

“IT’S A VERY COMPLEX THING”: DISCOURSE ABOUT CAPACITY IN AUSTRALIA’S NORTHERN TERRITORY

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ABSTRACT

In the years following the introduction of the Convention on the Rights of Persons with Disabilities (CRPD), there has been considerable debate about the validity of ‘lack of capacity’ as a legal justification for involuntary (unconsented) psychiatric treatment. In Australia however, mental health legislation reforms completed following the CRPD have not resulted in the abandonment of substituted decision-making based on lack of capacity. Capacity considerations remain relevant.

The Northern Territory (NT) of Australia has been undertaking a prolonged review of its current mental health legislation. It is expected to soon become the last Australian jurisdiction to introduce new mental health legislation following the CRPD. This paper presents the findings of a recent study of capacity discourse, involving a review of NT caselaw and an interview with a medical practitioner. The data collected provides support for defining the concept of capacity when it is used in legislation; it suggests that when ‘capacity’ is left *undefined* in legislation, the test for capacity can become vague, amorphous, subjective, and focused on compliance.

The study of capacity discourse enhances the visibility of decision-making about capacity under current NT mental health law. From a methodology perspective, the study highlights how interviews with clinicians can provide rich data about how mental health law is understood and operationalised in practice.

Keywords: mental health, capacity, consent, insight, legislation, definition, assessment, reform, Australia, Northern Territory

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INTRODUCTION

Australian law places a high value on personal autonomy, and as a result, medical treatment without consent is generally unlawful.¹ The situation is different, however, where a person is deemed to lack 'capacity'. This article examines how considerations of 'capacity' currently feature, at a practical level, in the regulation of involuntary (unconsented) treatment for mental illness in a small Australian jurisdiction (the Northern Territory).

Treatment for mental illness has, for many decades, been an area where the normal requirements of informed consent do not apply. For much of the 20th century, treatment without consent was justified on the basis that those with mental illness lacked 'sound mind' – which was considered the threshold requirement for informed consent.² In more recent decades, this status-based approach to decision-making ability has given way to a cognitive approach focused on individual assessment, with 'capacity' replacing 'sound mind' as the threshold requirement for informed consent.³ The corollary to this, is that *lack* of capacity has become a key part of the justification for providing treatment *without* consent.

Over the past 18 years, the Convention on the Rights of Persons with Disabilities (CRPD) has called into question the validity of 'lack of capacity' as a legal justification for treatment without consent.⁴ Article 12(2) of the CRPD calls on parties to recognise people with disabilities as enjoying 'legal capacity on an equal basis with others', while Article 12(3) calls for people with disabilities to be provided 'the support they may require in exercising their legal capacity'. In this way, the CRPD attempts to de-couple the principle of informed consent from assessments of individual decision-making ability, effectively insisting that everyone should have the right to decide, regardless of decision-making ability, and that 'support' should be provided to enable this.⁵

There has been continuing debate about the practical implications of Article 12, and whether compliance can be achieved while retaining a role for substituted decision-making. The Australian Government has previously argued there is still a (limited) place for substituted decision-making.⁶ This argument rests on interpreting the phrase 'all measures that relate to the exercise of legal capacity' in Article 12(4) as including

¹ *Rogers v Whitaker* (1992) 175 CLR 479; *Department of Health & Community Services v JWB & SMB* (1992) 175 CLR 218; *Hunter and New England Area Health Service v A by his Tutor T* (2009) 74 NSWLR 88.

² Penelope Weller, 'Towards a Genealogy of "Coercive Care"' in *Coercive Care: Rights, Law and Policy* (Routledge, 2013) 15, 22–23.

³ *Ibid* 24.

⁴ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008). Australia ratified the CRPD on 17 July 2008.

⁵ Sascha Callaghan and Christopher James Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *UNSW Law Journal* 596, 602.

⁶ See Australia's interpretative declaration to this effect: Australia, *Declarations and Reservations under the Convention on the Rights of Persons with Disabilities* (Instrument of Ratification, 17 July 2008), available online at https://treaties.un.org/pages/ViewDetails.aspx?chapter=4&clang=en&mtmsg_no=IV-15&src=IND#EndDec.



substituted decision-making measures. Others, including the Committee administering the Convention, have taken an absolutist approach, arguing that upholding universal capacity requires that decision-making ability never be removed. The Committee has called for the repeal of all legislation enabling involuntary mental health treatment,⁷ and an interpretation of Article 12 that wholly rejects the use of functional capacity tests justifying substituted decision-making.⁸

Australian jurisdictions which have undertaken mental health law reform following the CRPD have tended to take a moderate, pragmatic approach — rejecting absolutist approaches and enlarging the scope for ‘supported decision-making’ (to varying degrees) while allowing for involuntary (unconsented) treatment in limited circumstances.⁹ Relevantly, every Australian jurisdiction currently treats capacity considerations as relevant to decisions about involuntary treatment, although not all jurisdictions include capacity considerations in the core criteria for involuntary treatment.¹⁰ A comparative view of legislative provisions across the Australian states and territories can be found at Appendix A.

The Northern Territory (NT) of Australia has been undertaking a multi-year review of its mental health legislation. While the review process has been incredibly protracted, the expectation is that the NT Government will soon introduce legislation in similar terms to the *Mental Health Bill* released as an Exposure Draft in 2024. The NT will then become the last Australian jurisdiction to review and reform its legislation following the CRPD. Like other Australian jurisdictions, the NT currently includes consideration of capacity in its legislative criteria for involuntary treatment. However, the current NT legislation is unique in not prescribing what constitutes capacity, and in not indicating what factors are relevant (or not relevant) to the assessment. The pre-reform context in the NT therefore provides a unique opportunity for study into how the concept of capacity is understood and operationalised when there is no legislative guidance.

This article presents findings from a small research study examining capacity discourse in the NT using data drawn from existing caselaw and an in-depth interview with a psychiatric practitioner. While the dataset is limited, it provides a useful starting point for understanding how the concept of capacity is interpreted in decisions made under the current NT legislation.

Parts 1-3 provide the contextual backdrop for the study. In Part 1, I highlight how ‘capacity’ has been constructed through the common law and in legislation. In Part 2,

⁷ Committee on the Rights of Persons with Disabilities, *General Concluding Observations on the Initial Report of Australia*, 10th sess, 118th mts, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 5[34].

⁸ Committee on the Rights of Persons with Disabilities, *General Comment No 1, Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014), [15].

⁹ See Callaghan and Ryan (n 5), noting this doesn’t factor in recent South Australian and Victorian reforms.

¹⁰ *Mental Health and Related Services Act 1998 (NT)* s 14(c) (‘NT Act’); *Mental Health Act 2009 (SA)* s 21(1)(ba) (‘SA Act’); *Mental Health Act 2013 (Tas)* s 40(e) (‘TAS Act’); *Mental Health Act 2014 (WA)* s 25(1)(c) (‘WA Act’); *Mental Health Act 2015 (ACT)* s 58(2)(b) (‘ACT Act’); *Mental Health Act 2016 (Qld)* s 12(b) (‘Qld Act’); *Mental Health and Wellbeing Act 2022 (Vic)* s 89(1)(a) (‘VIC Act’); *Mental Health Act 2007 (NSW)* s 68(h1) (‘NSW Act’).

I highlight how questions of capacity fit into NT legislation and the role they play in the regulation of involuntary treatment. I consider points of similarity and difference with mental health legislation in other Australian jurisdictions. In Part 3, I provide a brief review of some relevant literature.

Parts 4-6 highlight the study's findings on how the concept of capacity is understood and operationalized by those applying current NT legislation. How is it constructed? What is the normative basis for decisions that a person lacks capacity? What evidence or markers are used to establish a lack of capacity? How do medical and legal constructions of capacity differ? How are differences resolved by the Tribunal? In Part 4, I analyse discourse about capacity in the key NT case, and highlight the need for empirical research that goes beyond 'the law on the books'. In Part 5, I share and analyse pilot data from a semi-structured qualitative interview conducted with a medical practitioner. In Part 6, I highlight how the findings of this study support the case for legislative reform.

STATEMENT OF POSITIONALITY

From 2017-2019, I worked as a lawyer representing individuals in hearings before the Mental Health Review Tribunal, which is now part of the Northern Territory Civil and Administrative Tribunal (NTCAT) (hereafter, the Tribunal). Through this work, I became aware (at a general level) of differences between legal and clinical approaches to capacity. While my colleagues and I approached capacity through the lens of functional common law tests, the doctors ('authorised psychiatric practitioners') who appeared in the Tribunal seemed to approach capacity differently. The concept of 'insight' came up regularly – a concept that does not feature expressly in NT mental health legislation, or any other Australian mental health legislation.

During this work, I was also struck by the lack of transparency and accountability surrounding decision-making about whether a person could be treated without consent. Tribunal review proceedings were closed to the public, and few decisions were ever published or given scrutiny via an appeals process. This was due to multiple factors, both legal and practical. There was the need to identify legal error without written reasons (which I discuss further on). There were also considerable practical obstacles to obtaining instructions to file an urgent injunction from a person involuntarily detained. And while appeals on behalf of those treated involuntarily in community were more practicable, the wheels of justice turned very slowly. In the case of *AX v Mental Health Review Tribunal & Anor* (in which I was involved),¹¹ the Supreme Court handed down its decision over 11 months after the Tribunal's original decision to order involuntary treatment. For all these reasons, appeals did not provide a satisfactory solution to the lack of transparency I encountered.

It is now over six years since I was a participant in NT mental health tribunal proceedings. I have moved 'down south' (as the Darwin locals say) and into other, unrelated roles. The passing of time has sharpened my awareness of how difficult it is for those on the outside (which now includes me) to find out how decisions about

¹¹ [2019] NTSC 34.

involuntary mental health treatment are made in practice. The research presented in this paper was motivated by a desire to provide some of this missing information, for the benefit of those considering legislative reform.

PART 1: CAPACITY ASSESSMENTS IN CONTEXT

I begin with a brief analysis of how the concept of ‘capacity’ has been interpreted and constructed in legal discourses – specifically, in the common law¹² and in contemporary Australian mental health legislation. This will provide some points of comparison for when we look, later, at how capacity is interpreted by medical practitioners and Tribunal members in the NT.

A. Capacity is presumed unless there is evidence to the contrary.

The common law has recognised a rebuttable presumption of capacity that applies in the context of all decisions about medical treatment.¹³ Underlying this presumption is a rejection of the older, status-based approach to capacity. As Bell J said in the Victorian Supreme Court case of *PBU*: ‘a person does not lose the benefit of the presumption of capacity upon the basis of their status as a person with a mental disability’.¹⁴

Most Australian states and territories (although not the NT) have now codified the common law *presumption* of capacity in their mental health legislation,¹⁵ although legislation in these jurisdictions does not necessarily reflect the common law approach as a whole. For example, while the ACT and Victoria include a presumption of capacity in their mental health legislation, they also allow for substituted decision-making in some situations where a person has capacity but is refusing treatment.¹⁶

Relevantly, courts have found that where a party seeks to rebut the presumption of capacity in the context of involuntary mental health treatment, the standard of proof set out in the High Court case of *Briginshaw*¹⁷ applies.¹⁸ That is, the evidence must be ‘clear, compelling and of high probative value’, because a finding that a person lacks capacity would produce grave or adverse consequences.¹⁹

B. Capacity is defined in ‘functional’ terms.

¹² For the benefit of readers who are not from this tradition, the common law system involves judges developing the law on a case-by-case basis, building on the reasoning and interpretation contained within earlier decisions by superior courts. In Australia, legislation operates in tandem with the common law. Tribunals are bound by the decisions of courts on the meaning of legislation that is within their jurisdiction. The NT Tribunal then, when it decides mental health matters, is bound by NT judicial decisions on the interpretation of NT mental health legislation. Other cases (for example, by courts of another state or territory) may be persuasive but are not binding.

¹³ *Re MB* (1997) 2 FLR 426, 436, cited with approval in *Hunter* (n 1) [23].

¹⁴ *PBU & NJE v Mental Health Tribunal and Others* (2018) 56 VR 141 (*‘PBU’*) [145].

¹⁵ See: *ACT Act* (n 10) s 8(1)(a); *Qld Act* (n 10) s 5(b); *TAS Act* (n 10) s 7; *VIC Act* (n 10) s 85; *WA Act* (n 10) s 13(1); *SA Act* (n 10) s 5A.

¹⁶ See *ACT Act* (n 10), s 58(2); *VIC Act* (n 10) s 89(1)(a).

¹⁷ *Briginshaw v Briginshaw* (1938) 60 CLR 336 (*‘Briginshaw’*).

¹⁸ *AX v Mental Health Review Tribunal & Anor* (2019) NTSC 34 (*‘AX’*) [33]; *PBU* (n 14) 207 [206].

¹⁹ *Ibid* [33].

In the common law we also see capacity constructed as a 'functional test' (looking at decision-making ability), rather than an 'outcome-focused test' (looking at the content of the decision and how it aligns with prior decisions or social norms).²⁰ In *Hunter*, McDougall J focused attention on 'the ability of the person to receive, retain and process information that bears on the decision'.²¹ In *Heart of England NHS Foundation Trust*, Jackson J stated:

The temptation to base a judgment of a person's capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided.²²

Consistent with the functional approach, capacity has also been interpreted in the common law as 'issue specific',²³ and temporal.²⁴ The issue-specific notion stems from discourse that constructs capacity as existing on a continuum, with some decisions requiring a higher degree of capacity than others. As MacDougall J highlighted in *Hunter*, making a decision to buy a cup of coffee does not require the same degree of capacity as making the ('more important') decision 'to give away one's fortune'.²⁵

The 'functional' approach is reflected in the mental health legislation of most Australian states and territories. Those statutes that *define* capacity generally define it in terms of whether a person can do the following four things: (1) 'understand' the information relevant to a decision (2) 'retain' or remember the information (3) 'use' (or 'weigh') the information, or both, in making a decision and (4) 'communicate' the decision.²⁶ Many jurisdictions have also included, in their legislation, guidance which reflects a functional approach. They might have provisions that construct capacity as time-specific and issue-specific, or that explicitly reject an outcome-focused approach (looking at whether the decision is consistent with recommendations, or whether it is wise).²⁷

C. Insight is relevant, but not determinative.

Finally, it is worth drawing attention to how the common law has interpreted the relationship between capacity and the psychiatric concept of 'insight'.

While 'insight' does not have a consistent definition within psychiatry, there are some approaches to definition that have been influential. One is Lewis' 1930s definition of insight as 'a correct attitude towards a morbid change of self'.²⁸ Another is David's

²⁰ Bernadette McSherry, 'Legal Capacity under the Convention on the Rights of Persons with Disabilities' (2012) 20 *Journal of Law and Medicine* 22, 24.

²¹ *Hunter* (n 1) [40].

²² [2014] EWHC 342 (COP); cited in *PBU* (n 14) [171].

²³ *Re S* [2010] 1 WLR 1082, 1094 [53] (Judge Hazel Marshall QC); cited in *PBU* (n 14) [148].

²⁴ *Re N* [2017] 2 WLR 1011, 1022 [25]; cited in *PBU* (n 14) [149].

²⁵ See *Hunter* (n 1) [24].

²⁶ See: *VIC Act* (n 10) s 87; *SA Act* (n 10) s 5A; *ACT Act* (n 10) s 7; *WA Act* (n 10) s 15(1); *TAS Act* (n 10) s 7(1); *Qld Act* (n 10) s 14(1).

²⁷ See: *VIC Act* (n 10) ss 85(2), 87; *SA Act* (n 10) s 5A; *ACT Act* (n 10) s 8; *Qld Act* (n 10) s 14(2).

²⁸ Aubrey Lewis, 'The Psychopathology of Insight' (1934) 14(4) *British Journal of Psychiatry* 332; for discussion of influence, see Paula Case, 'Dangerous Liaisons? Psychiatry and Law in the Court of

1990 definition. David defined insight as having three characteristics: recognition of mental illness, compliance with treatment, and the ability to relabel unusual events as pathological.²⁹

The Victorian case of *PBU* (while not binding on courts in the NT) is worth mentioning as a rare example of an Australian superior court considering the relevance of insight in the context of capacity assessments.³⁰ In the context of applying the Victorian mental health legislation, Bell J found that insight into illness and need for treatment was relevant as a factual consideration, but not as a normative criterion for capacity.³¹ Thus, a person who lacks insight may also lack capacity, but it does not follow that they *must* be lacking capacity.³² Insight, according to this case, is not determinative of capacity.³³

In Part 2, I will highlight how the concept of capacity features in current NT mental health legislation.

PART 2: THE NORTHERN TERRITORY LEGISLATIVE FRAMEWORK

In the NT, involuntary mental health treatment is currently regulated by the *Mental Health and Related Services Act 1998* (the NT Act). The NT Act provides that a person can be treated on an 'involuntary' basis (without their consent) if certain criteria are met. These are set out in s 14:

- (a) the person has a mental illness; and
- (b) as a result of the mental illness:
 - i. the person requires treatment that is available at an approved treatment facility; and
 - ii. without the treatment, the person is likely to:
 - A. cause serious harm to himself or herself or to someone else; or
 - B. suffer serious mental or physical deterioration; and
 - iii. the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment; and
- (c) there is no less restrictive means of ensuring that the person receives the treatment.³⁴

A. Capacity is a key consideration

There are two legal justifications for involuntary treatment at work in the NT Act. In s 14(b)(i) and (ii), involuntary treatment is justified by reference to harms that may result if a person does not receive treatment. In s 14(b)(iii), involuntary treatment is justified by reference to *lack of consent*; either the person does not have capacity to provide consent or, they do have capacity, but are 'unreasonably' refusing to consent.

Protection - Expert Discourses of "Insight" (and 'Compliance') (2016) 24(3) *Medical Law Review* 360, 366.

²⁹ A David, 'Insight and Psychosis' (1990) 156(6) *British Journal of Psychiatry* 798; for discussion of influence, see Ivana Markova, *Insight in Psychiatry* (Cambridge University Press, 2005) 71.

³⁰ *PBU* (n 14).

³¹ *Ibid* [191], [206].

³² *Ibid* [193], [198].

³³ *Ibid* [194].

³⁴ *NT Act* (n 10), s 14. See also s 16 which sets out similar criteria for involuntary treatment in the community.

While the *lack of consent* criterion can be met by establishing either 'lack of capacity' or 'unreasonable refusal', capacity needs to be assessed in every case. Capacity assessments then, are a key part of the regulation of involuntary treatment for mental illness.

B. Guidance around interpretation of capacity

The NT Act is marked by a lack of clarity when it comes to the concept of 'capacity'. Strikingly, of the seven Australian jurisdictions that include consideration of capacity in the criteria for involuntary treatment,³⁵ the NT is the *only* jurisdiction that has not (yet) provided guidance on what constitutes capacity, and how it should be assessed. In contrast to other jurisdictions, the current NT Act does not provide:

- a definition of capacity; or
- a presumption in favour of capacity; or
- relevant considerations/principles that apply when assessing capacity; or
- confirmation of whether a person can be deemed to lack capacity based on the content of a decision (eg. whether it is wise, whether it is consistent with recommendations); or
- an indication of whether capacity assessments can take account of what the person can do with assistance (the supported decision-making approach).

As a result, the meaning of 'capacity' is currently left for those implementing the legislation to resolve.

Included, at Appendix A, is a table providing a comparative view of the approach to capacity across different Australian jurisdictions.

C. Who makes decisions?

Under the current NT Act, decisions about whether a person meets the criteria for involuntary treatment are made by two distinct groups of people: medical clinicians, and in particular 'authorised psychiatric practitioners' (APPs); and members of the Northern Territory Civil and Administrative Tribunal (the Tribunal), acting in a review capacity.³⁶

Initially, it is clinicians who make the assessments and authorise involuntary treatment for mental illness. Decisions are made at two key intervals. At the first interval, a clinician makes a preliminary decision about whether a person meets the criteria for involuntary treatment under the Act.³⁷ If the clinician assesses that the person *does* meet the criteria, that compels a formal examination and assessment by an APP.³⁸ However, the practical effects go well beyond this. The preliminary decision can have the effect of authorising transfer to and/or detention at an approved treatment facility

³⁵ See: *NT Act* (n 10), s 14(c); *SA Act* (n 10), s 21(1)(ba); *TAS Act* (n 10), s 40(e); *WA Act* (n 10), s 25(1)©; *ACT Act* (n 10), s 58(2)(b); *Qld Act* (n 10), s 12(b); *VIC Act* (n 10), s 89(1)(a).

³⁶ The Tribunal deciding matters under the NT Act is constituted by a Legal Member, a Medical Member and a Community Member.

³⁷ *NT Act* (n 10), ss 32(4), 33 (in community); s 30(1) (in hospital).

³⁸ *Ibid* ss 34(1), 38(1).

or hospital, administration of a narrow range of treatment, and detention for a period of up to 24 hours.³⁹

At the second interval, the APP examines and assesses the person, and makes a further assessment of whether the person meets the criteria for involuntary treatment, either in hospital or in the community.⁴⁰ In both cases, an assessment by the APP that a person *does* meet treatment criteria has the effect of authorising a range of treatment without consent for a period of up to 14 days.⁴¹

The Tribunal becomes involved if clinicians assess, after two weeks have expired, that longer term involuntary treatment is required.⁴² Such treatment must then be approved by the Tribunal. If the Tribunal finds criteria for involuntary treatment in hospital are met, it can order involuntary admission for up to 3 months.⁴³ If the Tribunal finds that criteria for involuntary treatment in the community are met, it can make a Community Management Order (CMO) for a period of up to 6 months.⁴⁴

It follows that if we want to know how the concept of capacity is currently understood and applied in practice, we need to look at the interpretative and decision-making practices of the Tribunal and of those clinicians who are making capacity assessments outside the Tribunal.

PART 3: EXISTING LITERATURE ON HOW CAPACITY IS ASSESSED IN PRACTICE

There is currently only a slim body of Australian work that explores *how* capacity is assessed in decision-making under mental health legislation. In recent years, as focus has shifted to supported decision-making, this matter has received almost no attention in Australian academic quarters.

One exception is a recent Queensland study which investigated mental health clinicians' perspectives on reasons for the rise in involuntary treatment.⁴⁵ While the study did not focus solely on decision-making about capacity, it made a number of interesting findings relevant to this topic. Researchers found clinicians regarded capacity as vague and open to interpretation, thought emphasis on 'stability of capacity' provided a 'free pass' for involuntary treatment, and had the impression that capacity could be implicated where patient's views differed from those of the treating team.⁴⁶

Going back a bit, we find several smaller Australian studies that have looked at Tribunal decision-making about capacity through the lens of published decisions in the

³⁹ Ibid s 34(3).

⁴⁰ Ibid ss 38 (2)(a), 38(2)(c).

⁴¹ Ibid ss 39(1)(b), 45(3)-(4), 55(2).

⁴² Ibid ss 123(1)(a), (2).

⁴³ Ibid s 123(5)(a).

⁴⁴ Ibid s 123(5)(c).

⁴⁵ Kimballi Wild et al, 'Reasons behind the Rise in Involuntary Psychiatric Treatment under Mental Health Act 2016, Queensland, Australia – Clinician Perspectives' (2025) 98 *International Journal of Law and Psychiatry* 102061.

⁴⁶ Ibid 4.

state of Victoria. In their study of decisions between 2015-2016, Maylea and Ryan found that when considering decision-making capacity under the former *Mental Health Act 2014* (Vic), the Victorian Tribunal regularly linked capacity to consent with a person's compliance with proposed treatment, and treated 'insight' as a precursor to capacity.⁴⁷ In a 2010 chapter, Freckelton highlighted 'insight' and 'compliance' as among the extra-legislative labels used by clinicians and mental health tribunals in their decision-making, and drew on decisions of the Victorian tribunal to illustrate this.⁴⁸ The tendency of tribunals to rely on de facto criteria was also reported in a study involving mental health duty lawyers in Victoria, together with a tendency to defer to clinical opinion.⁴⁹ In a much earlier study, looking at published Victorian decisions from 1997-1998, Diesfeld and Sjostrom found that 'insight' was frequently raised in cases, especially those involving consideration of whether the person had refused or was unable to consent to treatment, but also in connection with issues of compliance.⁵⁰

In addition to the small studies highlighted above, there is also the 2011 monograph by Carney *et al*, which examined the operations of three mental health tribunals in Australia (in NSW, Victoria and the ACT). While the study did not include a strong focus on issues of capacity, it did find evidence of a tendency (by psychiatrists and Tribunal members) to treat denials of mental illness as indicative of a lack of 'insight', and to use the psychiatric concept of insight as a substitute for engaging with the question of capacity.⁵¹

The findings of these Australian studies accord with the findings of other studies from the UK, Sweden and New Zealand. Three specific themes about the role of 'insight' in decision-making about capacity can be drawn from these international studies. Firstly, there is a large body of literature which highlights that 'insight', while not typically mentioned in mental health legislation, is relied on extensively in decision-making about capacity (and other criteria) under mental health legislation.⁵² Secondly, studies

⁴⁷ Christopher Maylea and Christopher James Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2018) 2017(24) *International Journal of Mental Health and Capacity Law* 87.

⁴⁸ Ian Freckelton 'Extra-Legislative Factors in Involuntary Status Decision-Making' in *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010) 203.

⁴⁹ Eleanore Fritze, 'The Variable Treatment of (in)Capacity in the Practical Operation of Victoria's Key Substituted Decision-Making Regimes: View from the Frontline' in *Critical Perspectives on Coercive Interventions* (Routledge, 2018) 65, 80.

⁵⁰ Kate Diesfeld and Stefan Sjostrom, 'Interpretive Flexibility: Why Doesn't Insight Incite Controversy in Mental Health Law?' (2007) 25 *Behavioral Sciences and the Law* 85.

⁵¹ Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection & Treatment?* (Law and Justice Foundation, Themis Press, 2011) 200, 205, 302.

⁵² Magdalena Furgalska, "'Informed Consent Is a Bit of a Joke to Me": Lived Experiences of Insight, Coercion, and Capabilities in Mental Health Care Settings' (2023) *International Journal of Law in Context* 1; Sándor Gurbai, Emily Fitton and Wayne Martin, 'Insight under Scrutiny in the Court of Protection: A Case Law Survey' (2020) 11(Article 560329) *Frontiers in Psychiatry* 1; Susanna Radovic, Lena Eriksson and Moa Kindström Dahlin, 'Absence of Insight as a Catch-All Extra-Legislative Factor in Swedish Mental Health Law Proceedings' (2020) 27(4) *Psychiatry, Psychology and Law* 601; Case (n 28). The same theme was highlighted in older studies, see for example: Elizabeth Perkins, *Decision-Making in Mental Health Review Tribunals* (London Policy Studies Institute, University of Westminster, 2003); Stefan Sjostrom, *Party or Patient? Discursive Practices Relating to Coercion in Psychiatric and Legal Settings* (Borea Bokforlag, 1997); Jill Peay, *Tribunals on Trial: A Study of Decision-Making under the Mental Health Act 1983* (Clarendon Press, 1989).

have highlighted ambiguity (or ‘flexibility’)⁵³ in the meaning of ‘insight’. While regularly used in decision-making under mental health legislation, the term is generally left undefined.⁵⁴ Thirdly, studies have highlighted the various functional uses of ‘insight’ in decision-making under mental health law: as a proxy or shorthand for legislative criteria;⁵⁵ to undermine the patient perspective and endorse medical authority,⁵⁶ and as a tool for assessing likely compliance with treatment.⁵⁷

In Parts 4 and 5, I discuss the recent mixed methods study done in the NT, and the extent to which the findings of my study resonate with the Australian and international literature highlighted above. Clearly the body of Australian research on how capacity is interpreted and operationalised under mental health law is thin and, for the most part, dated. My study stands to make a small but valuable contribution to the existing literature. Relevantly, it is unique in its focus on the NT. The study also provides some indications of how decisions about capacity are made in practice. Further, it highlights how qualitative interviews with medical practitioners can yield rich information about this.

PART 4: DISCOURSE ANALYSIS OF NORTHERN TERRITORY CASELAW

The Foucauldian concept of ‘discourse’ is used across disciplines to draw attention to the way that language is used to create meaning, to structure knowledge and to create or reinforce relationships of power.⁵⁸ Drawing on Foucault, Norman Fairclough has defined discourse analysis as a process of analysing language, with a view to its social effects.⁵⁹ In Parts 4 and 5 of this article, I draw on this social-theoretical form of discourse analysis,⁶⁰ to study how various actors (in particular, Tribunal members and APPs) use language to constitute and construct ‘capacity’ when making decisions under mental health legislation. My aim is not to provide a normative assessment of whether the approach of various actors is correct, but rather to call attention to what various discourses reveal about how the concept of capacity is being interpreted and deployed in practice.

In Part 2 I highlighted the lack of prescription in the NT Act around what capacity is, and how it should be assessed. In Part 4, I draw on NT caselaw for indications of how capacity is understood and applied in practice, and highlight the need to look beyond doctrinal sources.

⁵³ Diesfeld and Sjostrom (n 50).

⁵⁴ Case (n 28); Diesfeld and Sjostrom (n 50); Kate Diesfeld and Brian McKenna, *Insight and Other Puzzles: Undefined Terms in the New Zealand Mental Health Review Tribunal* (Mental Health Commission, 2005); Perkins (n 52); Sjostrom (n 52).

⁵⁵ Furgalska (n 52); Carney et al (n 51); Freckelton (n 48); Perkins (n 52).

⁵⁶ Furgalska (n 52) 7–10; Radovic, Eriksson and Dahlin (n 52) 613–614; Case (n 28) 367; Diesfeld and Sjostrom (n 50) 97.

⁵⁷ Furgalska (n 52) 8–9; Case (n 28) 367; Freckelton (n 48) 213; Diesfeld and Sjostrom (n 50) 93–94; Perkins (n 52) 124.

⁵⁸ See eg. Michel Foucault, *The Archaeology of Knowledge and the Discourse on Language* (Pantheon, 1972).

⁵⁹ *Analysing Discourse: Textual Analysis for Social Research* (Routledge, 2003).

⁶⁰ Norman Fairclough, *Discourse and Social Change* (Polity Press, 1992) 3–4.

A. Doctrinal sources are limited in number

In recent years, the Northern Territory Civil and Administrative Tribunal (the Tribunal) has dealt with an average of 724 mental health matters per year.⁶¹ A large percentage of these matters result in orders for involuntary treatment (almost 50% in 2022-2023).⁶² However, at the time of writing, there are zero published Tribunal decisions highlighting decision-making on substantive matters arising under the NT Act. This is despite the current NT Act having been in operation for over 25 years.

Judy Harrison has coined the term ‘conditions of observability’ to capture and frame the conditions which make legal problems observable, and actionable.⁶³ The ‘conditions of observability’ surrounding Tribunal decision-making on mental health matters are limited as a result of several provisions in the current NT Act. These provisions provide that: mental health hearings are closed to the public;⁶⁴ the general obligation to provide written reasons does not apply in mental health matters;⁶⁵ and if the Tribunal *does* decide to provide written reasons, it has discretion whether to publish a de-identified version of the reasons.⁶⁶ Further, unlike in other Australian jurisdictions like the ACT and Victoria, there is no obligation on the Tribunal to provide written reasons if requested to do so by a party to proceedings.⁶⁷ A person subject to Tribunal review is only entitled to an audio recording of the review proceedings.⁶⁸ Together, these provisions create an operating environment where the norm is for the Tribunal to provide only brief oral reasons at the conclusion of the hearing (*ex tempore*) – nothing in writing, and nothing accessible to those outside the hearing room.⁶⁹

The legislative restrictions outlined above appear motivated by a desire to protect the privacy of the patient, and their health and safety.⁷⁰ This comes, however, at the cost of procedural justice. Without written reasons, it is significantly more difficult for a patient — and their lawyer — to know and understand the basis for the Tribunal’s decision, and whether the decision involves error. This in turn bears directly on the patient’s ability to appeal to the Supreme Court, because the right to a ‘rehearing’ provided under the current Act *depends* upon the existence of a legal, factual or discretionary error.⁷¹ In short, the lack of written reasons undermines access to review, such that the right of appeal is attenuated.

⁶¹ Information obtained by the writer under the *Information Act 2002* (NT) (13 October 2023) (‘*FOI Release*’); Northern Territory Civil and Administrative Tribunal, *NTCAT Annual Report 2021-2022* (2023) 10 [21].

⁶² *FOI Release* (n 61).

⁶³ Judy Harrison, ‘Conditions of Observability’, *ANU School of Legal Practice* (15 September 2017) <<https://legalpractice.anu.edu.au/news-and-events/news/conditions-observability>>.

⁶⁴ *NT Act* (n 10), s 135(1).

⁶⁵ *Ibid* s 141.

⁶⁶ *Ibid* s 141A.

⁶⁷ *ACT Civil and Administrative Tribunal Act 2008*, s 60; *VIC Act* (n 10), s 380.

⁶⁸ *NT Act* (n 10), s 136.

⁶⁹ In 2022-2023, there was only one matter where a written statement of reasons was produced, and this was provided to the parties only: *FOI Release* (n 61).

⁷⁰ *NT Act* (n 10), ss 135(2), 145A.

⁷¹ *Ibid* ss 142(1), (3); *CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43 (‘*CH*’) [31]; affirmed in *AX* (n 18) [13] - [14].

The limited conditions of observability, created by the legislation, also impede public understanding of the interpretive and decision-making practices of clinicians. It is only when the Tribunal's decisions are appealed to the NT Supreme Court that non-participants in the Tribunal process can observe how APPs, and the Tribunal, make decisions about whether someone should be given involuntary treatment. Unsurprisingly however, given the obstacles to appeal, the data set is limited. In the whole time that the NT Act has been in operation, there have (at the time of writing) been only eleven Supreme Court decisions involving appeals of Tribunal decisions under the NT Act.

B. Capacity discourse in Supreme Court appeal decisions

Of the eleven NT Supreme Court decisions that involve appeals of Tribunal decisions under mental health legislation, only one case addresses questions of capacity in any detail: *AX v Mental Health Review Tribunal & Anor* (2019) 34 NTSC. A further five cases address capacity issues only in passing.⁷²

The paucity of Supreme Court decisions (combined with the lack of published Tribunal decisions) means that, to gain a deeper understanding how capacity is being interpreted and operationalised in practice, we need to go beyond the 'law on the books'. In the section below, I highlight what we can draw from the case of *AX*, before moving on to analyse pilot data from an interview with an APP.

C. AX v Mental Health Review Tribunal & Anor

As the only NT case that addresses issues of capacity in detail, the case of *AX* provides the best indication of how capacity is interpreted and operationalised in the NT context. The Supreme Court in that case was required to consider whether, based on the evidence, it was open to the Tribunal to find that the appellant lacked capacity to provide informed consent to treatment. It is because the Supreme Court refers in detail to the Tribunal transcript, that we can get a glimpse of how capacity was interpreted and operationalised by those involved in the Tribunal proceedings.

By analysing the Tribunal transcript (excerpted in the Supreme Court judgment) we can see how the duty lawyer, the APP and the Tribunal seemed to understand and operationalise the concept of capacity.⁷³

(i) The duty lawyer's approach

There is a passage in the Tribunal transcript (cited by the Supreme Court) where the duty lawyer leads evidence from *AX*, taking an approach that aligns with common law

⁷² See *CLM v Northern Territory Civil and Administrative Tribunal & Ors* [2025] NTSC 12 at [38]; *EJ v Mental Health Review Tribunal & Anor* [2024] NTSC 47 at [30]; *ET v The Northern Territory of Australia* [2022] NTSC 94 at [10], [13], [15]; *CH* (n 71) at [14]; *KMD v the Mental Health Review Tribunal & Anor* [2020] NTSC 13 at [16]–[17].

⁷³ In the interests of full disclosure, I note that I (the writer) was the duty lawyer in this case, and the instructing solicitor in the Supreme Court appeal.

discourse about capacity. First, the lawyer highlights that AX understands information relevant to the decision (about treatment) and has retained it.⁷⁴

HQ: So, [AX], do you think you have a mental illness?

AX: Yes.

HQ: And what is it, does it have a name?

AX: Schizo-affective bipolar.

HQ: And do you think you need medication for that illness?

AX: Yes.

HQ: What happens if you don't have medication for it?

AX: I'll be sick.

[...]

HQ: And how do you remember to take the tablets?

AX: I set my alarm on the phone.

HQ: You set your alarm, okay. And do you think the medication helps you?

AX: Yes.

HQ: How does it help you?

AX: It makes me feel better, think better, do things a bit better, and functions a bit better.

Then, the lawyer highlights that AX can *use or weigh* the information: ⁷⁵

HQ: Do you have any concerns about your medication?

AX: Um, at the moment, just a bit too much I think, it's just that I get a lot of pains and sickness and all of that.

HQ: Yeah.

AX: So, but I'm putting up with it.

HQ: Yeah, and I understand you've been talking to Dr Willcocks about that?

AX: Yes.

HQ: And working with her on how to manage some of those side effects?

AX: Yes, we are.

HQ: Yeah, that's good. Are you happy to continue doing that, taking the medication and talking to Dr Willcocks?

AX: Yes. Yes.

...

The lawyer then provides an opportunity for AX to *communicate* her decision:⁷⁶

HQ: Would you keep taking the medication if you were not on a CMO?

AX: Yes.

Later in the Tribunal hearing, the lawyer submitted that the test for capacity (in the criteria for involuntary treatment) 'should be interpreted as a point in time test, rather than as a longitudinal test involving speculation about what will happen in the future'.⁷⁷

(ii) The APP's approach

⁷⁴ AX (n 18) [29] (citing Tribunal transcript).

⁷⁵ Ibid.

⁷⁶ Ibid.

⁷⁷ Ibid [46].

AX's psychiatrist (APP) takes a different approach to assessing capacity. The APP had submitted, in her report to the Tribunal, that AX was not capable of providing informed consent to treatment because:

[AX] continues to attribute her symptoms to 'nervous breakdowns' and has poor insight evidenced by nonadherence to medications.⁷⁸

In the tribunal hearing, the APP then gives the following additional evidence about compliance:

We know that when AX has come into hospital unwell, we know that generally she has told us that she's not been fully compliant. I think generally when she's well, she's compliant. I wonder if something, you know, makes you start becoming unwell and then the change in thinking is what then leads to some non-compliance....

I don't think you deliberately go off it, you know, all the time...⁷⁹

These excerpts from the APP's evidence, highlighted in the Supreme Court decision, reveal four things about how the APP understood and assessed capacity. First, they reveal that for this APP, insight was the normative consideration underlying the capacity assessment. Second, insight comprises (at least) two elements: insight into illness, and insight into the need for treatment. Third, insight is related to compliance. Non-compliance is presented, in the APP's written report (cited above), as indicative of a lack of insight (*'poor insight evidenced by nonadherence to medications'*). Further, while the logic behind the APP's oral evidence is somewhat opaque, there seems to be a suggestion that lack of insight (through a 'change in thinking') causes non-compliance. This is consistent with Diesfeld and Sjostrom's study, which found a mutually reinforcing relationship between insight and compliance in published Victorian decisions.⁸⁰

(iii) The Tribunal's approach

It is instructive to see how the Tribunal, considering AX's matter, responds to the competing legal and clinical discourses about capacity that surfaced during the hearing. In delivering the Tribunal's decision, the Legal Member of the Tribunal starts by saying:

We have listened very carefully.... But right now we're not accepting that you have the sort of insight that is necessary that would give us the confidence not to make a CMO [Community Management Order] today. We certainly believe that you have a degree of insight, but we think that at times that changes.⁸¹

After explaining that the Tribunal is satisfied that AX had a mental illness, requires treatment, and without treatment would suffer a serious mental or physical deterioration, the Legal Member concludes:

... right now you are not capable of giving the informed consent that is required. There are times where we think you've reached it, but there are times very recently where it hasn't as well. It

⁷⁸ Ibid [25].

⁷⁹ AX (n 18) [31] (citing Tribunal transcript).

⁸⁰ Diesfeld and Sjostrom (n 50) 93–94.

⁸¹ AX (n 18) [32] (citing Tribunal transcript).

fluctuates. But it's not so far, your refusals, your lack of insight is not so long ago, that we accept what your lawyer has said...⁸²

These excerpts are very revealing. They show the Tribunal adopting and, in some ways, extending the clinical constructions of capacity that had been presented. For example, the Tribunal adopts the APP's focus on insight as a central consideration when assessing capacity. The Tribunal actually seems to go further, using insight as a proxy for capacity in its reasons for decision. We see this in the way that the Legal Member moves quickly from talking about fluctuating insight, to a lack of capacity, and then back to fluctuating insight. This resonates with studies from both Australia and the UK that have found evidence of insight being used as a 'shorthand', or 'rule of thumb' substituting for actual legislative criteria.⁸³

Functionally, the concept of insight provides a basis on which the Tribunal can reject other evidence that may suggest the patient has capacity, and thereby reconcile the competing accounts of the patient and her treating doctor. This echoes other studies that have highlighted the use of insight to undermine counter perspectives,⁸⁴ to minimise the scope for disagreement,⁸⁵ and to pathologise patient perspectives.⁸⁶

In the case of *AX*, we also see the Tribunal constructing insight/capacity as something that exists on a continuum. In the Legal Member's words, *AX* had 'a degree of insight' but not 'the sort of insight that was necessary' to satisfy the Tribunal that a CMO should not be granted.⁸⁷ This approach, whereby the decision-maker presents insight as existing on a continuum but does not define the grading of insight that is sufficient or necessary, has also been detected in other studies.⁸⁸ Diesfeld and Sjoström have suggested that it may be motivated by a desire to give assessments of insight 'the appearance of scientific objectivity'.⁸⁹

The Tribunal also follows the APP in linking non-compliance back to lack of insight ('*your refusals, your lack of insight...*'). Again it goes further, linking deterioration (evidenced by admissions) back to non-compliance. The admissions were '*very very recent*', and therefore there must have been non-compliance ('refusals') '*not so long ago*'. The Tribunal's reasons for decision suggest a chain of logic whereby a lack of insight leads to non-compliance, which leads to deterioration. Further, this chain of logic seems to be applied in a way that enables the past to be used as a predictor of the future. Diesfeld, noting the use of insight as a tool for predicting future behaviour, has suggested that this use of the concept stems from concern for patient well-being; in a context where there is considerable uncertainty, decision-makers want to know whether a vulnerable person will be able to seek care when they need it.⁹⁰ Radovic,

⁸² Ibid.

⁸³ Furgalska (n 52); Carney et al (n 51); Freckelton (n 48); Perkins (n 52) 127.

⁸⁴ Diesfeld and Sjoström (n 50) 97.

⁸⁵ Furgalska (n 52) 7–10; Radovic, Eriksson and Dahlin (n 52) 613–614.

⁸⁶ Case (n 28) 367.

⁸⁷ *AX* (n 18) [32].

⁸⁸ Diesfeld and Sjoström (n 50); Diesfeld and McKenna (n 54); Gurbai, Fitton and Martin (n 52).

⁸⁹ Diesfeld and Sjoström (n 50) 95.

⁹⁰ Kate Diesfeld, 'Insight: Unpacking the Concept in Mental Health Law' (2003) 10(1) *Psychiatry, Psychology and Law* 63, 67.

who conducted interviews with professional participants in Swedish mental health court proceedings, found that interviewees considered compliance with medication a measure of 'true' insight and decisive of whether a person needed involuntary treatment.⁹¹

(iv) The Supreme Court's approach

As highlighted earlier, NT mental health cases rarely make it to the Supreme Court. It is APPs and Tribunals who primarily make decisions about involuntary treatment under current legislation. The Supreme Court decision in *AX* provides a useful window into the competing approaches to capacity in that case – practices that would otherwise be quite invisible. Beyond this, of course, the decision of *AX* also has precedential value: it provides guidance for future decision-making on capacity in the NT.

Before the Supreme Court, *AX*'s counsel submitted that in the context of the APP's evidence on the day of the hearing (and *AX*'s own evidence), it was not open for the Tribunal to find, to the *Briginshaw* standard, that *AX* lacked capacity to provide informed consent.⁹² In this way, the appeal invited the Supreme Court to provide guidance on how capacity should be assessed, and which of the competing approaches from the Tribunal hearing should be preferred.

Unfortunately, the Supreme Court did not embark on a fulsome exposition of how capacity should be assessed under NT legislation, or the specific relevance of 'insight' and 'non-compliance'. The decision does seem to involve, however, a rejection of the duty lawyer's submission that capacity is a point in time test, and endorsement of a longitudinal approach. We see this in *Blokland J*'s finding that it was open for the Tribunal to reject oral evidence presented on the day of the hearing (that was favourable to the appellant) and find that *AX* *lacked* capacity, relying on the APP's written report about what had happened in the past, and information about previous admissions which was on the Tribunal's file:⁹³

I am not persuaded the Tribunal fell into error on this point when all of the relevant material is considered. It is accepted the Tribunal appeared to rely quite heavily on the history of the appellant's treatment including previous orders. History is important and relevant in these cases, although over reliance on history may lead to unfairness. The oral evidence before the Tribunal was only part of the material relevant to the question of informed consent. [The APP's] evidence before the Tribunal, much of which may be interpreted as favourable to the appellant's case, was focussed on the appellant's appearance on the day of the hearing. She did also observe the appellant to be 'relatively stable' in the past 6 months. However, her evidence needs to be considered against the material in the Form 15 which pointed to 'fluctuating insight, erratic adherence with medications and treatment plan, and the risks *AX* is exposed to while unwell'.⁹⁴

... In this matter it is the case, as submitted by the second respondent, that the Tribunal's state of satisfaction was in fact informed by...the appellant's history of non-compliance with medication,

⁹¹ Radovic, Eriksson and Dahlin (n 52) 609.

⁹² *AX* (n 18) at [35].

⁹³ *AX* (n 18) at [41]-[42].

⁹⁴ *AX* (n 18) at [41].

documented in the Form 15 prepared in May 2018, and the records of her previous hospital admissions.⁹⁵

It is unclear from these Supreme Court findings exactly *how* and *why* a person's previous mental health history (including non-compliance and admissions) is relevant to the question of capacity. However, the leading NT decision clearly upholds a backwards-looking approach to capacity assessments and puts emphasis on patient stability over the longer term.⁹⁶ Further, the decision in *AX* highlights the immense difficulty that individuals who have a history of involuntary treatment may face, in demonstrating that they can now be treated on a voluntary basis.

PART 5: DISCOURSE ANALYSIS OF THE INTERVIEW DATA

A. Methodology

I turn now to highlight some data drawn from a semi-structured interview that I conducted with an Authorised Psychiatric Practitioner (APP) who was (at that time) appearing regularly before the NT Tribunal seeking involuntary treatment orders. The interview was conducted in October 2023, with approval from the Australian National University Ethics Committee⁹⁷ and with organisational approval from NT Health.⁹⁸ While the plan was originally to conduct a set of interviews, this could not be achieved within the short timeframe for the research project.⁹⁹ The data collected thus serves as 'pilot data' for a larger project, demonstrating how semi-structured interviews with psychiatrists can extend our understanding of how capacity is interpreted and operationalised and also, providing a practical check on the methodology.

Recruitment occurred at arms-length, with the interviewee volunteering to be a participant in the research in response to a written invitation distributed to the target group with the assistance of NT Health employees (the target group being APPs who regularly appear before the Tribunal). The interviewee signalled their willingness to participate by returning a signed written consent form by e-mail. The interview was conducted by phone, with the interviewee being asked questions relating to how they assess whether someone has capacity to consent. The interview covered topics including: the role/place of capacity assessments, working approaches to assessing capacity, markers of capacity/incapacity, the relationship between capacity and insight and the meaning of 'unreasonable refusal'. The interview was recorded, transcribed, de-identified and then analysed.

The data collected through the interview provides an interesting case study of how one APP interprets and applies the capacity test (in the NT Act) when considering the

⁹⁵ *AX* (n 18) at [42].

⁹⁶ This resonates with findings in the recent Queensland study, see: Wild et al (n 45) 4.

⁹⁷ Protocol 2023/1143.

⁹⁸ EFILE2023/21201.

⁹⁹ The study was conducted within the context of the writer's LLM coursework program at the Australian National University. In the limited time between receiving relevant ethics approvals and finalizing the paper, only one interview was conducted. The reliance on potential participants taking initiative seems to have been a factor preventing the study from reaching its intended scale (of 5 interviews), but the condensed time frame for data collection likely also contributed.

need for involuntary treatment. Based on data collected through the first interview, there would be value in conducting a wider set of interviews. For this to eventuate however, the methodology would probably need to be revised to allow for more direct means of recruitment, over a longer period of time.

B. Analysis of interview data

Using discourse analysis, I have drawn out seven key points of interest about the interviewee's approach to capacity. These are arranged under thematic headings (A-G) below.

Theme A: Underlying the approach to capacity is a merging (or blurring) of capacity and insight

Interestingly, when *initially* asked to define 'capacity to consent', the interviewee offered the following construction:

A1. 'I guess you would define it as the capacity to weigh up the pros and cons of treatment according to one's own values, in a way that's not unduly affected by the mental illness in question, and is able to be consistently acted on'.¹⁰⁰

There are three elements to this construction of capacity. First, there is the framing of capacity as the ability to 'weigh' up the pros and cons of treatment. As we have seen, 'weighing' is a common element of the functional capacity tests that have been developed in the common law and reflected in mental health legislation. Secondly, in this construction, the normative standard that the exercise of the person's abilities (their 'weighing') must rise to is determined by the individual's values, not the doctor's view of what they should do. This appears to be an effort to signal that the approach to capacity is not affected by paternalistic considerations of what is in the person's 'best interests', but rather driven by the individual's internal rationality. (The interviewee went on to describe how the values must be 'part of their baseline' personality, not affected by mental illness.¹⁰¹) Thirdly, there is an emphasis on the need for consistency between the person's decision and their subsequent actions. This is a recurring theme in the interview data, discussed in more detail below ('Theme B').

Over the course of the interview, the interviewee's discourse about capacity evolved to reveal that underlying the surface definition of capacity initially offered (see Quote A1) are requirements of insight. For example, when asked to describe what 'indicators or markers' they look for when assessing capacity, the interviewee invoked the concept of insight, at first indirectly, then directly:

A2. (*Indirect*) Their understanding of the illness. Do they believe that they have *an* illness? Or, it doesn't even necessarily have to be conceptualized by them as an illness, but some kind of problem

¹⁰⁰ Transcript of research interview (16 October 2023) ('*Transcript*') 1.

¹⁰¹ *Ibid.*



that requires treatment and that they have an understanding of the effect of treatment. And what effect treatment has, and what risks not having treatment would have.

(Direct) But I think you're also looking at the person's behavior as well, because although insight isn't directly part of capacity...Part of insight, the highest level of insight is emotional insight and below emotional insight is cognitive insight where people might have some cognitive understanding, but they're not able to act on those [understandings] necessarily. So, if a person is able to say some of the right things, but their behavior previously has indicated that they are consistently not following through on engagement with treatment, then I think you have to look at that as potentially being an indication of lack of capacity, to follow through on those decisions...¹⁰²

In the second paragraph above, the interviewee conveys a theoretical understanding that capacity and insight are different ('insight isn't directly part of capacity'). But then, the interviewee's discussion about types of insight ('cognitive' vs 'emotional') leads directly to a conclusion about capacity, suggesting that in practice the concepts do blur together.

Shortly after, the interviewee seems to reconstruct their original definition of capacity as involving two questions of insight, the first involving 'cognitive'/'superficial' insight and the second involving 'emotional'/'higher level insight that drives behaviour':

A3. ...the insight has to contribute to a decision or an agreement that treatment's appropriate, which is sort of the first part of [capacity]*, the weighing up the pros and cons of treatment. Then the next step is to be able to act on that.. Making a decision around doing something involves actually doing it... You can have insight and decide that you don't want treatment, which is slightly different – and that would be why you're not adhering... But to passively agree to treatment and then to not follow through on that - that might be due to a lack of insight, [because] there's something there, but you're not actually making that decision to do it. You're just saying something, if that makes sense...I think it is in some ways related to the concept of emotional insight – that's where it's more than just a superficial understanding of the risks and benefits. You [also] have a sort of an emotional connection - that I'm going to make an effort to do this, because I'm fearful that if I don't, then I may become unwell. Whereas if it's more of a superficial insight, when it's put to you, you can say 'yeah, I can see that I became unwell', and then when you're asked if you're going to take medication you say, 'Yeah, okay, I guess I can'. That's different from having a belief that's strong enough to actually drive behavior.¹⁰³

**the interviewee added the content in square brackets on review of the interview transcript.*

Clearly, requirements of insight are integral to the way that the interviewee understands and operationalizes the capacity test.

Theme B: Capacity (insight) needs to be demonstrated by actions, not just words

The interviewee's approach to capacity entails a striking focus on a person's actions (or behaviour) – specifically their actions in relation to recommended treatment. The effect of this is to constitute capacity in a way that is outcomes-focused and not just functional (cf legal discourses: Part 1). In the initial definition of capacity offered (see Quote A1), acting 'consistently' (with the decision produced by the 'weighing') constitutes the third element of the capacity test. In the interviewee's reconstruction of capacity as two questions of insight (see Quote A3), acting on a decision to take

¹⁰² Ibid 2.

¹⁰³ Ibid 2-3.

treatment is indicative of whether a person has the higher level of insight. The interviewee went on to frame 'following through' as a core component of decision-making:

B1. I mean, a decision doesn't really have any meaning if somebody doesn't follow through on it. If I say I'm going to drive down to the shops, have I really decided to drive down to the shops if I don't ever arrive at the shops? Have I made a decision to go to the shops just because I've said it? Probably not.¹⁰⁴

These comments echo the approach of leading American psychiatrists Appelbaum and Grisso, who in a seminal paper argue that capacity requires 'the ability to maintain and communicate stable choices long enough for them to be implemented'.¹⁰⁵ A similar focus on 'following through' was observed by Radovic *et al* in their interviews with mental health court participants (in the Swedish context): 'Patients might demonstrate insight both in terms of awareness that they are ill and in terms of awareness that they need medication, but if that realization does not manifest itself as actually complying with prescribed medication, compulsory measures will need to continue'.¹⁰⁶ While not unique then, the interviewee's emphasis on 'following through' provides an angle on the insight-compliance nexus that is missing in the NT caselaw. Where the caselaw highlights only simplistic connections between insight and compliance, the interview data reveals *why* insight, compliance and capacity are so closely tied. For the interviewee, higher level (emotional) insight is what drives compliance. Thus, if a person does not follow through on what they have said, that is an indication that they lack the insight necessary to implement their reasoned decision. And if they cannot implement a decision, they cannot truly *make* a decision.

With this more detailed explanation from the interviewed APP in hand, we can perhaps better understand the evidence given by the (different) APP who appeared in the case of AX: although the patient had given evidence (at hearing) demonstrating capacity at a cognitive level, there had been 'previous times where [AX] felt concerned that she was getting side-effects and so therefore has stopped medication regimes'.¹⁰⁷ This failure to 'follow through' in the past, may have been the basis for why the APP in AX considered that, in spite of AX's evidence at the hearing, she did not have capacity to consent to treatment.¹⁰⁸

Theme C: Divergence from clinical recommendations is difficult to accommodate.

There were multiple times in the interview when the interviewed APP expressed a commitment to assessing capacity in a way that did not require agreement and compliance with clinical recommendations. For example, in the initial definition of capacity (see Quote A1), the interviewee placed emphasis on the need for pros and

¹⁰⁴ Ibid 2.

¹⁰⁵ 'Assessing Patients' Capacities to Consent to Treatment' (1988) 319(25) *New England Journal of Medicine* 1635; cited in Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49(4) *Australian & New Zealand Journal of Psychiatry* 324.

¹⁰⁶ Radovic, Eriksson and Dahlin (n 52) 608–609.

¹⁰⁷ AX (n 18) [35] (citing Tribunal transcript).

¹⁰⁸ Ibid [41].

cons to be weighed up according to their individual's '*own values*'. In other discussions, the interviewee signaled an openness to finding that a person who did not follow clinical recommendations could have capacity. For example, in the discussion about 'following through', the interviewee distinguished a situation where a person says they will engage with treatment but doesn't, from a situation where the person is '*not following through on it [the treatment plan], because they've got capacity, but they don't agree with treatment*'.¹⁰⁹

Close study of the interviewee's discourse about capacity suggests that in practice, however, the interviewee's own values and assumptions do creep into their capacity assessments, making divergence from medical opinion difficult to accommodate. For example, recall that in the reconstruction of capacity as a two stage insight test (see Quote A3), the interviewee said:

'...the insight has to contribute to a decision or an agreement that treatment's appropriate'.

In this construction, there is no scope for finding that a person who disagrees that treatment is appropriate has capacity (or insight). This aligns with the focus in Lewis' definition of insight on having a '*correct attitude*', and the focus in David's definition of insight on 'compliance' (see Part 1).

Similarly, we see the interviewee's own values creeping in as they consider the relevance of what a person could do with support:

C1. Yeah, I guess if that support is effective in them being able to make *good decisions*, or sorry, make decisions, then I guess you do take that into account.¹¹⁰ (emphasis added)

Theme D: While relevant, the impact of support does not change the assessment of capacity

While the interviewee indicated that the effect of support was relevant, it was seen as more relevant to the assessment of whether involuntary treatment was the least restrictive option, than to the assessment of capacity:

D1. So sometimes, even when people don't have capacity, we need to treat them in a less restrictive way. For example, if they have a really supportive person at home, or they're willing to accept treatment, even if they don't really quite understand why... There would be people who may not have...who may not meet certain criteria for having capacity, on one view, but if they have support to either make the decisions or, particularly, to follow through on those decisions, then that might make you less likely to need to involuntarily treat that person.¹¹¹

Implicit in this is an individualistic approach to capacity. For the interviewee, what matters for the capacity assessment is what the individual can do alone.

Theme E: Capacity (insight) is complex, and layered

¹⁰⁹ Transcript (n 100), 2.

¹¹⁰ Ibid 5.

¹¹¹ Ibid.



At several points during the interview, the interviewee indicated that, in their view, questions of whether a person had insight, or capacity, were not straight-forward equations.

On 'insight', the interviewee said:

E1. it's a very complex thing, and it's not all or nothing...there's one fellow who has a six step categorization of insight, and there's insight into some things and not others. So some people might have insight into the fact that they have an illness, but not insight into the influence of medications. Or they might have insight into the illness, and the need for medication, but not other insight into the role of substances in their illness. Or they may have insight into different aspects. Or they may have insight into having an illness but lack insight into the degree of associated risk. For example, if they have been very violent in the past, they might know that there's a risk of becoming unwell, but they're underappreciating the risk that if that happens that could end up killing someone and end up in prison. So it's very complex in terms of insight, what the insight is into. You can have a degree of each aspect as well, it's very complicated.¹¹²

These comments about the variable meaning of insight, and its range of applications, resonate with the findings of other studies discussed in Part 3.

Later, the interviewee was asked to respond to the possibility of there being a definition of capacity in future legislation. The interviewee, in their response, suggested that the lack of definition around capacity and its amorphous nature was potentially helpful to clinicians applying for involuntary treatment orders:

E2. I think there's potential pros and cons to that [having a definition]. It could make it narrower and harder to argue. But I guess it could also make it easier to argue because you've got a bit of a benchmark of what you're arguing...I guess it's also not all about what's good for me to be able to argue or not!¹¹³

The interviewee went on to say:

E3. ...capacity is such a vague term, and it's certainly not black and white. Like where in the continuum of capacity do you decide that a person has it or hasn't? ... it's not a very easily definable thing.¹¹⁴

These comments accord with recent findings of a study involving mental health clinicians in another Australian jurisdiction (Queensland), where researchers found clinicians considered capacity a vague concept that was open to interpretation.¹¹⁵

Theme F: What is required for capacity is relative to risk

At another point, the interviewee suggested that the threshold level of capacity required in any given situation is relative to risk.

F1. So if the risk is that somebody might kill themselves...you're naturally going to put a high value on, or raise the threshold for, insight and being able to weigh out those pros and cons. That's

¹¹² Ibid 3-4.

¹¹³ Ibid 6.

¹¹⁴ Ibid 7.

¹¹⁵ Wild et al (n 45) 4.

different to where the biggest risk is that they might say something – you know, put a post on the internet that sounds silly and mildly damages their reputation.¹¹⁶

This application of the sliding scale of capacity is slightly different to what we see in legal discourses, where the standard of the capacity required is related more to the gravity of the *decision* that a person needs to make, rather than level of *risk* that the decision entails (see Part 1).

In Part 6, I consider what implications might be drawn from the pilot interview data.

PART 6: WHERE TO FROM HERE?

In this article I have presented and analysed a small set of data drawn from existing NT caselaw and my own interview research. The dataset that I have relied on is clearly limited in scope; only one published decision deals with the question of capacity in any detail, and I have supplemented that decision with a single in-depth interview. Given these limitations, the dataset must be treated as indicative rather than representative. What the data presented here does, is provide a useful starting point for understanding how the concept of capacity is interpreted and operationalised by decision-makers when there is no legislative definition. In addition, the pilot interview data demonstrates the utility of qualitative interviews with medical practitioners in allowing us to 'see' and understand clinical perspectives in greater depth than what existing published decisions afford.

While the caselaw data and interview data I have presented are only indicative, what we see in them is worth highlighting:

- APPs may construct capacity differently from how capacity is constructed in the common law and in other legislation.
- APPs may understand capacity as something that is complex and amorphous.
- The concept of insight can be integral to clinical constructions of capacity and also, complex and amorphous. The concept of insight can be imported by the Tribunal into decision-making and used as a proxy for capacity.
- Compliance (or 'following through') with recommended treatment can be a key focus of clinical and Tribunal decision-making about capacity, and insight.

From a legal policy perspective, these findings provide cause for concern and support the case for legislative reform. Let me explain why.

A. Legislative criteria must be clear and precise

Complex, amorphous concepts make poor legislative criteria. This is because, as Lord Diplock said, 'absence of clarity is destructive of the rule of law'.¹¹⁷ Laws need to be

¹¹⁶ *Transcript* (n 100) 4.

¹¹⁷ *Merkur Island Shipping Corporation v Laughton* [1983] 2 AC 570 at 612.

sufficiently clear to allow the public to understand their requirements, and to allow for transparency in decision-making.

The need for legal criteria to be clear and precise is particularly pronounced where satisfaction of the criteria leads to serious consequences. Under the NT Act, a finding that a person lacks capacity can be the trigger for removing a person's decision-making power and exposing them to coercive action. It is difficult to see how evidence relating to capacity could be 'clear, compelling and of high probative value' (the *Briginshaw* standard)¹¹⁸ if the criterion itself is not clear and unambiguous. Vague concepts, or concepts like insight, with 'potential to be a portmanteau for many different components',¹¹⁹ are an unacceptable legal basis for involuntary treatment.

B. The focus on compliance is problematic, especially in the NT

We can readily understand why medical practitioners and Tribunals would take an interest in whether someone intends to accept treatment and has in the past followed treatment plans. However, the tendency to assess capacity through the lens of insight, and to assess insight based on compliance (or 'following through') is problematic on a number of levels. As Case writes, the 'compliance connection' ignores the possibility that medical practitioners, like lawyers, might sometimes be wrong.¹²⁰ This possibility increases where communication is impaired by cultural or language factors, or where evidence relied on is unclear. The compliance connection also leaves little room for constructive dialogue between patient and doctor about treatment options and management of side effects.¹²¹ It amplifies the risk that counter perspectives will be pathologised.¹²² And it precludes recognition of the complex and subtle factors that might cause a person to stray from the doctor's treatment plan.¹²³ For example, the side-effects of a particular medication may be intolerable.

Heavy reliance on 'compliance' in capacity assessments is also problematic in a context, such as the NT, where many patients are Indigenous. In the year 2022-2023, over 42% of those who attended mental health hearings before the NT Tribunal were identified as Aboriginal or Torres Strait Islander.¹²⁴ This is a large percentage and should prompt reflection on whether assessments of capacity are culturally safe. Having regard to the role that psychology and psychiatry have played in colonisation,¹²⁵ Indigenous people may have historically based reasons for non-compliance. Indigenous people from remote communities may also face other barriers

¹¹⁸ *Briginshaw* (n 17).

¹¹⁹ Freckelton (n 48) 213.

¹²⁰ Case (n 28) 367; Radovic, Eriksson and Dahlin (n 52) 614.

¹²¹ Ian Freckelton, 'Mental Health Review Tribunal Decision-Making: A Therapeutic Jurisprudence Lens' (2003) 10(1) *Psychiatry, Psychology and Law* 44, 55.

¹²² Case (n 28) 367.

¹²³ Freckelton (n 121) 55.

¹²⁴ *FOI Release* (n 61) (16 October communication). Unfortunately, the NT data only differentiates between ATSI and non-ATSI when the patient is physically present at hearing (13 October communication).

¹²⁵ See Pat Dudgeon et al, 'A History of Indigenous Psychology' in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Commonwealth of Australia, 2nd ed., 2014) 39.

to engagement with treatment. Tricia Nagel has previously highlighted the foreignness of the hospital environment, the trauma associated with being transported miles from country, as well as cultural and language factors, as potential constraints on 'compliance'.¹²⁶

As this discussion highlights, assessments of capacity that assume a straight-forward connection between 'compliance' and a person's understanding of illness/need for treatment carry danger. They may have an unfair, discriminatory effect on those who — for a wide range of reasons, unrelated to cognitive decision-making ability — have not followed treatment plans to the letter.

C. Looking to the future

The two concerns I have outlined both relate to, or stem from, the conceptual vagueness of the term 'capacity' and the lack of guidance in the current legislation as to how it should be interpreted.

There is scope for these issues to be addressed through the legislative reform project currently underway. One answer is to provide a legislative definition of what capacity is, and guidance marking out the parameters within which assessments about capacity are to be made. In other words, to make the concept of capacity less vague and amorphous, less complex, less subjective, and less focused on compliance. Another answer, which is in keeping with the CRPD framework, is to shift the focus away from what an individual can do at an independent level, and instead look at what an individual can do with support. In other words, to expand the scope for supported decision-making – as a way of both eschewing some of the difficulties and complexities within discourse about individual decision-making capacity, and as a way of enlarging the concept of capacity itself.

In May 2024, the NT Government circulated a draft of the new mental health legislation it proposed to introduce, and sought public comment.¹²⁷ The Exposure Draft includes a number of positive features, such as significant legislative guidance on what decision-making capacity entails, and increased scope for supported decision-making. The draft legislation provides a presumption of capacity,¹²⁸ and a definition of capacity that buttresses the functional approach.¹²⁹ It also includes, in s 29(2), principles that must be considered when assessing capacity:

- (a) a person's decision making capacity is specific to the decision that the person is to make;
- (b) a person's decision making capacity may change over time;
- (c) a person must not be treated as not having decision making capacity unless everything practicable has been done to assist the person to make decisions, including by giving appropriate supports;
- (d) a person must not be treated as not having decision making capacity merely:
 - i. Because the person makes a decision that could be considered unwise; or

¹²⁶ 'Involuntary Mental Health Treatment in the Remote Northern Territory' (2003) 10(1) *Psychiatry, Psychology and Law* 171, 174.

¹²⁷ *Mental Health Bill 2024 ('Exposure Draft')*.

¹²⁸ *Exposure Draft*, s 27.

¹²⁹ *Exposure Draft*, s 29.



- ii. Because of the person's age, appearance, disability, condition or behaviour.

By defining capacity, highlighting capacity as decision-specific and time-specific, and extending the concept of capacity to include what an individual can do with support, the proposed legislation (if ultimately passed) may shift some of the problematic aspects of capacity discourse that were identified in this study. Arguably, the case of *AX* would have been decided differently if the proposed provisions had been in force at that time.

Relevantly however, the draft legislation does not seem likely to reduce the need for capacity assessments. Lack of capacity remains a key prong in the criteria for involuntary treatment. Further, while the draft legislation explicitly recognises and directs attention to how the will and preferences of the individual might be expressed through formalised supported decision-making measures (eg. advance consent decisions and nominated support people), it is unclear exactly how these supported decision-making structures are intended to interact with assessments of whether involuntary treatment is justified.

How is capacity understood and operationalised by those applying NT mental health legislation? Judging by the draft legislation introduced, this is a question that will remain relevant into the future. Further research — which is clearly needed — could assess the impact of future reforms on capacity discourse, and whether the changes have any impact on the incidence of involuntary treatment.

APPENDIX A: COMPARATIVE TABLE OF LEGISLATIVE PROVISIONS

Jurisdiction	Criteria for involuntary treatment for mental illness	Approach to capacity
ACT: <i>Mental Health Act 2015</i> (ACT)	Section 58(2): The ACAT may make a psychiatric treatment order in relation to the person if— (a) the person has a mental illness; and (b) either— (i) the person does not have decision-making capacity to consent to the treatment, care or support and refuses to receive the treatment, care or support; or (ii) the person has decision-making capacity to consent to the treatment, care or support, but refuses to consent; and (c) the ACAT believes on reasonable grounds that, because of the mental illness, the person— (i) is doing, or is likely to do, serious harm to themselves or someone else; or (ii) is suffering, or is likely to suffer, serious mental or physical deterioration; and (d) in relation to a person mentioned in paragraph (b) (ii)—the ACAT is satisfied that the harm or deterioration, or likely harm or deterioration, mentioned in paragraph (c) is of	- Capacity defined in section 7 (functional approach). Definition reflects supported decision-making approach ('if the person can, with assistance if needed') - Section 8 sets out principles that apply when assessing decision-making capacity. - Capacity is decision-specific: s 8(1)(a). - Rebuttable presumption in favour of capacity: s 8(1)(b), also reflected in s 6(i). - Person who lacks capacity must always be supported to make decisions to the best of their ability: s 8(1)(c). - A person is not to be treated as lacking capacity unless all practical steps to assist the person to make decisions have been taken: s 8(1)(d).

Jurisdiction	Criteria for involuntary treatment for mental illness	Approach to capacity
	such a serious nature that it outweighs the person's right to refuse to consent; and (e) the ACAT is satisfied that psychiatric treatment, care or support is likely to— (i) reduce the harm or deterioration, or the likelihood of the harm or deterioration, mentioned in paragraph (c); or (ii) result in an improvement in the person's psychiatric condition; and (f) if an application has been made for a forensic mental health order—the ACAT is satisfied that a psychiatric treatment order should be made instead; and (g) the ACAT is satisfied that the treatment, care or support to be provided under the psychiatric treatment order cannot be adequately provided in another way that would involve less restriction of the freedom of choice and movement of the person.	○ Person is not to be treated as lacking capacity only because 'the person makes an unwise decision': s8(1)(e) ○ Person is not to be treated as having capacity only because the person complies with treatment: s 8(1)(f) ○ Person who has fluctuating capacity must, if reasonably practicable, be assessed at a time when they have decision-making capacity: s 8(1)(g).
NSW: <i>Mental Health Act 2007</i> (NSW)	Section 12(1): A patient or other person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that – (a) the person is a mentally ill person or a mentally disordered person, and (b) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person. Section 14: (1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary— (a) for the person's own protection from serious harm, or (b) for the protection of others from serious harm. (2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.	• Section 68(h1) (Principles for care and treatment) states that: 'every effort that is reasonably practicable should be made to obtain the consent of people with mental illness or mental disorder when developing treatment plans and recovery plans for their care, to monitor their capacity to consent and to support people who lack that capacity to understand treatment plans and recovery plans'
Qld: <i>Mental Health Act 2016</i> (Qld)	Section 12: (1) The treatment criteria for a person are all of the following: (a) the person has a mental illness (b) the person does not have capacity to consent to be treated for the illness	• Section 5(b) (matters to be considered in making decisions) includes a presumption in favour of capacity. • Capacity defined in s 14(1) (functional approach).

Jurisdiction	Criteria for involuntary treatment for mental illness	Approach to capacity
	(c) because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in – (i) imminent serious harm to the person or others; or (ii) the person suffering serious mental or physical deterioration (2) For subsection (1)(b), the person's own consent only is relevant	- Section 14(2) provides that a person 'may have capacity to consent to be treated even though the person decides not to receive treatment' - Section 14(3) provides that 'a person may be supported by another person in understanding the matters mentioned in subsection (1)(a) and making a decision about the treatment'
TAS: <i>Mental Health Act 2013 (Tas)</i>	Section 40: The treatment criteria in relation to a person are – (a) the person has a mental illness; and (b) without treatment, the mental illness will, or is likely to, seriously harm – (i) the person's health or safety; or (ii) the safety of other persons; and (c) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1); and (d) the treatment cannot be adequately given except under a treatment order; and (a) the person does not have decision-making capacity.	- Section 7 includes a presumption in favour of capacity and definition of capacity (functional approach). - Section 7(1)(a) provides that a person has capacity unless they are 'unable to make the decision because of an impairment or, or disturbance in, the functioning of the mind or brain' <u>and</u> cannot pass the functional test in s7(b).
Vic: <i>Mental Health and Wellbeing Act 2022</i>	Section 143: [compulsory treatment criteria] (a) the person has mental illness; and (b) because the person has mental illness, the person needs immediate treatment to prevent— i. serious deterioration in the person's mental or physical health; or ii. serious harm to the person or to another person; and (c) if the person is made subject to a temporary treatment order or treatment order, the immediate treatment will be provided to the person; and d) (there are no less restrictive means reasonably available to enable the person to receive the immediate treatment. Section 89: [An authorized psychiatrist can make a treatment decision if...] - the patient does not have capacity to give informed consent to treatment proposed, or has capacity but does not give informed consent: s 89(1)(a); and - the treatment is not ECT or neurosurgery: s 89(1)(b); and - the treatment is clinically appropriate: s 89(3)(a); and - there is no less restrictive way for the patient to be treated [taking into account factors in s 89(4)]: s 89(3)(b)	- Section 85 includes a presumption in favour of capacity. - Section 87(1) provides definition of capacity (functional approach). - Section 87(2) sets out factors that must be considered in deciding capacity: - capacity is decision-specific: s 87(2)(a) - capacity may fluctuate: s 87(2)(b) - lack of capacity should not be assumed based on age, appearance, disability, condition or behaviour: s87(2)(c), or because decision could be considered unwise: s87(2)(d) - whether the person can provide informed consent with appropriate supports: s87(2)(e) [supported decision-making] - Section 87(3) requires that: - assessment be done in a time/place where capacity can be determined most accurately: s 87(3)(a) - the person is provided with appropriate supports to enable them to give informed consent: s 87(3)(b)

Jurisdiction	Criteria for involuntary treatment for mental illness	Approach to capacity
WA: <i>Mental Health Act 2014 (WA)</i>	Section 25(1): [criteria for inpatient treatment] (a) that the person has a mental illness for which the person is in need of treatment; and (b) that, because of the mental illness, there is – (i) a significant risk to the health or safety of the person or to the safety of another person; or (ii) a significant risk of serious harm to the person or to another person; (c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself; (d) that treatment in the community cannot reasonably be provided to the person (e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order. [Criteria for community treatment order set out in s 25(2)]	• Section 13(1) includes presumption in favour of capacity. • Section 15(1) includes a general definition of capacity (functional approach). • Section 18 applies the criteria in section 15 to 'treatment decisions' specifically.
SA: <i>Mental Health Act 2009 (SA)</i>	Section 21(1): [Criteria for level 1 inpatient treatment order] (a) the person has a mental illness; and (b) because of the mental illness, the person requires treatment for the person's own protection from harm (whether physical or mental, and including harm involved in the continuation of deterioration of the person's condition) or for the protection of others from harm; and (ba) the person has impaired decision-making capacity relating to appropriate treatment of the person's mental illness; and (c) there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness. See also section 25(2) setting out criteria for level 2 (longer) inpatient treatment orders. See s 10 setting out criteria for level 1 community treatment orders.	• Section 5A includes presumption in favour of capacity and definition of 'impaired decision-making capacity' (functional approach, also taking into account advanced care directives). • Section 5A(3) recognises capacity as fluid [at (c)] and stipulates that capacity is not impaired merely because decision results or may result in an adverse outcome for the person [at (d)].
NT: Mental Health and Related Services Act 1998 (currently under review)	Section 14: (a) the person has a mental illness; and (b) as a result of the mental illness: i. the person requires treatment that is available at an approved treatment facility; and ii. without the treatment, the person is likely to: A. cause serious harm to himself or herself or to someone else; or	• No presumption for/against capacity. • No definition of capacity or guidance on assessing capacity. • Informed consent is defined in s 7. The definition includes the requirement that 'the person is <i>capable of understanding</i> the effects of giving consent': s 7(2)(b).

Jurisdiction	Criteria for involuntary treatment for mental illness	Approach to capacity
	B. suffer serious mental or physical deterioration; and iii. the person is not capable of giving informed consent to treatment or has unreasonably refused to consent (c) there is no less restrictive means of ensuring that the person receives the treatment [See also s 16 setting out criteria for community treatment orders]	

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