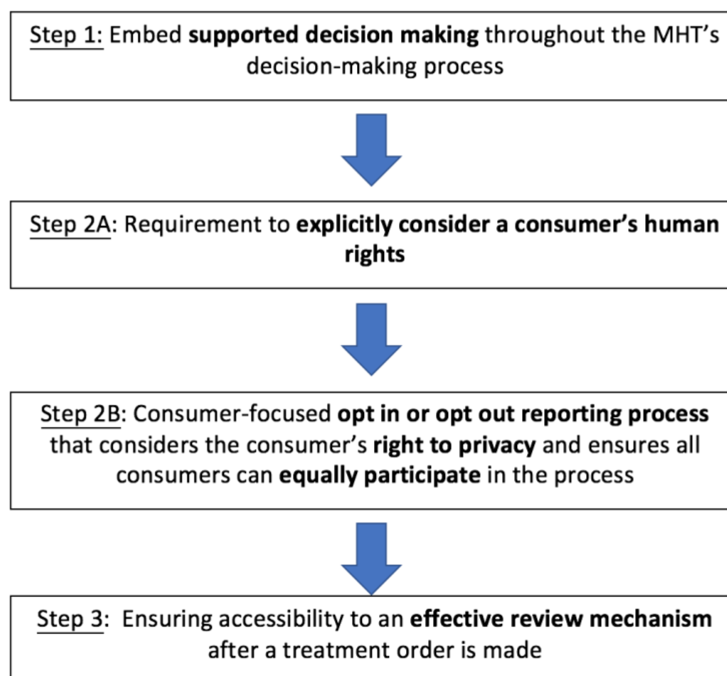
[106] *Annual Report* (n 28) 21, 24, 31.

[107] Hannah Cross, Ilan Rauchberger and Jayashri Kulkarni, 'Perspectives on the Mental Health Act 2014 (Vic)' (2014) 22(6) *Australasian Psychiatry* 569 ; for example, *MHA* (n 1) s 191.

[108] Katterl and Maylea, 'Keeping human rights in mind' (n 5) 58.

[109] Chris Maylea et al, 'Consumers' Experience of Rights-based Mental Health Laws: Lessons from Victoria, Australia' (2021) 79 *International Journal of Law and Psychiatry* 3.

Figure 2: Visual Representation of Key Recommendations



Step 1 relates to Recommendation 1. Step 2A relates to Recommendation 2A. Step 2B relates to Recommendation 2B. Step 3 relates to Recommendation 3.

CONCLUSION

This report has sought to identify trends in MHT cases and to discuss how the MHT could state human rights more consistently and explicitly. Firstly, the relevance of the Charter and s 11 principles to MHT decisions was clarified. Secondly, general trends, such as consistent use of generic statements rather than individualised analysis, were elucidated. Thirdly, specific case studies were utilised to demonstrate the variance in approach and the most common approach which lacks explicit documentation of rights. Finally, recommendations have been made as to how the MHT could further incorporate human rights in their decision-making process and recording of the decision. This would involve reforms such as, strengthening SDM practices, requiring MHT to record explicit and meaningful consideration of human rights and employing consumer-focused reporting mechanisms. Ultimately, these reforms aim to reduce the high number of compulsory orders through a rights-compliant approach.

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APPENDIX I

Summaries of the 40 recent MHT decisions, utilised throughout the research and preparation of this report, are listed below.

BVR [2020] VMHT 16

Overview: BVR's CTO was about to expire, and their treating team applied for another treatment order, while BVR applied to have the treatment order revoked.

Submission: Legal representative told the tribunal that because BVR was complying with their recovery plan, engaging with AOD services and had community support, there was no need for treatment order to prevent serious deterioration of mental health or harm to self or others. Also, BVR was seeing the treatment team twice a month, not receiving immediate treatment as required by criteria. Further they had an NDIS package, engaged with a job service provider and safe course, and were looking for a rental. Legal representative reminded the Tribunal that this decision should allow a person to develop and take on risks.

Treating Team Medical Notes/Reports: Treating team referred to a report on compulsory treatment and said BVR had been attending appointments and answering their calls generally. There had been improvement in mental state and psychotic symptoms and delusional thoughts. Dr TD, confirmed that none of the presentations had resulted in an admission, but advised that all BVR's presentations featured substance abuse and failure to take medication. Expressed concerns that BVR did not give enough weight to their diagnosis.

Tribunal Decision: Did not dispute that BVR had mental illness. Based on uncontested evidence, it was decided that BVR would need immediate treatment. Upon deciding whether BVR would receive immediate treatment if a voluntary patient as per their preference, they acknowledged that they had expressed a desire not to take medication, but accepted the treating team's evidence that voluntary treatment was not reasonable due to residual psychotic symptoms. Thus the Tribunal made a 26 week CTO.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. The Tribunal referred to BVR's preference, by summarising evidence of their preference but did not document that they considered this preference or other statements that demonstrated meaningful engagement with s11 rights.

***AAP* [2020] VMHT 17**

Overview: AAP's CTO was due to end, the treating team asked the Tribunal to make another Treatment Order.

Submission: AAP told the Tribunal that they did not agree that they had a mental illness. They also disputed information in the compulsory treatment report, specifically, that they threatened to kill their mother. AAP described the experience after this argument as being 'shot up and knocked out', they felt that the medical staff in the Emergency Department 'abused their power'. They denied delusions about their computer and camera being hacked. Further they told the Tribunal that if they were a voluntary patient that they would not take medication or have anything to do with the treating team. Legal representative provided a letter from the GP, who they had been seeing for seven years, which said that they had not observed any symptoms of mental illness. They also stated that they have full time employment, live with their mother and that they can have very expressive arguments. Further, they submitted that there was no evidence of an active mental illness, and that the principles in *Briginshaw v Briginshaw* applied, which cautioned against the use of and reliance on second-hand information for decision making, adding that there was no reliable evidence of a significant disturbance in thinking, mood, perception or memory. They also reminded the tribunal of the exclusionary factors in subsection 4(2) of the Act which states that a person is not to be considered to have a mental illness by reason only of antisocial behaviour; the use of drugs or alcohol; family conflict; or the fact that a person has previously been treated for mental illness. Lastly, the legal representative submitted that the report's characterisation of poor insight as evidence of mental illness was unfair and not relevant to the Tribunal's decision. She said section 5 of the Act did not require that a person accept they have mental illness or to accept a specific diagnosis.

Treating Team Medical Notes/Reports: The report stated a diagnosis of schizophrenia and use of cannabis and methamphetamine. It further stated that AAP has had limited interactions with the treating team and refused to attend the clinic. A 2013 report indicated delusional beliefs that caused AAP to break into their walls and exert verbal aggression towards their mother. The impact of illicit substances was flagged as a risk factor in deterioration and serious harm to others. Psychiatrists noted that AAP was functioning well and had ongoing employment but characteristically 'poor insight'.

Tribunal Decision: The Tribunal did not agree that AAP had mental illness as defined by the Act. They were not satisfied on the basis of cogent and compelling evidence that AAP experienced symptoms of mental illness, particularly due to s4(2) excluded factors. This was due to strong reliance on collateral information about symptoms in the report and limited personal observations from the treating team. No further criteria needed to be considered.

Human Rights: not abrogated.

***YDK* [2020] VMHT 18**

Overview: YDK's CTO was due to end, and their treating team asked the Tribunal to make another treatment order.

Submission: YQT's legal representative told the Tribunal that YDK wanted to be a voluntary patient and that this was the least restrictive form of treatment. They indicated that they would continue to take injectable medication, and would rather take it in the community than go to hospital. They would also keep in contact with the case manager and NDIS worker. YDK believed when they were on a CTO the doctors could perform psychosurgery while they were asleep, which gives them a strong incentive to take their medication. YDK had come to terms with the side effects of the medication and enjoyed engaging with hobbies, shopping and cooking for themselves and support from their mum. YDK was forthright about drug use and reminded the Tribunal that being a voluntary patient was their right.

Treating Team Medical Notes/Reports: The report stated YDK had a medical condition for 30 years, with symptoms of hallucinations and persecutory delusions that can cause them to be irritable and even hostile at times. The report further stated that they would need treatment to prevent serious deterioration in mental and physical health, as well as harm to self and/or others. Their psychiatrist expressed concern about them becoming a compulsory patient due to lack of follow up and deterioration in the past, as well as concern that YDK was still using drugs.

Tribunal Decision: The Tribunal accepted that YDK did have mental illness and needed immediate treatment, this was not contested. They were satisfied that stopping treatment could lead to serious harm, which has sometimes happened despite receiving treatment. The decision makers in this case applied the principle that patients should be supported to make decisions about their treatment and that voluntary treatment is preferred. This included looking at the circumstances from YDK's point of views and their preferences to achieve the least restrictive form of treatment. The Tribunal also stated it was empowered to make decisions that may involve an element of risk. The Tribunal indicated that risks can be managed with support, and the patient's willingness to take medication and desire to remain out of hospital meant that they could be treated as a voluntary patient.

Human Rights: Charter rights were not considered, however, there was evidence of s11 principles being considered and contributing to the decision that YDK could be a voluntary patient.

***BHI* [2020] VMHT 19**

Overview: The Tribunal had to decide whether to make an order for ECT for BHI.

Submission: Ms Murphy told the Tribunal that BHI understood the information about ECT and was of the firm opinion that they did not want it. BHI accurately described to the Tribunal the procedure for ECT in some detail, including the fact that it delivered an electric shock which caused convulsion. They had never had ECT before and did not want it. BHI was worried about the potentially bad effect it may have on their artistic work which was very important to them, and they would rather continue with their current treatment and medications. Ms Murphy submitted that BHI did have capacity to consent to ECT. Ms Murphy referred to the presumption of capacity in the Act and said that there was not sufficient evidence to rebut that presumption. She referred to the Supreme Court's decision in *PBU* and submitted that BHI was not required to make rational decisions or to have insight into their mental illness. Ms Murphy also submitted that there was a less restrictive way for BHI to be treated and that the test was not what was in their best interests. A less restrictive treatment option was to continue with the current treatment. BHI was happy to stay for a longer time in hospital and continue to trial different medications and dosages.

Treating Team Medical Notes/Reports: According to the report on Compulsory Treatment, BHI had used marijuana on a regular basis and was admitted to hospital in 2017 with a drug induced psychosis, and in 2019. BHI experienced a psychotic relapse in May 2020 after losing their job, ceasing all psychotropic medications and increasing his marijuana use. He was brought into the emergency department and diagnosed with a psychotic relapse of his schizoaffective disorder. BHI was currently being given oral psychotropic medications. BHI appeared able to understand the information regarding the proposed ECT treatment and was able to remember the information, they could not use or weigh the information due to the impact of their formal thought disorder.

Tribunal Decision: The Tribunal was satisfied that BHI was able to remember the relevant information about ECT treatment given their description of it. Consistent with the principles outlined in *PBU & NJE*, insight into a person's illness and the need for treatment is not the only consideration when assessing capacity to give informed consent. The Tribunal decided that BHI was able to weigh up the benefits and disadvantages of ECT and therefore the Tribunal was satisfied that BHI was able to use and weigh the relevant information about ECT. The Tribunal also indicated that they have considerable weight to the fact that BHI had a clear preference not to have ECT. They confirmed that their decision is based on the least restrictive way for BHI to be treated rather than being based on the best interest of BHI. Overall, as the Tribunal was satisfied that BHI has the capacity to give informed consent and there is a less restrictive way for BHI to be treated, it refused to grant the application.

Human Rights: Capacity discussions reflected, and explicitly referred to, human rights principles from *PBU & NJE*. S 11 principles were also explicitly weighed when making the decision to refuse the application.

***AGD* [2020] VMHT 20**

Overview: AGD had been admitted to hospital as a voluntary patient, a month later their treatment team contended circumstances had changed and wanted to make an ITTO.

Submission: Agreed with the treatment history that had been provided by treating team. In this past, AGD had engaged with treatment and therefore should continue to be a voluntary patient as the least restrictive option. They explained that they were feeling better than when they had showed up to hospital and wanted to continue with the treatment that was being provided. Their daughter talked about how their depression relapsed before they moved to Melbourne. The daughter also acknowledged the difficulty in family not being able to visit due to Covid. One son, BB, said that he thought AGD would not continue treatment as a voluntary patient.

Treating Team Medical Notes/Reports: The report stated history of treatment for depression, and that AGD described being fearful, extremely worried, experiencing no enjoyment in life and having constant suicidal thoughts. The treating team were also concerned about psychotic symptoms. The treating team wanted to make AGD a compulsory patient because they were having trouble making treatment decisions which was causing interruptions. Further, AGD had expressed wanting to live with daughter then return interstate, but the doctor thought they still needed to be in hospital.

Tribunal Decision: The Tribunal accepted that AGD needed treatment now to prevent deterioration in mental health and harm to self. The question to be decided was whether AGD could receive treatment on a voluntary basis. AGD's long history of voluntary treatment supported revoking a compulsory order. However, the treatment needed was only available in an inpatient environment. They considered that decisions could involve some degree of risk, however decided that given the seriousness of this relapse and how complex and difficult it had been to begin to relieve symptoms, the risks were too high for this approach to be a reasonable one. ITO was made.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. The s 11 principle of degree of risk was considered.

DDQ [2020] VMHT 21

Overview: DDQ was on a CTO and applied to have it revoked.

Submission: DDQ believed that their episodes of illness were due to delirium, but they were open to the possibility that there was an underlying problem. They wanted a new treating team and they felt that they could manage episodes of illness as a voluntary patient. They found side effects of medication distressing, and that it was unclear if medication was necessary as they preferred to live life 'half full', rather than 'half empty'. They only wanted to have medication if they had another

episode of illness. Their husband said that they are well between episodes, whether on medication or not. A letter from their Case Manager stated that, post discharge, there was no ongoing mental illness.

Treating Team Medical Notes/Reports: The treating team diagnosed late onset psychosis and said DDQ was admitted to a medical hospital ward three times last year, as well as two psychiatric ward admissions. They responded well to oral medication, but each time they were discharged from hospital they ceased the prescribed tablets, whereby mental state would deteriorate.

Tribunal Decision: The Tribunal could not be satisfied, on balance, that they had an ongoing mental illness that required immediate treatment.

Human Rights: Not abrogated.

***EHI* [2020] VMHT 22**

Overview: EHI was on an ITO and the treating team wanted to make an order for ECT.

Submission: EHI did not want ECT, and discussion of it made them very angry and upset. They would prefer to take more tablets, had no side effects and no problem taking them. Their legal representative submitted that EHI does not believe it is a good treatment for them and that there is less restrictive treatment available where they could have oral medication increased. Their brother submitted that although he thought ECT was good for EHI, it pained him to think about it being forced against their will.

Treating Team Medical Notes/Reports: the treating team stated EHI's long standing diagnosis of schizoaffective disorder and both recent hospital admissions were in context of aggressive behaviour causing risk. Discussion on ECT could never be complete because EHI would become very agitated. EHI had been trialled on several medications, and their treating team believes they need medication plus ECT weekly to stay stable. Their doctor said that they tolerated ECT well and did not experience side effects so far, and the doctor would be concerned about side effects if they increased dosage of medication.

Tribunal Decision: No assessment of capacity was necessary because the Tribunal decided there was a less restrictive option available, especially considering EHI's views. They confirmed that 'the question is not whether it is in your best interests or whether it is clinically the best treatment for you, rather the Tribunal is required to consider your views and preferences about ECT and any alternative treatments as well as the medical or clinical considerations.' Here, there was a viable treatment alternative, that is, increasing medication.

Human Rights: Charter rights consideration was not documented but s11 principles were engaged with.

SUN [2020] VMHT 23

Overview: SUN was on a CTO that was due to end, the treating team applied to make another order.

Submission: Legal representative spoke on SUN's behalf. They said that agitation and aggression in living circumstances with sibling were not a sign of mental illness. They submitted that while there was acceptance of intellectual disability and autism, there was no firm diagnosis of mental illness. Their legal representative further submitted that even if the tribunal decided that there was mental illness, it is unlikely that without immediate treatment deterioration in mental and physical health would occur. Further, there would be no greater risk of harm because the trigger for aggression they have exhibited in the past was living with their sibling, which was no longer the case and behaviour had not been a problem since. They have ample support without the need for a treatment order, including an NDIS package and engagement with Headspace. Under the Charter, they are entitled not to be subjected to medical or scientific experimentation or treatment without full, free and informed consent.

Treating Team Medical Notes/Reports: The report stated that they had a diagnosis of first episode psychosis. This is from the fact that they had ideas and paranoia to a delusional intensity that their sibling was trying to harm them, an obsession with America, intense preoccupation with their sibling and past suicidal thoughts. treating team believed that the reason behaviour had settled since being home was due to taking medication. They contended a further order was needed to make a firm diagnosis and because medication may be stopped if they were to be a voluntary patient.

Tribunal Decision: Not satisfied on balance that SUN had a mental illness, taking s4(2) of the Act into account which says a person is not considered to have a mental illness by reason only of having an intellectual disability, or because they engage in antisocial behaviour, or has previously been involved in family conflict.

Human Rights: Not abrogated.

CFQ [2020] VMHT 24

Overview: CTO was due to end, CFQ's treating team applied to have another Treatment Order made.

Submission: CFQ did not agree that they had limited insight; they realised that they have schizophrenia and have been seeing a psychologist recently and a psychiatrist long term. Further, they had been seeing a peer worker and found it helpful to have someone to talk to. They told the tribunal they had been enjoying hobbies and looking for work. They had obtained NDIS support for gym and psychology costs. If voluntary, they would see a psychiatrist and stay on medication. Their

previous relationship with psychiatrist ended because they suggested ECT which CFQ was strongly opposed to. Their peer worker was impressed with CFQ's dedication to recovery.

Treating Team Medical Notes/Reports: Did not have an up-to-date report at the time of hearing. The report from 12 months ago stated that, when unwell, they present as irritable, agitated, misinterpreting, with delusional memory and persecutory delusions. The report stated that they require immediate treatment to prevent serious deterioration in their mental health, and to prevent serious harm to themselves and to others. Case Manager said that in the past when they had been voluntary, their adherence to treatment dropped off. However Case Manager also said that their breakthrough symptoms are under control now and that they have medication and coping strategies through their psychologist.

Tribunal Decision: There was no contestation that CFQ had mental illness. The Tribunal accepted what the Case Manager told the Tribunal during the hearing and found that CFQ required immediate treatment to prevent serious deterioration in their mental health. However, due to progress noted from CFQ and the treating team, the Tribunal accepted that the least restrictive course would be to make CFQ a voluntary patient.

Human Rights: Charter rights consideration not documented, however, s 11 principles (least restrictive test and degree of risk principles) were considered.

***VBD* [2020] VMHT 25**

Overview: The Tribunal held a hearing to decide whether to revoke VBD's Inpatient Temporary Treatment Order ('ITTO') or make another Treatment Order.

Submission: VBD's legal representative, Mr Gahan, said that VBD disagrees with their diagnosis of schizoaffective disorder. VBD believes that the experienced symptoms were a consequence of their ADHD diagnosis. VBD recognises that they used to experience hallucinations and were quite unwell. They said their goal is to be medication free but that they recognise the need to take prescribed medication when required to. VBD elaborated that if it were their choice, they would not take prescribed medication. Overall, VBD was willing to engage with their treating team but would prefer to do so on a voluntary basis. They also expressed a desire and intent to stop gambling and using drugs, which has negatively impacted on their mental health and relationships in the past.

Treating Team Medical Report/ Submissions: The report set out VBD's mental health history. It indicated that several of their admissions were connected to drug use and the resulting deterioration in their mental health. The report detailed a long history of drug use, confirmed by their mother. The report also said that VBD had been diagnosed with schizoaffective disorder, including delusions, that constitute a significant disturbance of thought and perception. Dr MO said that the medication has had positive effects. They said hallucinations had ceased but delusions were still present. VBD maintained that they did not need medication. The goal was to keep VBD in SECU

until the delusions lessened and then allow them to have home leave with their mother. However, the COVID-19 restrictions meant this leave was not possible.

Tribunal Decision: The Tribunal decided to make a CTO for 26 weeks as all four treatment criteria were fulfilled. The Tribunal noted that VBD presented mentally well during the hearing, but it was satisfied they had a mental illness that required immediate treatment based on the treating team's evidence. It emphasised the need for community support as part of the holistic treatment, particularly to address their drug use. The Tribunal decided that VBD would not engage with the Community treating team without the Order and would discontinue from the medication. The Tribunal decided to make a CTO rather than the previous ITO. It referenced that the treating team focused on past symptoms and did not present a clear pathway for community treatment and discharge. On this basis, the Tribunal considered Charter rights and were satisfied that the patient could receive treatment in the community under the Order as an alternative to in hospital.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. It also referenced the Charter rights when discussing why it was a CTO instead of an ITO.

***NKI* [2020] VMHT 26**

Overview: NKI's treating team applied for another Inpatient Treatment Order ('ITO') which would mean that they would remain a compulsory patient. There was also an electroconvulsive treatment order before the Tribunal. The statements of reasons requested focus on the ITO decision, specifically on the duration of the ITO.

Submission: NKI said that they would prefer to be at home rather than in the Secure Extended Care Unit ('SECU'). They also indicated that they have job opportunities and wish to become involved in the community, for example, in their church and its activities. Notably, NKI preferred to proceed with the hearing notwithstanding their organised representation through Victoria Legal Aid not dialling into the conference call.

Treating Team Medical Report Submissions: The report included information about NKI's mental health history. It said that NKI had a mental illness characterised by significant disturbance of thought, mood, perception and memory. When unwell, NKI experiences distressing delusions, thoughts of harming themselves and frustration by perceived memory issues. NKI had not lived independently for approximately ten years and the Treating Team believes that NKI still requires immediate treatment, specifically in SECU, to prevent their serious deterioration in their mental and physical health and to prevent serious harm to themselves and others. The treating team referred to the COVID-19 restrictions impeding the discharge and necessitating the Treatment Order at present. For example, SL referred to the fact that community treating team has no access to

maintenance ECT because of the restrictions. Dr CP said that NKI's treatment plan has developed over years, and he could speak to the chief psychiatrist's office about community ECT. Dr TD said that the goal is for NKI to be managed in the community but due to the complexity of their illness they required a combination of therapies.

Tribunal Decision: The Tribunal decided to make an ITO for 12 weeks and an Order approving 12 electroconvulsive treatments. The Tribunal found that the criteria for the Order was fulfilled; including having a mental illness characterised by significant disturbance of thought, mood and perception which necessitates immediate treatment to prevent serious deterioration in mental health. These conclusions were largely drawn based on the treating team's report. The Tribunal also noted that during the hearing, NKI had significant delays in answering questions and the answers were short with minimal content. They found that NKI would receive immediate treatment if an Order was made, and the Order was necessary due to the complexity in management and NKI's disagreement with their medications. The Tribunal accepted that this was to be an ITO rather than CTO due to the severity of symptoms. Importantly, the Tribunal decided to make a 12-week Order rather than the 26-week Order that the treating team recommended. This was because the Tribunal anticipated that 12-weeks would be sufficient time for COVID-19 restrictions to ease and for NKI's discharge plan to be consolidated, and to explore Dr CP's possibility of community ECT. Further, the fact that the Legal Aid lawyer had not attended the hearing like planned, and this shorter period would allow them to be involved in further Tribunal hearings. Lastly, the Tribunal got the impression that NKI was close to being discharged from SECU, so if this did not occur within the 12-week period then the Tribunal could have some oversight into the reasons for the delay and progress in discharge planning.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter.

***AKU* [2020] VMHT 27**

Overview: The consumer applied to the Tribunal to have their ITTO revoked.

Submission: AKU said that they currently felt stable and well. They said that they had previously experienced a drug-induced psychosis in 2014 and had most recently been admitted to an inpatient psychiatric unit after voluntarily admitting themselves to hospital when suicidal. During this recent admission to hospital, AKU felt they had symptoms of mania but disagreed with the hospital doctor's suggestion of bipolar disorder. AKU detailed their history with medication in the past and how they changed prescriptions after their private psychiatrist said that they had anxiety rather than bipolar disorder in 2019. AKU trusted their psychiatrist. They said they would take their prescribed medication but wanted to leave the hospital as they felt it was no longer necessary. AKU's partner

supported their claim that they would take medication as they had always fulfilled this responsibility in the past.

Treating Team Medical Report/ Submissions: The report said that during the current admission, AKU's diagnosis was revised to bipolar affective disorder. It detailed the experienced symptoms. It also detailed the medication used to treat AKU since admission, which includes both antipsychotic and mood stabilising medication, that has seen improvements in behaviour. It was noted that when the mood stabilising medication was reduced there had been increased irritability that deteriorated relationships with staff. Dr AP said there had been good progress, with only oral medication used, and that he had considered treating. He said he was confident in diagnosis of bipolar affective disorder and unsure of the impact of recent medication change. Dr AP also said he had spoken to the private psychiatrist and he was unsure at which point they could take over treatment or be able to provide case management. He said he anticipated that AKU would be discharged in the week after the hearing and the aim of further period in hospital was to prepare ground work for recovery and relapse prevention (including linking with community supports, working with AKU to understand their illness and importance of managing stress and sleeping). The evidence to the Tribunal was the purpose of a longer hospital admission was to ensure that there was appropriate discharge planning for transition to community care.

Tribunal Decision: The Tribunal decided to make an ITO for six weeks. The Tribunal agreed that, based on the evidence, AKU had experienced symptoms of a mental illness which needed to be treated immediately to prevent mental health deterioration and that this will be received on a Treatment Order. However, the fourth criterion was disputed among the members. The majority decision was that AKU would not receive treatment if a voluntary patient. AKU and their partner said that they would take the medication if prescribed by a doctor, however, the majority were still concerned that AKU did not agree with all aspects of diagnosis and treatment. This included the fact that AKU did not accept their new diagnosis, and the medication. They also emphasised the need for a discharge plan.
However, the community member dissented and said that AKU gave a coherent and articulate account of their situation. They referenced the AKU and their partner's evidence that they were regimented about taking medication and would continue to take it. Further, they pointed to the fact there had been improvement in mental health, an absence of suicidal thoughts and discharge was planned for next week. They therefore found that AKU could be treated as a voluntary patient. They said this decision was aligned with mental health principles as it was the least restrictive method and consumers should be able to make decisions regarding their treatment and recovery that involves a degree of risk.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. The dissenting member considered s 11 principles.

***AMX* [2020] VMHT 28**

Overview: The Tribunal held a hearing to decide whether AMX should continue to receive treatment on an ITO. The treating team also made an application for an ITO.

Submission: AMX' legal representative, Robyn, made submissions on their behalf. She said that the patient acknowledges that they have anorexia nervosa, require treatment and are medically unwell. However, the AMX preferred to be a voluntary patient and felt this level of self-determination was essential to their recovery. They indicated that if this control was taken, their recovery would suffer and they would be more resistant, as evidenced by unsuccessful past periods of compulsory treatment. It was submitted that although there would be a degree of risk involved in receiving treatment voluntarily, this was contemplated by the MHA and mitigated by protective factors. An alternative treatment plan was proposed, where AMX intended to remain in hospital and comply with treatment until medically well. The Tribunal was provided with a copy of their advance statement and a document responding to the report which clearly articulated AMX' preference for treatment, that is, for it to be voluntary and in the community. AMX indicated that they had insight into how unwell they were. AMX gave a further statement reiterating the above and highlighting that they knew that their physical health was to the point that they may have died. AMX indicated they had no rapport with the treating team, but they were grateful for medical treatment and confident that they could see others for treatment. AMX denied assertions that they behaved in ways to interfere with their physical recovery. They became audibly distressed when a plan to transfer them to an inpatient eating disorder unit was discussed.

Treating Team Medical Report/Submissions: The treating team detailed AMX' mental health history and their diagnosis with anorexia nervosa. They detailed that AMX was significantly underweight and required careful medical treatment to reduce their risk of death and get them physically healthy. They detailed past admissions and had been close to death in the past due to how severely unwell they were. They said that AMX has diminished awareness of the seriousness of their illness. They said that AMX has struggled to recover in the community, drawing on examples of them absconding from appointments and requiring police and ambulance assistance during hospital admissions. They said that during the current treatment, AMX has not been compliant and refused medical assessments. They said that community treatment had been unsuccessful in the past. The treating team emphasised the significant stress on family relationships due to AMX' negative response to their concern. Overall, the treating team said that due to severity of illness, AMX cannot be treated in a less restrictive manner, they require inpatient medical treatment to prevent risk of death and further deterioration. AMX was described as one to always try to negotiate their treatment and was difficult to work with.Dr CP, who was a psychiatrist in the community, emphasised the transfer to community should occur when they are medically stable, rather than necessarily well. Dr CP questioned whether compulsory care would be counter therapeutic given AMX' degree of opposition. Dr TD said while AMX is slowly improving, their health is still precarious, and a feeding tube is still necessary.

Tribunal Decision: The Tribunal decided to make an ITO for 12 weeks. The first three criteria were clearly met. In consideration of whether AMX would still receive immediate treatment as a voluntary patient, the Tribunal considered their strong preferences as per above and whether compulsory treatment would be counter therapeutic given their strong opposition and visible distress. They noted that they considered AMX' self-determination and the mental health principles under the Act. However, the Tribunal was satisfied that the risk of AMX discontinuing necessary treatment was too substantial. They accepted evidence that the staff have difficulty treating AMX due to behavioural issues and non-compliance. They noted that AMX said they recognised the need for treatment, however, they were not convinced that they recognised the severity and consequences of their illness. They indicated that the alternative treatment plan AMX provided would be difficult to organise during COVID and lacked workable details. Overall, noting AMX's 'distress', the Tribunal found an ITO necessary, and that it was the least restrictive approach.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. They referred to the s 11 principles.

***JJM* [2020] VHMT 29**

Overview: The Tribunal held a hearing to decide whether the JJM's CTO should be revoked or whether another Treatment Order should be made.

Submission: JJM believed that they did not have a psychotic illness, and the experienced symptoms were a feature of their autism spectrum disorder. They claimed the report was historically incorrect and they did not give permission for this information to be accessed. They indicated that a previous admission was the result of their housemate manipulating a situation to the police and the health system. They said that the admission had damaged their business and relationships. Additionally, they had been abused by the hospital staff. JJM, with support of their lawyer, asserted that the spiritual beliefs that led to their admission, was a special interest rather than evidence of psychosis, and that this was not unusual by virtue of their autism. JJM believed that their diagnosis was a means for physicians to manipulate them into having an operation. They did not believe they had paranoia and asserted that their concerns were in connection to real life events. The lawyer submitted that immediate treatment was not required because it would be unlikely to affect their autism and there was no psychotic illness to treat.

Treating Team Medical Report/Submissions: The report stated that JJM was diagnosed with autism spectrum disorder and schizophrenia. JJM had been hospitalised after an episode of psychosis and while their mental health had improved with treatment, they continued to express paranoia. The report details JJM's history of mental health admissions, treatment and experienced symptoms, including details on their delusions and paranoia. The report stated that JJM required immediate

treatment to prevent serious deterioration in their mental health. This opinion was informed by their history of admissions. The report also indicated concern for JJM's physical health and a possibility of serious harm to themselves as during previous psychotic episodes they had become homeless, fasted and walked into traffic.

Tribunal Decision: The Tribunal decided to make a CTO for 26 weeks. The Tribunal found that JJM was experiencing symptoms of a mental illness. They found that despite the patient believing the report was incorrect, they had no reason to discount the information and believed what was described were beliefs of a persecutory and delusional nature rather than being explainable by autism. The Tribunal, based on detailed evidence from the Treating Team, well-documented previous admissions, evidence from the JJM's sister, life events and presentation at the hearing, supported the finding that JJM had a psychotic illness. The Tribunal found that without immediate treatment, their mental health could significantly deteriorate, and their physical health or safety may be compromised. The Tribunal accepted that JJM was responding well to medication with a reduction in delusionary beliefs and that there was a risk of significant relapse if medication was ceded based on history. The Tribunal also found that JJM would receive immediate treatment if on a Treatment Order and that they would discontinue from treatment if they were a voluntary patient. Therefore, they found as JJM did not agree with their diagnosis and treatment, there was no less restrictive way for them to receive treatment.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter.

CGP [2020] VMHT 30

Overview: CGP applied to the Tribunal to revoke their ITO.

Submission: CGP's lawyer submitted that CGP did not accept their diagnosis of schizophrenia. They instead believed that their mental health issues were the result of substance use, and they have since been resolved. CGP did not believe that they required treatment for mental illness but stated they would agree to accept treatment to remain out of hospital. CGP's lawyer submitted that CGP was compliant with and willing to continue taking antipsychotic medication. They were also willing to engage with the community team and had opportunities for work when discharged. It was submitted that compulsory treatment was not appropriate as it should not be used as a precaution to prevent substance use. Further, that CGP should be allowed to make decisions about their treatment that involve a degree of risk. This was to respect rights to dignity and autonomy.

Treating Team Medical Report/Submissions: The report stated that CGP has a significant history of substance abuse. It also stated that he has a significant history including many assault charges, several of which are still pending. It stated that CGP was diagnosed with schizophrenia,

antisocial personality traits and poly substance use disorder which constituted a significant disturbance of thought, mood and perception. It detailed the extent of their illness, including experiencing delusions of paranoia, consuming their own urine and faeces, mood disturbances and command hallucinations. The report indicated that CGP required immediate treatment to prevent further deterioration in their mental health. They were currently being treated with depot antipsychotic medication. Dr TD pointed to the fact that CGP had poor insight into their condition and did not believe they required treatment. The report also indicated that CGP requires immediate treatment to prevent deterioration to their physical health, pointing to their past of consuming urine and faeces, as well as further assessments needed to investigate the seizures that CGP experienced. Additionally, it was needed to prevent serious harm to another due to their extensive forensic history. Dr TD was concerned that CGP would cease medication if he was a voluntary patient.

Tribunal Decision: The Tribunal decided to make a CTO for 26 weeks. The Tribunal, in acceptance of the treating team's evidence, found that CGP experienced a significant disturbance of thought, mood and perception. However, they were satisfied that CGP's mental state improved since they stopped using substances and accepted that there were two possibilities; that their mental health issues were a result of the substance use or the result of enduring schizophrenia. The Tribunal was satisfied that CGP required medication to prevent serious deterioration in their mental and physical health, and to prevent serious harm to another person. The Tribunal found that immediate treatment will be provided to CGP if the Tribunal made a Treatment Order. The Tribunal indicated that they considered a range of factors, including CGP's views, their treatment history, their support network, and their social situation. The Tribunal was satisfied that a Treatment Order was needed, emphasising their lack of genuine insight into their mental illness. However, the Tribunal made a CTO instead of an ITO. In making this decision they noted that there was a degree of risk but were satisfied that the negative impacts of continued detention in hospital outweighed the treatment benefits for CGP. They noted that CGP was motivated to accept treatment in the community.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. S 11 principles (s11(1)(a), (d) and (e) were briefly considered when the Tribunal decided to make a CTO instead of an ITO.

***OYC* [2020] VHMT 31**

Overview: The Tribunal held a hearing to decide whether to revoke OYC's ITTO or make another Treatment Order.

Submission: OYC's legal representative, Olivia, submitted that OYC should be treated voluntarily. However, if the Tribunal deemed a Treatment Order necessary, OYC should be subject to a CTO rather than an ITO. Both Olivia and OYC emphasised that they believe that they have a different diagnosis to that suggested by the treating team. OYC felt misunderstood and not listened to by the

treating team. For example, OYC emphasised that their speech characteristics arise from their autism and ADHD whereas the treating team used it as evidence of bipolar affective disorder. OYC's friend supported their claim that their speech pattern and manner is often misinterpreted. OYC outlined their social and family struggles, their history of diagnosis and their history with medications. OYC indicated their willingness to take antidepressants, attend a Prevention and Recovery Centre ('PARC') as a voluntary patient and continue their relationships of care with their general practitioner, private psychiatrist and psychologist.

Treating Team Medical Report/Notes/Submissions: The report chronicled the OYC's history of mental health treatment and diagnosis. This included the circumstances of the OYC's current admission. It said that OYC abruptly ceased their medication two weeks before admission, and their NDIS support worker contacted the CAT team after being concerned for OYC's mental health. OYC was assessed as experiencing a manic episode of bipolar affective disorder. It was determined that this was a significant disturbance of thought and mood and there was a need for immediate treatment to prevent serious deterioration in mental health and to prevent serious harm to themselves and others. Dr IN spoke of how the OYC's presentation at the hearing was very different to how it was earlier in the admission as the symptoms of mania had dissipated. Dr IN said there was a bed available at PARC immediately and agreed that they were approaching transition to community treatment. Dr TD indicated that the manic episode could alternatively have been caused by an increase of antidepressant dose.

Tribunal Decision: The Tribunal decided to revoke the Temporary Treatment Order on the basis that OYC would receive immediate treatment voluntarily. The Tribunal indicated that while there was disagreement over the diagnosis, it was nevertheless a significant disturbance of thought and mood consistent with a manic episode as per the evidence. The Tribunal also found immediate treatment was needed to prevent serious deterioration of OYC's mental health, but not to prevent serious harm to themselves or others. However, the Tribunal found that there was no clinical reason to prevent voluntary treatment, and therefore revoked the Order. This was largely due to the available beds at PARC and OYC's indication that they would attend a PARC facility and continue to get treatment in the community.

Human Rights: Not abrogated.

***XNA* [2020] VMHT 32**

Overview: The Tribunal held a hearing to decide whether to revoke XNA's CTO or make another Treatment Order.

Submission: The Tribunal was provided with XNA's Advance Statement made in February 2020. The statement outlined their medication preferences; for example, they named specific kinds of medication they did not want, their preference for small doses and their knowledge of how to improve their health without severe medications. At the hearing, XNA said that they did not want

to be on a Tribunal Order due to its restrictive nature. XNA articulated that they would prefer to see their private psychiatrist, that they felt that their current medications were not treating their anxiety and which oral medications they preferred. They indicated that they had no compliance issues for the past nine months and that they would be open to discuss continuing with medication under the care of their private psychiatrist. Nicholas, on behalf of XNA, made submissions that treatment could continue without a Treatment Order by providing evidence that XNA could be trusted with their own care, had a strong support network and would be willing to take oral medication. The patient's two main supports, CA (carer) and SI (friend), who had known the XNA for 15-25 years also made statements in support of their position. They endorsed previous statements that the XNA was compliant, functional in periods without medication and at a new stage in their life.

Treating Team Medical Report/Notes/Submissions: The report said that XNA was diagnosed with paranoid schizophrenia in 2005 and detailed periods of treatment through a private psychiatrist and community mental health teams. The report also said that XNA last saw the private psychiatrist in early 2019 and in late 2019 there were a series of hospital admissions and suicide attempts. The report indicated that XNA needed treatment for their significant mental health issue to prevent serious deterioration in their mental and physical health. The clinical notes said that the private psychiatrist was willing to work with XNA again and was not aware of the recent difficulties. The doctor relied heavily on historical information but was concerned that XNA not accepting their diagnosis would have implications on their willingness to continue with medication and increase their chance of relapse. The doctor said that XNA had no active psychotic symptoms currently, but the case manager confirmed that they had psychotic beliefs in the past, including about their private psychiatrist. The Case Manager also found it difficult to engage with XNA as they required all communications through their private solicitor. The doctor and Case Manager agreed that there could be a transition of care to the private psychiatrist but this requires XNA to attend reviews with them to aid this transition.

Tribunal Decision: The majority of the Tribunal decided that all the treatment criteria applied and therefore made a Community Treatment Order for six-weeks. All three members were satisfied that the first three criteria for a Treatment Order was fulfilled. The majority of the Tribunal (the psychiatrist and legal members) found that the fourth criterion was fulfilled; a Treatment Order was necessary and the least restrictive way for XNA to receive treatment. They found this on the basis that, despite XNA acknowledging that they are doing much better and they are well supported, they did not accept that the medication they received could be contributing to this progress. Importantly, there was also not yet a plan to transition care from the current treating team to the private psychiatrist and the members decided that a 6-week order would be sufficient to achieve this. However, the community member dissented and said that XNA could receive treatment as a voluntary patient. They pointed to factors such as XNA having received treatment voluntarily for approximately 15 years, the private psychiatrist being willing to resume their care for XNA, the interfamily legal matter XNA was involved in being resolved, and the acknowledgement by XNA

that they need treatment and a transition plan. Further, they had a support network and clear goals to engage and study, motivating them to stay well.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter.

***LJV* [2020] VHMT 33**

Overview: The consumer applied to the Tribunal to review a decision made by their authorised psychiatrist. The psychiatrist sought to transfer the patient's treatment from Ursula Frayne Centre ('UFC') to the Adult Mental Health Rehabilitation Unit ('AMHRU') at Sunshine Hospital.

Submission: LJV explained why they wished to remain at UFC. They had long-term goals of living more independently in the community and enjoyed the freedoms at UFC. They had a negative experience at a different secure extended care unit and this informed their view that these same freedoms would not be available at AMHRU. James, the LJV's lawyer, submitted that a transfer would be against their will, and that their preference was to remain at UFC until they could go to a Supported Rehabilitation Service ('SRS'). LJV had established good relationships of support and camaraderie with the staff and other patients at UFC. Further, James submitted that the treating team's report did not establish that the transfer was necessary. He emphasised that the Tribunal must be satisfied with the proposed plan for LJV and have clear information about the different, and necessary, treatment that was available at AHMRU. James also recognised the COVID environment made AMHRU more restrictive and that LJV would benefit from more information about AHMRU.

Treating Team Medical Report/Submissions: The treating team's report outlined that LJV would benefit from treatment at AMHRU due to factors such as a better ability to optimise medications, manage medication compliance and provide adequate supervision. It noted that AHRMU allows for more activities, linkages, interactions with others and services, however, acknowledged that these could be limited by the COVID environment. The Tribunal directly asked the treating psychiatrist about how this treatment would only be available at AMHRU and there was no clear answer except reiterating that it allowed medication to be optimised. Upon further questioning, the treating psychiatrist noted that AHMRU has an occupational therapy input that is not available at UFC. They also said that there was a meeting with LJV about the transfer but it did not go well.

Tribunal Decision: The Tribunal decided that one of the criteria in the Act was not satisfied and consequently granted LJV's application to stay at UFC. The Act specifies that an authorised psychiatrist can only vary the patient's Treatment Order if they are satisfied that the variation is necessary and the transfer is accepted. While the transfer was accepted, the Tribunal found that the treatment available at AHMRU was not necessary and sufficiently important to justify overriding

LJV's views and preferences. It said that there was not sufficient detail of the treatment or assessments that would be provided at AHMRU. The Tribunal noted that during the hearing, LJV seemed to become more open to considering the transfer, especially considering his long-term aims of independence. Therefore, it highlighted that this decision does not prevent the authorised psychiatrist making a variation later if circumstances change, such as LJV agreeing to the transfer or if more information about why the transfer is necessary is found.

Human Rights: Charter rights not considered, s 11 principles (views and preferences) weighed in decision to deny transfer.

***CIE* [2020] VMHT 34**

Overview: This case involved an application by CIE's treating team for another Treatment Order.

Submission: CIE submitted that they lived alone and worked in their parent's business. They informed the Tribunal of the medical issues they were facing including issues with digestion. It was difficult for them to concentrate, coupled with eyesight issues that made reading and other work problematic. They believed that their medication had a negative impact on them. They were unhappy with the report that emphasised deficits rather than gains. They did not agree with the schizophrenia diagnosis and did not believe that medication was either necessary or helpful. An alternative medicine practitioner was engaged by the consumer. They believed that they had psychic abilities that antipsychotic medication was impeding.

Treating Team Medical Notes/Reports: The treating team provided a report that outlined CIE's history with mental health services. They had engaged with community health services between 2010 and 2011. They re-engaged with public health services in 2020 following concerns raised by family and neighbours. Upon assessment it was concluded they were experiencing tangential thoughts, pressured speech and elevated moods. The Team was concerned with the risks to the CIE's housing and reputation if treatment was not administered. Their CM provided that they were now less agitated and engaged more readily with the Team. The treating doctor stated their health had improved but they were not yet at their baseline.

Tribunal Decision: The Tribunal was satisfied that when unwell CIE experienced disorganised thoughts and was agitated. It concluded that they had a significant disturbance of thought and mood. It was accepted that treatment had reduced their symptoms and could prevent further relapse. Thus it was held that immediate treatment was required to prevent deterioration in their health. The Tribunal took into account the CIE's opposition to antipsychotic treatment. They wished to pursue alternative therapies and were aware of the risks of relapse. Considerable support was available from their parents who were aware of the early warning signs and would take action if necessary. The Tribunal acknowledged the evidence of deterioration. However, it also took into account that CIE had managed for a significant number of years on their own. The Tribunal determined that the use of the Act to enforce treatment would be unnecessarily restrictive. It found that the treating

team had not presented a plan that was cognisant of CIE's rights as articulated and enshrined in the principles of the Act. The Tribunal gave weight to the principles of the Act particularly subsections 11(a), (d), and (e). It was concluded that the negative impacts of continued compulsion under the Act outweighed the treatment benefits. Therefore, the tribunal decided the criterion was not and the Treatment Order was revoked.

Human Rights: Charter rights not discussed, s 11 principles (11(a), (d) and (e)) considered when making the decision.

***DTM* [2020] VMHT 35**

Overview: This case involved an application by DTM to have their Treatment Order (TO) revoked

Submissions: DTM applied to have their TO revoked because they did not believe they were paranoid or psychotic and did not hear voices. They were concerned with the side effects of medication which included tremors, tiredness, ulcers and hair loss. They believed that ECT had no positive effects but did affect their memory. Without the TO, they would cease medication and not continue to see their Case Manager or doctors. They provided that if they needed help they would rely on family and friends. They anticipated ceasing medication presented no risks and would result in improvement. Their husband supported their wishes to come off medication. The husband stated that there would not be any risks to the relationship if they came off medication.

Treating Team Medical Notes/Reports: The treating team's report provided that DTM lived with their husband and had good support from their three adult children. They had a diagnosis of schizophrenia. The report stated that medication kept them reasonably well. The Team was of the view that medication reduced DTM's symptoms as well as the risk of damage to their relationships and reputation. Their psychiatrist informed the Tribunal that they had an obsessive desire to cease treatment and did not have insight into their condition. The psychiatrist was of the impression that DTM was not on the right medication. The CM submitted that DTM was concerned with side effects and had explored changes with previous psychiatrists at the service. The CM added that DTM had a full life with a supportive family.

Tribunal Decision: The Tribunal accepted the information in the report and concluded that DTM had a medical condition which caused significant disturbances in their thoughts. The Tribunal acknowledged that they were at the time relatively well and had been stable without hospital admission for six years. Though it was satisfied that treatment was beneficial, there was no recent evidence of deterioration nor harm to themselves or others. The Tribunal took into account their support system. Consideration was given to their strong desire to stop treatment which they believed was extremely harmful to them. The principles in the Act state that individuals are entitled to make decisions that involve a degree of risk. The husband's admissions were taken into consideration. The Tribunal concluded that though there were risks of deterioration those risks could be managed. It was of the view that given the patient's significant support and their lengthy

period of compulsory treatment, it was reasonable for them to make their own decisions. As a result, immediate treatment was not necessary and the Treatment Order was revoked.

Human Rights: Charter rights not discussed, s 11 principles considered when making the decision.

***OSR* [2020] VMHT 36**

Overview: This case involved an application from OSR's treating team to extend their Inpatient Treatment Order (ITO) by 26 weeks.

Submission: Christal, the legal representative, informed the Tribunal that OSR accepted they had bipolar affective disorder and needed treatment. They were willing to accept treatment. There were mistakes in the report OSR wished to correct. These included information on OSR's children, that they had not used cannabis in three years, that they were only a social drinker, had stopped smoking and were compliant with prescribed medication. OSR was keen to go home where they lived with their wife. OSR acknowledged that their mental state had improved since admission. They only asked questions about their medication in order to have a say and always took what they were prescribed. They wanted to be placed on a CTO and were happy to continue seeing their Treatment Team. OSR submitted that they disagreed with the aspects of the report that stated they were violent. They provided that their wife knew their early warning signs. Their wife informed the Tribunal that she wanted her husband to come home. The wife believed OSR was doing better and supplied that they had always taken their medication.

Treating Team Medical Notes/Reports: The treating team's report provided that OSR needed a TO due to issues with them complying with medication. The Team was concerned with their health deteriorating. Their doctor acknowledged that while in hospital OSR was agreeable to taking medication. The doctor was concerned with the low levels of medication in the OSR's bloodstream. However the doctor admitted there was no evidence that OSR had not been taking their medication. Dr TD agreed that OSR was genuine in saying that they would take their medication. The doctor submitted that the community treatment team had reported non-compliance with medication. It was provided that if OSR's health deteriorated there was risk of verbal abuse to their wife. However there was no risk of harm to OSR.

Tribunal Decision: The Tribunal accepted that OSR had a condition that was characterised by significant disturbances of thought and mood. The Tribunal was satisfied that they required immediate treatment to prevent deterioration. The Tribunal was not satisfied that immediate treatment was required to prevent harm to themself. However, the Tribunal accepted that the abusive behaviour that came with a deterioration in OSR's health warranted immediate treatment to prevent harm to their family. The Tribunal acknowledged OSR's statements that they understood they needed treatment and agreed to the proposed treatment. The Tribunal noted the treating team's concerns with non-compliance. However, there was uncertainty as to what the source of some of this information was. In addition, the Tribunal determined that deterioration of OSR's

health in the community did not mean they were not taking medication as prescribed. It took into account the wife's submissions. It was noted that the Tribunal is required to take into account the principle that voluntary treatment is preferred and persons receiving mental health services should be allowed to make decisions that involve a degree of risk. The Tribunal concluded that it was satisfied that OSR would receive treatment if they were a voluntary patient. The Treatment Order was revoked.

Human Rights: Charter rights not discussed, s 11 principles discussed when making the decision.

***CKH* [2020] VMHT 37**

Overview: This case involved an application by CKH's treating team to have another Treatment Order made.

Submissions: Sophie, the legal representative, submitted that each of the four treatment criteria were in dispute. CKH's position was that their symptoms were drug induced psychosis and they had not taken ice since September/October 2019. They were willing to attend the clinic voluntarily, undergo a supervised trial off medication and participate in regular urine screens. Sophie submitted that there was insufficient evidence of symptoms at the time or that symptoms would recur if made voluntary. Sophie noted that the second opinion from 2019 was twelve months old and contained no reference to antipsychotic symptoms. The document referred to CKH's views on public mental health services and Centrelink. Sophie stated these views were not conclusive evidence of psychosis. CKH submitted that since they had ceased using ice, they felt good. They did not believe that they had any symptoms of a mental illness at the time that required treatment. They informed the Tribunal they had not experienced symptoms of mental illness before they started using ice. Ceasing the use of ice had made a big difference to their mood. They had been able to rebuild their relationship with their family. They lived with their parents, they were anxious to return to work and find a job and a partner. They had been abstinent for more than a year and had not experienced any drug induced symptoms of mental illness in that time.

Treating Team Medical Notes/Reports: The treating team's report stated that the diagnosis was 'drug induced psychosis vs schizophrenia'. CKH had eight inpatient admissions between 2016 and 2019. During their fourth admission they were diagnosed with schizophrenia. The last 4 admissions were stated to have occurred in the context of psychotic relapse. The treating doctor believed CKH had schizophrenia and that they had shown negative symptoms of the illness for a number of years. The doctor submitted that it would be difficult to provide treatment in the absence of medication. The treating team felt that without an order CKH would cease taking medication, putting them at risk of psychotic relapse. The team believed this would pose a risk to their health and the safety of others.

Tribunal Decision: The Tribunal decided that CKH did not have a mental illness so that it was only necessary to consider the first matter. The Act states that a person is not to be considered to

have a mental illness only because they have previously been treated for one or because they use drugs or consume alcohol. The Tribunal was satisfied that CKH had experienced episodes of drug induced psychosis between 2016 – 2019. Evidence of abstinence was taken into account. CKH was held to understand the impact of drug use on their life. It was determined there was no evidence indicating psychotic symptoms after they ceased using drugs. The Tribunal considered it would be useful to trial CKH off their medication as they had suggested. On the evidence before it the Tribunal was not satisfied that they had a mental illness at the time of the hearing. Weight was given to the fact that CKH appeared to have been substance affected at the time of most if not all of their episodes. Their views of the health system and Centrelink had been explained in a coherent and logical manner. Thus the Tribunal decided they did not have a mental illness and the Treatment Order was revoked.

Human Rights: Not abrogated.

***OSH* [2020] VMHT 38**

Overview: This case involved an application by OSH's authorised psychiatrist for another Treatment Order.

Submissions: Charlotte, the legal representative, submitted that OSH had been treated with ECT against their will since 2018. Charlotte explained that OSH was afraid of ECT and concerned about its impact on their brain injury and heart condition. They preferred medication, which they had never refused. They also found counselling and therapy helpful. Charlotte submitted that OSH should have been living more independently and at the time had no rights, autonomy or dignity. Charlotte believed the OSH could be treated less restrictively without the need for a Treatment Order. OSH submitted that study had helped them over the years. They did not believe that ECT was helpful or that their mental health had deteriorated when they stopped ECT in 2018. The ECT caused difficulty in walking and memory loss.

Treating Team Medical Notes/Reports: The treating team's report provided that OSH had experienced a wide spectrum of medication trials of which ECT was the most effective. The report stated that they had treatment resistant schizophrenia. It provided that ECT had the effect of calming OSH, and they were more motivated and organised as a result. OSH had fixed delusions and thought disorder, the treating team was of the view that ECT reduced these symptoms. Their psychiatrist submitted that ECT was planned to continue indefinitely. The report provided that OSH's symptoms were difficult to treat due to their adverse reaction to certain medication.

Tribunal Decision: The Tribunal concluded on the evidence that OSH had a condition that caused significant disturbance in thoughts, mood, perception, and memory. The Tribunal accepted that without treatment their health would deteriorate, which would have an impact on many aspects of their life. They noted the information in the report that provided OSH's health improved with ECT. It was held these improvements meant OSH was more able to manage their physical health issues

and less likely to be aggressive to others. As a result it was determined that treatment was required to prevent serious harm. The Tribunal acknowledged the OSH's concerns with ECT which indicated they would not continue with the treatment without an order. Due to the conclusion that without ECT their mental health would deteriorate, the Tribunal determined that an order was necessary. They were of the view that there were no less restrictive means of treatment. The Tribunal made an Order for 16 weeks, taking into consideration OSH's strong feelings about continuing ECT indefinitely.

Human rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. S 11 principles considered implicitly in deciding the length of the order.

***BYG* [2020] VMHT 39**

Overview: This case involved an application by BYG's treating team to have another Treatment Order made.

Submission: Michael, the legal representative, submitted that BYG wanted to take control of their treatment and use their own treating team. BYG did not contest that they had a mental illness however this did not mean they agreed with the treating team's diagnosis. They acknowledged that they needed treatment. Michael submitted there was a less restrictive means of receiving immediate treatment. BYG told the Tribunal that they were feeling good and were participating in art therapy and psychology. They submitted that drugs and alcohol were not a problem and they used cannabis out of choice as it was a totem of theirs. They explained that they had chosen a new private psychiatrist as their previous one had been unsuitable. They explained that they were familiar with their early warning signs, which varied.

Treating Team Medical Notes/Reports: The treating team's report provided that BYG had schizoaffective disorder and substance use disorder. They had been previously diagnosed with schizophrenia. The treating team was concerned that, without assertive care, they would end up in hospital for longer periods. They had long periods of reasonable stability in the private sector in the past and the Team wanted the opportunity to contact BYG's previous psychiatrist to work towards care in the private system or a shared-care model. BYG's condition was characterised by significant disturbances in thought, mood and perception. The report specifically noted BYG's delusions and pointed out that they were elevated, irritable and threatening during their recent admission. The team believed immediate treatment was required to prevent deterioration and harm.

Tribunal Decision: The Tribunal was satisfied that BYG experienced symptoms of mental illness in the form of a significant disturbance of mood and thought. It was acknowledged the BYG was a mystical and spiritual person however the Tribunal accepted that their delusions stemmed from the mental illness. They took into account the evidence that BYG had a difficult 12 months with several

health relapses. It was decided immediate treatment was required to prevent serious deterioration. The Tribunal acknowledged BYG's preference to take control of their treatment plan. However, they were of the view that BYG's plan was not yet fully formulated to enable them to receive immediate treatment on a voluntary basis. Given this, the Tribunal decided that the Treatment criteria applied and a Treatment Order was made.

Human rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. S 11 principle (views and preferences) briefly noted in consideration.

***HVT* [2020] VMHT 40**

Overview: This case involved an application from a treating psychiatrist to allow ECT to be used.

Submissions: Daniel, HVT's legal representative, submitted that it was his understanding that HVT's preference had been to have ECT and this continued to be the case. HVT had informed Daniel that their psychosis might be drug related rather than a mental illness. HVT was currently irritated and bored due to their lengthy stay in hospital. They recalled discussion about ECT including the positive and negative effects. They spoke to the Tribunal setting out their understanding of ECT and preference 'to give ECT a try'.

Treating Team Medical Notes/Reports: The Registrar relied on a report prepared by the previous registrar (Alexander). The report stated that HVT had declined to attend a number of medical reviews. In the one review that HVT had attended there had been talk about ECT however they only wanted to talk about leaving the hospital. From Alexander's perspective the HVT did not seem to understand why they were in hospital and had a limited understanding of ECT. The report also stated that HVT had said that they wanted medication and not ECT. The Registrar acknowledged that HVT had clearly explained their views in the hearing, however had concerns that their thoughts would not be so clear later. HVT's nurse submitted that HVT had seen gradual improvement during admission. The nurse believed HVT had a reasonable understanding of ECT and their ability to retain information was improving as their level of sedation was reduced. The nurse was of the view that HVT wanted ECT because they believed it was a means of achieving their most important goal which was being discharged.

Tribunal Decision: From the discussions in the hearing the Tribunal was satisfied that HVT had the capacity to make a decision about ECT. They understood and remembered information relevant to making a decision about ECT including how it was administered and its role in treating symptoms of mental illness. They also understood that they had experienced symptoms such as psychosis which meant they understood why the treating team recommended ECT. They told the Tribunal that they felt that the potential positives of ECT, including recovery, outweighed the possible negative effects on their short-term memory. Thus, the Tribunal held that HVT was using and

weighing information relevant to making a decision about ECT. Given the patient had capacity to give informed consent the Tribunal refused to grant the application. This did not mean ECT should or could not be used. It meant that HVT could make their own decision and thus unless they changed their mind and withdrew their consent, or something caused their capacity to become impaired, ECT could be administered as part of their treatment.

Human Rights: Not abrogated.

***KAL* [2020] VMHT 41**

Overview: This case considered whether to revoke KAL's CTO or to make another order.

Submission: KAL had read reports from their previous hearings and did not agree with them. They said there had been no concerns since an incident in 2001. The medication clouded their mind and ability to articulate. When asked about their delusional beliefs, KAL responded that they had not been diagnosed until their religious conversion. KAL believed there would be no risks associated with them coming off medication. The Tribunal enquired about the weighing up of potential risks of deterioration and KAL preferred to make up their mind themselves. KAL agreed to staying in contact with a previous CM well as their current CM who would have contact with their GP. KAL's friend submitted that they had always been as they were now and had a very organised life with a great routine. The friend also expressed concerns about coming off medication too suddenly. KAL's support worker stated that they saw the risks of the medication and that KAL was at times not as aware of things around them. Michael, the legal representative, asked the Tribunal to consider whether the harms and risks met the required level of seriousness. Michael submitted that the Tribunal ought to give weight to the principles in the Act regarding dignity and autonomy.

Treating Team Medical Notes/Reports: The reports provided showed that KAL had been hospitalised many times with features of psychosis and when unwell had impaired judgment. The treating team believed the patient would cease treatment without an order. It was submitted that KAL was evasive, and a rapid relapse would occur without treatment. According to the Registrar the risks involved KAL becoming disorganised, failing to maintain their lifestyle and experiencing psychosocial decline. KAL's CM submitted the condition was episodic and treatment was required to endure living with some stability. The CM also pointed out that KAL functioned well and had demonstrated their ability to reason and articulate an argument during the hearing.

Tribunal Decision: The Tribunal stated that they must have regard to the principles in the Act in making a decision. These principles included that which states that mental health services are to be provided to bring about the best therapeutic outcomes and promote recovery and participation in community life. Another principle taken into account was that which provides people should be allowed to make decisions in relation to treatment that involve a degree of risk. The Tribunal accepted that KAL had experienced symptoms of mental illness that affected their thoughts and mood when not receiving treatment. They acknowledged that KAL lived an active, rewarding and

rich life. They concluded that medication played a significant role in KAL's stability and treatment prevented serious deterioration. It was clear that if a TO was made treatment would continue. The Tribunal considered that continuous compulsory treatment would be burdensome to KAL. They took into account that some risk existed without a TO however KAL was in contact with their Treating Team and had a support system that mitigated the risks. The Tribunal decided through balancing the various principles, KAL's preferences and the level of support they had, the criterion was not satisfied. Thus the Tribunal revoked the Treatment Order.

Human Rights: Charter rights not discussed, s 11 principles engaged with in deciding not to make the order.

***DNP* [2020] VMHT 42**

Overview: This case involved the question of whether to revoke DNP's ITTO.

Submission: Robert, DNP's legal representative, submitted that three of the criteria required for a Treatment Order (TO) did not apply to them. These included, whether the patient had a mental illness, whether immediate treatment was required to prevent deterioration or harm and less restrictive alternatives. Robbert explained that DNP had some past symptoms caused by lack of sleep and other stressors but no current symptoms, could manage their triggers and was willing to continue the medication they were on whilst seeing a private psychiatrist and psychologist. DNP submitted that their mental health had improved, and they would not resist either medication or monitoring. They did not think a TO was necessary and conveyed how difficult being in hospital had been, away from their family. Their husband agreed that it was time for them to come home where the necessary support was waiting.

Treating Team Medical Notes/Reports: The report provided by the treating team stated that DNP had experienced their first manic episode 12 years ago and had since managed their mental health on an entirely voluntary basis. No relapse had occurred for more than 10 years. A short TO had been imposed once in 2018. On this occasion the CATT had been involved due to concerns about DNP ceasing medication and experiencing mood disturbances. The report also included mental state examinations that indicated DNP's mental health had stabilised and improved over time in hospital. It was explained that it had been decided that further time in hospital would be counterproductive. The plan was that DNP would receive support from the CATT and a private psychiatrist upon returning home.

Tribunal Decision: The Tribunal was satisfied that DNP had a medical condition that they had managed very successfully, however when relapse occurred it caused significant disturbance in their mood and thinking. They were also satisfied that voluntary treatment was not possible at the time of the hearing. It was also accepted that treatment was required immediately to prevent a deterioration in their mental health. The Tribunal recognised that DNP had managed their health on a voluntary basis except briefly in 2018. They stated that mental health clinicians played an

important role in this. There were potential changes looming to DNP's clinicians. The Tribunal was of the view that public mental health services would need to play a more significant role and the DNP's connection with those services was tenuous so an Order was needed to ensure ongoing contact. Thus a Treatment Order was made in the community, taking into account the downside of DNP remaining in hospital. This downside included the level of distress it would cause DNP to be separated from their family.

Human rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter.

YQT [2021] VHMT 1

Overview: YQT applied to the Tribunal to have their CTO revoked.

Submission: YQT believed that there was insufficient evidence to prove that they were mentally ill. They acknowledged that they had symptoms of mental illness five years ago but felt that they had since fully recovered due to treatment, therapies and a changed lifestyle. They emphasised that it was important for them not to be subject to medical intervention. They felt that a CTO was stigmatising and wanted to feel empowered to handle the difficulties in their life without medication. They expressed a willingness to continue their recovery with a former private psychiatrist, albeit with no medication.

Treating team medical notes/reports: The reports detailed their history of being diagnosed with schizoaffective disorder and first receiving treatment approximately 10 years ago. It was reported that YQT has had a series of hospital admissions due to symptoms such as mania, paranoid and grandiose delusions and disinhibition. It was also reported that in the past, when YQT was mentally unwell, family violence incidents, police charges, and the involvement of child protection services have ensued. The treating team believed that without adequate treatment, YQT would have a severe and rapid deterioration in their mental health. They thought that this would be of risk to YQT and other people due to their history of being aggressive, impulsive and abusive when mentally unwell. YQT was currently being treated with fortnightly injections of antipsychotic medication and the treating team believe this medication has contributed to YQT's improved and stable mental state. A SPOS report from 2018 supported the diagnosis and symptoms of the patient. Dr MO, who met the patient once prior to the hearing, expressed the opinion that YQT was not currently experiencing manic or psychotic symptoms but there were risks in removing the treatment order.

Tribunal Decision: The Tribunal rejected the application and made an Order for 15 weeks, aligning with the original CTO. This was decided as all the treatment criteria applied. The Tribunal found that YQT was sufficiently mentally ill, accepting the treating team's evidence. The Tribunal accepted that YQT's relatively stable state was evidence that YQT was responding well to

medication and treatment rather than evidence that they were completely cured. The Tribunal also found that YQT required treatment to prevent serious deterioration in their mental health. The Tribunal noted that YQT's professional and personal integrity, their status, and their relationships (including with their child) were important to them and there was a risk of damage to this if treatment stopped. The Tribunal also found that 5(c) and 5(d) were fulfilled. In acceptance of the treating team's evidence, the Tribunal concluded that there was no less restrictive way to ensure the continuation of adequate treatment, drawing on the YQT's evidence that they would cease with medical treatment if the CTO was lifted.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter.

***RGV* [2021] VHMT 2**

Overview: RGV applied to the Tribunal to have their CTO revoked.

Submission: RGV believed that they were no longer mentally ill, and their manic symptoms were cured by alternative medicine in 2015. They believed that the depot antipsychotic medication was unjustified because it does not improve their mental health and gives them physical side effects. RGV provided the Tribunal with a letter from their private psychiatrist, Dr PP, who concluded that it is possible that RGV had a differential diagnosis, and their treating team should reconsider whether the patient needs to be released from the CTO when it would not be in their best interests.

Treating Team Medical Notes/Reports: The report said that RGV has a diagnosis of bipolar affective disorder and detailed the episodes of depression and mania, as well as a series of admissions to the hospital for treatment since 2008. It said that in the past RGV has required restraints due to psychotic symptoms that led to abusive behaviour towards the staff. It also stated RGV's history of being in significant financial difficulty after episodes of mania. The report, case manager and reviewing doctor said that RGV has had significant improvements in mood and is currently not exhibiting overt psychotic symptoms. However, the report emphasised that RGV still requires immediate treatment to prevent serious deterioration in health and prevent serious harm to another person. The case manager pointed out that the treating team and RGV maintain a good relationship despite their differences in opinion.

Tribunal Decision: The Tribunal rejected the application and decided to make a CTO, given all the treatment criteria applied. The Tribunal found that RGV had a mental condition that is characterised by a significant disturbance of thought and mood. The Tribunal accepted the evidence of the treating team because they had a longer history with RGV rather than the opinion of Dr PP (who noted the possibility only, that the patient did not have bipolar disorder). The tribunal found that 5(b) was also fulfilled, again, accepting the evidence of the treating team that immediate

treatment was required to prevent serious deterioration of RGV's health. The Tribunal drew on the evidence of relapse when RGV had previously ceased treatment. However, the Tribunal did not accept that they need immediate treatment to prevent harm to another person. The Tribunal found 5(c) was fulfilled, accepting the opinion of the treating team, that RGV required assertive and consistent treatment to allow stability of mental state and that this would be provided by a CTO. S5(d) was also found to be fulfilled and the Tribunal was satisfied that RGV would not receive immediate treatment if they were a voluntary patient. In its order, the Tribunal noted that a 23-week order is the longest a CTO can last, and the treating psychiatrist must revoke it at any time if they believe the treatment criteria no longer apply, for example, if treatment can progress on a voluntary basis (which the Tribunal hoped for).

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter.

HUZ [2021] VHMT 3

Overview: The treating team of HUZ applied to the Tribunal for another Treatment Order because the previous CTO was due to end.

Submission: On behalf of HUZ, the legal representative submitted that due to the lack of significant disturbance of thought and mood, there is no risk of serious deterioration in their health or harm to others if they begin the process of ceasing with antipsychotic medication under the care of doctors. It was also submitted that there was a lack of risk of financial harm as HUZ resides in supported accommodation and their finances are managed by the State Trustees. Additionally, it was submitted that HUZ would continue to receive the treatment they required immediately as a voluntary patient and continue to engage with the treating team, GP and psychologist due to the existence of a good relationship developed over the course of five years. HUZ gave both written and oral evidence supporting the submissions of their lawyer. They expressed a willingness to continue with antidepressant medication but wished for a controlled plan to reduce their antipsychotic medication, which they thought was ineffective and led to significant side effects. They emphasised the importance for them to regain control and spoke positively about the support in their life, including a NDIS worker, treating team, staff at their supported accommodation and family. The nominated person shared the HUZ's concerns about the side effects of medication and agreed that a structured approach to reduce the antipsychotic treatment was a positive step in promoting holistic recovery. The nominated person also encouraged monthly, rather than three monthly reviews by the treating team.

Treating Team Medical Notes/Reports/Records: The treating team said that HUZ had a diagnosis of schizoaffective disorder, as well as depression. The psychiatrist told the Tribunal that he had known HUZ for five years and HUZ has always engaged well and honestly but thinks that

they need to remain on the Treatment Order. They said that the antipsychotic medication is required to prevent serious deterioration of both physical and mental health. The doctor pointed to a risk of physical harm in terms of the ability of HUZ to maintain food and fluid intake in context of a deterioration. However, the doctor also conceded that if HUZ was voluntary and there was serious deterioration from planned reductions that it could be monitored due to the HUZ's support system and the availability of an Assessment Order.

Tribunal Decision: The Tribunal revoked the Treatment Order and decided that it would receive immediate treatment voluntarily. In considering the treatment criteria, the Tribunal accepted the view that HUZ suffered from significant mental illness that is responding well to the current treating regime. The Tribunal determined that immediate treatment is required to prevent serious deterioration in HUZ's mental health, but did not accept the treating team's view that there would also be a risk of serious harm to physical health. This was because HUZ had a support network that could monitor this. The Tribunal was satisfied that HUZ would continue to receive immediate treatment if required and this was not contested. However, the Tribunal did not find s5(d) was fulfilled as they were satisfied that if HUZ was a voluntary patient, they would continue to receive the immediate treatment required. This finding was substantiated in evidence of ongoing compliance and engagement, HUZ's support network, and a plan to gradually reduce the antipsychotic medication and increasing medical reviews.

Human Rights: Not abrogated, implicitly referred to degree of risk.

FZT [2021] VHMT 4

Overview: This case involved a treating psychiatrist that applied for an electroconvulsive treatment ECT order, which the consumer objected to.

Submission: Michelle, on behalf of FZT, made legal submissions that ECT was not the least restrictive way for them to be treated and there were concerns with its long-term effects. Further, the consumer had the capacity to make their own decision about ECT. This was evidenced by the fact that they understood ECT sufficiently. Michelle referenced the presumption of capacity and the principle that preferences do not need to be wise or balanced to demonstrate capacity.

Treating Team Medical Notes/Reports: The Tribunal had access to a report from the treating team and medical progress notes. These emphasised that ECT was helpful in treating the consumer, evidenced by positive changes in their mental health. Further, FZT had transitioned from seclusion to a low dependency area of the ward since commencing ECT. The report also expressed the view that there was an increased risk of mental health deterioration and relapse without the ECT. They also believed that it was the least restrictive treatment because high doses of antipsychotic treatment had not been effective and had compromised FZT's physical health in the past. Further, they contended that FZT did not have capacity to give informed consent as their ability to take in and

weigh information was impaired. This was supported by evidence of delusions they had in relation to ECT.

Tribunal Decision: The Tribunal granted the application to make the ECT order. It decided that FZT did not have the capacity to give informed consent because they did not understand and weigh up treatment options, or take into account the likely effect if ECT was discontinued. This was determined on the basis that FZT did not appreciate the significance of their illness before admission, the impact of various treatments (including ECT and medication) and the likely impact of ceasing ECT treatment. The Tribunal concluded that there was no less restrictive way for FZT to be treated at present, relying on information provided by the treating team.

Human Rights: The Tribunal stated that it understands this decision limits the consumer's rights to privacy, liberty and freedom from medical treatment without consent, but because the criteria for making the ECT Order were met, the limitations were reasonable and allowed under the Charter. Briefly considered FZT's treatment preferences.

***LSH* [2021] VMHT 5**

Overview: The Tribunal held a hearing to decide whether to revoke LSH's ITTO.

Submission: LSH's legal representative, Robyn, submitted that the benefits of voluntary treatment outweigh risks to their mental health due to protective factors. LSH has been engaged with treatment for over 30 years and has agreed to continue to see their private psychiatrist and take medication on the advice of their treating team. LSH's support include their private psychiatrist, family and a NDIS worker. LSH feels more comfortable with voluntary treatment; however, it was submitted that if the Tribunal was satisfied that the treatment criteria were met then a short Treatment Order of four weeks should be made. LSH also spoke of their negative experiences with other patients and the staff at the hospital, including feeling bullied, not listened to and fearful and confused by the medication process. LSH confirmed that they would follow the advice of their doctors who have their best interest. LSH's sister expressed her disappointment that the doctors did not recommence medication that had worked in the past sooner and spoke of the fact that LSH copes better at home, although they need more time to stabilise.

Treating Team Medical Notes/Reports: The report described LSH's condition as one affecting their thought, mood and perception and referred to both schizoaffective disorder and bipolar affective disorder. It detailed distressing hallucinations and delusions that LSH continued to exhibit. The report stated that LSH had the condition for over 40 years and had remained relatively well with treatment by their private psychiatrist. However, in 2018 to mid-2019 LSH had six hospital admissions and became increasingly unwell. The report indicated that LSH requires immediate treatment to prevent serious deterioration in their mental health. A series of doctors were referred to and confirmed that while there has been improvement on medications like lithium, there were still further improvements required before LSH was well enough to go home. The doctors were

worried that LSH would not stay in hospital if they were not on a Treatment Order. The doctors also confirmed that there had been confusion with LSH's lithium dose, and an incorrect dose had been given in admission which contributed to LSH's fear about others tampering with their medication.

Tribunal Decision: A majority of the Tribunal decided to revoke the Treatment Order.
The legal member and the community member agreed that not all the treatment criteria were satisfied. Specifically, they found that a Treatment Order was not the least restrictive way to provide treatment, and therefore, as voluntary treatment is to be preferred, the treatment criteria were not satisfied. The members stated that LSH had a significant mental health condition that required treatment, including staying in hospital, to prevent serious deterioration in mental health. However, the members also accepted LSH's evidence that they understand they have a mental illness, they have taken medication for a long time and intend to continue to receive medication in hospital under the advice of their doctors. This was despite LSH originally needing significant persuasion to receive medication in hospital and still struggling to believe that some of their symptoms were not based in reality. The dissenting decision, made by the psychiatrist member, stated that all the treatment criteria was satisfied. The member was of the opinion that LSH would not accept the treatment as a voluntary patient as they believed that LSH was not well enough to make competent commitments about their treatment. This member drew on LSH's concerns about medications and fears about intruders in their hospital room to support their decision.

Human Rights: Not abrogated.

***SXD* [2021] VHMT 6**

Overview: Tribunal held the hearing to decide whether to revoke SXD's CTO.

Submission: SXD's preference was to be treated by their GP, but the GP was unable to prescribe medication for depression because of SXD's treatment order. Robyn reminded the tribunal of important legal principles that it must apply, and submitted that in the case at hand legal criteria for a Treatment Order were not met. Robyn explained that SXD accepted their diagnosis of mental illness and agreed they needed treatment, however they were concerned about the side effects of medication (particularly weight gain). If concerns were to be addressed properly, SXD was prepared to continue with medication until reviewed by a private psychiatrist. Robyn pointed out that continuing to see the treating team was causing SXD stress, there was a lack of trust and, therefore, SXD should be a voluntary patient as they had been from 2016-2020. Robyn said SXD had seen their private psychiatrist twice since discharge and was aware of what could occur without treatment. Therefore, it was submitted that if the Tribunal is to make an order it should be a short order to allow for a transition of care to their own preferred treating team.

Treating Team Medical Notes/Reports: The treating team set out the history of symptoms and treatment SXD had experienced, including the fact that they were often distressed about their

neighbours. They were currently prescribed an injectable antipsychotic and mood stabiliser. They had several admissions to hospital in 2015 and 2016, then no further admissions until October 2020. The treating team was of the perspective that consistent treatment would be important for SXD, as mental health had deteriorated when they made their own decisions and adjustments to medication. If SXD would be able to make own treatment decisions and did not take treatment, it would be likely that more restrictive treatment would be required in future. They also noted that they had the aim to transition SXD to private care. Case manager explained that SXD was reluctant to attend the clinic and did not like being visited at home, and would regularly defer appointments and that some medication was being missed.

Tribunal Decision: Concluded that SXD had a significant disturbance in mood and thought when they were unwell and that, when they do not have treatment or treatment is inadequate, their mental state deteriorates requiring hospital admissions, and considerable distress and disruption, thus requiring ongoing treatment through a Treatment Order.
Further, at the time of hearing, the Tribunal could not be satisfied that there was a less restrictive way to be treated (citing too much uncertainty in going down the route of private care, especially considering two recent hospital admissions). The Tribunal said that private treatment as a voluntary patient may be available in future. Thus the Tribunal made CTO, for four weeks with a plan to transition to a private arrangement.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter.

***PED* [2021] VHMT 8**

Overview: PED was on a CTO that was due to end, and the treating team applied to have another Treatment Order made, while PED applied to have the Treatment Order revoked.

Submission: PED provided a letter requesting that the CTO be revoked on the basis that treatment should be least restrictive and promote full participation in community life. The letter also stated that they experience side effects including incontinence, sedation, weight gain, and depression. They would like to get a job and move out of the family home, but cannot accept a current job offer due to sedation from medication. They find going to the gym and training important for recovery, but they're currently unable to due to sedation from medication. They feel that their views are not listened to by the treating team and believe they have insight into their experience of mental illness and addiction, they want a chance to recover without being on a Compulsory Order. Michael submitted that the criteria for a Compulsory Order were not met because they can have treatment less restrictively as a voluntary patient, and that they're not planning to cease medication immediately, and would like to see a private psychiatrist as well as the Treating Team at the

community clinic. PED accepted that there are risks but this is consistent with the mental health principles in the Act.

Treating Team Medical Notes/Reports: The report said that they have a diagnosis of schizophrenia which has been treated since 2006, and when unwell they present with paranoid delusions. It also said PED has shown extreme lability of mood, and experienced derogatory auditory hallucinations. Their mental illness has been affected by their drug use, and they refuse to engage with the treating team or take medication when unwell, leading to multiple relapses and risk of homelessness. Tribunal said they have a lack of insight and they require medication monitoring and immediate treatment to prevent serious deterioration in mental state. Stated that PED poses risk to others (including violence) if undertreated and that they cannot be treated less restrictively due to relapses in the past, which have warranted hospital admissions.

Tribunal Decision: The Tribunal accepted evidence that PED has mental illness and that they need immediate treatment to prevent serious deterioration or harm. The majority of the tribunal accepted PED's submission that they wanted to gradually cease the medication and they were aware of the risks, noting that PED had mostly been well since stopping illicit drug use, and that they were committed to remaining abstinent from drugs. Weight was given to the fact that PED clearly knew that they could not stop medication without the continued support of the treating team. In these circumstances, it was decided that they could be treated less restrictively as a voluntary patient. Risk could be managed as the treating team could still intervene at any early sign of relapse. Considerable weight was placed on the side-effects PED had noted, that prevented them from achieving their goals. The reasoning included reference to mental health principles with the aim of promoting recovery and full participation in community life. The Tribunal was also guided by the principles that persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk. The majority decided not to make a treatment order. The community member dissented, saying that although significant steps were taken toward recovery, they would require significant support in the short term to gradually reduce the medication, under a 13-week CTO.

Human Rights: Charter rights not explicitly discussed, s 11 principles were engaged with.

QGG [2021] VMHT 9

Overview: Tribunal held this hearing to decide whether to revoke ITO so that QGG would be a voluntary patient or make a Treatment Order.

Submission: Michael told the Tribunal that QGG wanted to leave hospital (if necessary, on a CTO) with support being provided while they lived in their own home. He said QGG did not feel that they had issues with mood, perception or thoughts that were out of the ordinary and they did not feel that they were a risk to anyone else. Michael said that QGG was dedicated to taking the medication that their doctor prescribed, and that an ITO should only be made if the Tribunal was satisfied that

treatment in the community was not possible. QGG agreed with what Michael said and added that the medication makes them feel dizzy and that they don't feel they need it, but they are prepared to take it when the treating team tell them to. QGG's daughter said that QGG has issues with sorting bills and requested that the treating team help with this, and that it had been difficult to contact them on the phone in their home before admission.

Treating Team Medical Notes/Reports: Treating team said that QGG made good progress during the hospital admission, and that their delusions were mainly related to things around their home and not the hospital, and therefore there had not been any mental health issues evident while in the ward. However, it was unclear whether symptoms would recur when they returned home. The compulsory treatment report set out QGG's history and symptoms, stating their diagnosis of delusional disorder and possibly dementia. Delusions in their home led to QGG covering their air conditioner, regularly getting new mobile phones, not sleeping or eating properly, not looking after themselves, and not paying bills for a few months. The report also stated that they need treatment now to prevent serious deterioration in mental and physical health. QGG had been engaging well with the treatment team at the time of hearing. Additionally, the treating team said that since admission QGG had two injections of antipsychotic medication and they were happy to have an injection monthly in future, so they could be discharged from hospital if mental health issues were the only concern. However other concerns arose, that they could not look after themselves independently. An OT assessed functional decline, diminished memory, and possible early onset dementia. Thus, they would need more support to live at home, and could not return home before cognitive testing that was planned the week after the hearing. Moreover, they could not go home until their electricity was reconnected and the treating team had helped work out a payment arrangement for bills.

Tribunal Decision: Accepted the evidence that they have a significant disturbance of thought, perception and memory and that they needed treatment now for this condition to prevent serious deterioration in mental and physical health. It was clear that if the Tribunal made a CTO, they would continue to receive treatment, but they decided discharge from the hospital was not possible without a sound discharge plan in place and lack of support in place such as no electricity. Thus, as they would likely leave if it was up to them, an ITO was needed.

Human Rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter.

***CWR* [2021] VHMT 10**

Overview: CWR's psychiatrist made an application to the Tribunal for an Order to allow ECT to be used as part of treatment.

Submission: CWR told the tribunal that they do not want ECT because when they previously had it, they suffered memory loss which then led to losing their job. CWR submitted that they were physically fine and fully functioning except for having delusions, and they don't need to be in hospital, they would feel better at home. They knew that ECT involves applying electricity to the brain and would prefer to stay longer in hospital and have continued treatment by depot injection. Also reiterated that they would not accept oral medication. Gemma said that CWR does not agree with diagnosis of schizoaffective disorder but agrees they have delusions. Gemma also said that nursing notes indicated CWR's improvement over last few years and settling of their mental state. Thus Gemma submitted they had the capacity to make decisions about treatment and that there is less restrictive treatment available, namely the depot medication.

Treating Team Medical Notes/Reports: ECT report said CWR was being treated for severe mental illness, namely treatment resistant schizoaffective disorder. Prior to their admission, they had persuaded GP to reduce medication dosage and refused to engage with community mental health service. Since admission, they had refused treatment of oral medication which led to restraints being used to give it. According to the report, they had been treated effectively and rapidly in the past with ECT. They had a pattern over 20 years, becoming unwell due to non-adherence, convincing their doctor to reduce dosage and being admitted to hospital. Treating team contended that they do not understand or remember information about ECT, so would be unable to use or weigh the information. The report stated that, when unwell, CWR has no insight and they have said that they would not accept any treatment or see a doctor as a voluntary patient. Further, their mental illness impairs their ability to function and they may exhibit further agitation, assault, erratic behaviour and deterioration without the treatment. The report stated that ECT had been the most effective, and that there were issues with other medications in the past, and pharmaceuticals alone would not lead to improvement. In response to Gemma, the treating team conceded that CWR's baseline mental state may include the presence of some delusions but did not agree that CWR's mental state was more settled due to recent aggression and verbal abuse toward staff.

Tribunal Decision: In regards to capacity, the Tribunal followed the *PBU* decision, and focused on the process of making the decision not the content of the decision, that one should not lack capacity by making decision that others think unwise and stated the importance of considering self-determination, personal inviolability and dignity. Lack of insight does not equate to lack of capacity, and CWR understood basic information at the hearing about ECT including it involving electricity being applied under general anaesthetic. CWR also understood that the alternative is longer period in hospital and was willing to accept this despite their wish to be discharged. It was also noted that they were taking depot medication and nursing notes indicated some improvement. Since they were satisfied with capacity, it was not necessary to consider whether it was the least restrictive option.

Human Rights: Not abrogated.

***CPQ* [2021] VMHT 11**

Overview: This case involved an application from a CPQ to have a CTO revoked.

Submission: Marcus, CPQ's legal representative, indicated that the patient had received their current CTO due to their moving and the fear of disengagement with the new treating team. Marcus submitted that the patient had now established a relationship with the new treating team and thus requested to be a voluntary patient. Marcus stated that CPQ received great support from both their carer and their partner.

CPQ's partner submitted that he believed CPQ would be better off partaking in treatment voluntarily. They lived together and he had observed that CPQ was sedated to the point of not being able to dress under their current dosage of medication. The partner stated that CPQ had successfully been treated voluntarily for many years and that he supervised CPQ's medication.

Treating Team Medical Notes/Reports: The report provided by the treating team indicated that CPQ was diagnosed with mental illness as a teenager and had both compulsory and voluntary care in the past. The patient did not agree with the prescribed dosage and their treating team believed that which they were willing to take was not sufficient. They also believed that CPQ ought to be on both antipsychotic and anti-depressants and without a CTO relapse was possible.

Tribunal Decision: The Tribunal was satisfied that CPQ had a significant disturbance of thought and mood. It was held that it was apparent from all accounts that treatment had reduced CPQ's symptoms and may prevent further relapse and thus accepted that immediate treatment was required to prevent deterioration in their health.

In relation to whether CPQ would continue to receive voluntary treatment, the tribunal considered that CPQ was currently well and could describe their treatment preferences. The Tribunal took into account the support of CPQ's partner pursuant to subsection 10(h) and 11(1)(k) and (l) of the Act and decided the partner's support was a very important protective factor alongside their good relationship with their current treating team. The Tribunal stated that persons receiving mental health services should be provided treatment in the least restrictive way possible, should be allowed to make decisions about their treatment and recovery that involve a degree of risk and should have their rights, dignity and autonomy respected and promoted. They concluded that using the Act to enforce treatment would be unnecessarily restrictive in the circumstances and were satisfied the patient could receive treatment voluntarily and revoked the CTO.

Human Rights: Charter rights not discussed, s 11 principles considered.

***IMK* [2021] VMHT 12**

Overview: This case involves an application to revoke a CTO.

Submissions: Hamish (legal representative) submitted that it was the IMK's first preference to have the Temporary Treatment order revoked and their second for the Tribunal to make a Community Treatment Order. Hamish submitted it could not be satisfied on the evidence that the IMK had a mental illness as their beliefs and concerns were not outlandish and their concerns about poisonous gas were reality based. IMK denied experiencing a relapse and did not accept that they required treatment to prevent deterioration in their health. Hamish argued that IMK had been compliant with the treatment and leave arrangements and that the registrar had introduced new evidence that it would not be procedurally fair for the Tribunal to take that into account.

IMK was willing to accept treatment despite not accepting they had a mental illness. They were unsure what the medication was treating when asked. They acknowledged their hospital stay made a difference and that they had not been troubled with any noxious substances since admission. They were happy with the plan to go to PARC. They informed the Tribunal their greatest concern about treatment was its impact on their ability to return to work.

Treating Team Medical Notes/Reports: The report provided by the treating team stated the IMK had schizophrenia and significant delusional and paranoid ideas and hallucinations. The treating team believed that immediate treatment was required to prevent deterioration in health. The registrar (Dr TD) told the Tribunal that IMK's levels of distress had improved, and they no longer heard voices. They also noted that improvement deteriorated when IMK was on leave from the hospital. Dr TD raised concerns that the IMK may have been using illicit substances and was too focused on work rather than recovery.

Tribunal Decision: The Tribunal was satisfied that the IMK experienced symptoms of a medical condition that caused significant disturbance of thought and perception. The Tribunal accepted that without immediate treatment their health was likely to deteriorate. The Tribunal also accepted from the report, that IMK's behaviour in response to their symptoms potentially threatened stable work and accommodation opportunities and thus treatment was required to prevent serious harm to themself. However, the Tribunal did not accept that immediate treatment was required to prevent serious harm to others.

The Tribunal noted IMK's preference for voluntary treatment. They accepted IMK's statement that they would attend the community clinic for treatment, and they were highly motivated to do so due to their strong desire to return to work. The Tribunal also took into account the IMK's son and friend's submissions supporting compulsory treatment due to IMK ceasing their medication in the past. They also considered Dr TD's statements that a treatment order was required due to previous history of neglecting oral medication, and evidence of improvement when IMK was on medication, so treatment was necessary to prevent further serious incidents. Hamish's procedural fairness argument was rejected on the grounds that the Tribunal is an inquisitorial body and thus not bound by the rules of evidence. On balance the Tribunal decided that voluntary treatment was not currently possible and a Treatment Order was necessary.

Human rights: The Tribunal acknowledged that the Order limited the consumer's rights to privacy, liberty and freedom from medical treatment without consent but decided the limitations were reasonable as the treatment criteria were met and thus the limitations were allowed under the Charter. S 11 principles were briefly considered.

AJR [2021] VMHT 13

Overview: This case involved a AJR lodging an application to revoke or cancel a CTO.

Submission: Robbert, on behalf of AJR, made legal submissions that the legal criteria for compulsory treatment were not met. Robbert submitted while the treating team's report detailed AJR's thinking around politics to be symptoms of mental illness, the law states that a person cannot be considered mentally ill only because they express a political opinion. It was submitted there had been a single incidence of family violence that was not linked to mental illness, AJR regretted it and had joined a men's behavioural program. Although AJR did not believe they had a mental illness, they were willing to continue with the medication due its calming effects.

Treating Team Medical Notes/Reports: The report provided by the treating team detailed that they believed AJR had 'bipolar affective disorder with psychotic features on the background of an acquired brain injury'. They stated immediate treatment was required to prevent deterioration in the health of AJR and harm to others, and a treatment order may be the only way to administer treatment. The diagnosis was (according to the psychiatrist) not based on AJR's political beliefs but on their degree of preoccupation with them. Given the positive relationship between the treating team and AJR, the Tribunal enquired whether a CTO was necessary, and the psychiatrist stated it was a 'grey zone' and they would likely manage with or without one.

Tribunal Decision: The Tribunal concluded that AJR had a medical condition characterised by a significant disturbance in thought and mood. They agreed with the medical advice that AJR required treatment by means of medication, care and support. They acknowledged that the mental state of AJR was much improved, evidenced by medical advice and conduct at the hearing. AJR agreed that the medication helped and was prepared to remain on the medication for a year. They also had a good relationship with their treating team. The Tribunal came to the conclusion that a CTO was not necessary to ensure that AJR received treatment. Thus the treatment order in place was revoked.

Human Rights: Not abrogated.

LDH [2021] VMHT 14

Overview : This case involved a treating psychiatrist applying for an ECT order which the consumer objected to.

Treating Team Medical Notes/Reports: The report provided by the treating team detailed LDH's difficult time in hospital. They had delusions and acted aggressively towards staff and co-patients on a number of occasions. LDH had been receiving Acuphase and Droperidol, with no improvement seen. Due to these symptoms the team felt that LDH was not able to use and weigh information in order to make a decision about ECT. They continued to refuse medication which delayed the ability to treat their other medical condition.

Tribunal Decision: The Tribunal decided that the criteria for an ECT order had been satisfied. In relation to capacity they acknowledged that the consumer was able to recall and understand sufficient information to make and communicate a decision about ECT. However, what was less clear was the consumer's ability to weigh the relevant information. The Tribunal accepted that LDH had viewed their previous experiences with ECT as negative and this suggested 'in some respect' that they were able to weigh the relevant information. However, LDH did not believe they had the symptoms of a mental illness so that they did not appreciate that staying in hospital would be for ongoing treatment. The Tribunal also took into account the consumer's refusal to accept medication that was said to be critical to their recovery. They concluded that LDH did not have an appreciation of their situation or the alternatives that were available to them and thus did not have capacity.

On the question of less restrictive methods the Tribunal found that there were no real alternatives due to LDH's QTc-interval that cut off medication options and therefore no less restrictive method of treatment was available.

Human rights: The Tribunal stated that it understands this decision limits the consumer's rights to privacy, liberty and freedom from medical treatment without consent, but because the criteria for making the ECT Order were met, the limitations were reasonable and allowed under the Charter.