Statement of Reasons

This is an edited version of the statement of reasons issued pursuant to section 756 of the *Mental Health Act 2016*. The patient and persons attending the hearing have been de-identified and, in some cases, may be allocated pseudonyms for privacy reasons. Other details that may lead to the identification of the patient may have also been modified or omitted. The modification or omission of these details does not affect its decision or its reasons for the decision.

Decision made prior to 1 January 2020 so *Human Rights Act 2019* not applicable

Matter:	Application to approve electroconvulsive therapy (ECT)
Attendees	
Patient:	Attended
Patient's Legal Representative:	Attended
Psychiatrist:	Treating psychiatrist attended
Ward Nurse:	Nurse attended
Other attendees:	Peer support person attended
Decision	
Decision:	Application to perform ECT APPROVED, approval given for 12 treatments of ECT over a period of 90 days to commence on [*date*]

The patient is a gentleman currently subject to a Treatment Authority. He has a lengthy history of paranoid schizophrenia, polysubstance dependence and depressive episodes, well detailed in the application. The patient attempted suicide some years ago. His current admission commenced was preceded by a period of some months of a deteriorating mental state, depressed mood, poor sleep, self-care and oral intake and with active thoughts of suicide. He expressed that he wished to die and donate his organs after death so that others would live. Additionally, the patient was actively attempting to find a means of taking his own life.

This application follows a prior approval for an acute course of ECT and documents that, prior to this course of ECT, the patient has demonstrated little improvement to his depressive symptoms despite the re-commencement of his previous medications in up-titrated doses and the addition of an adjunctive antidepressant.

Following the acute course of ECT, there was a partial response documented wherein the patient described some improvement in his mood, reduced visual and auditory hallucinations and less morose thoughts. However, the patient remains worried about his outstanding criminal charges, has ongoing suicidal thoughts (he is under constant visual observations), and continues to have extensive, entrenched persecutory delusions.

Statutory Framework and Issues to be determined by the Tribunal

Set out in Appendix A to these Reasons is a summary of the principal provisions of the *Mental Health Act 2016* (**Act**) that are relevant to the Tribunal's consideration of an application to perform electroconvulsive therapy (**ECT**). Further reference will be made to these under "Application of evidence before the Tribunal to relevant provisions".

The issue for determination at the review was whether the Tribunal should approve the application to perform ECT.

<u>Summary of evidence and findings</u>

Under section 509(3), the Tribunal may give approval to perform ECT only if the Tribunal is satisfied:

(a) the performance of the therapy on the person is in the person's best interests;
(b) evidence supports the effectiveness of the therapy for the person's particular mental illness;
(c) if the therapy has previously been performed on the person – of the effectiveness of the therapy for the person; and
(d) if the person is a minor – evidence supports the effectiveness of the therapy for persons of the minor's age.

Section 509(2) states:
In deciding whether to give, or refuse to give, the approval, the Tribunal must have regard to-

(a) if the application relates to an adult who is unable to give informed consent to the therapy - any views, wishes and preferences the adult has expressed about the therapy in an advance health directive; or
(b) if the application relates to a minor:
    (i) the views of the minor's parents; and
    (ii) the views, wishes and preferences of the minor.

1. **What were the views, wishes or preferences of the person (and/or their parent if they are a minor) expressed at the hearing?**

The patient told the Tribunal that he had had ECT and he had coped with it. He said that people are talking to him and the ECT had helped with the voices and it cleared the fog that was on his eyes. He took some Panadol for a headache afterwards which helped, and he thought the ECT might have made his memory bad. The patient said that he thought it 'could keep helping me, the only issue is the criminal matter, and the other thing is a craving to learn more things'. He said that he had no concern about having ECT as his mum had had ECT for 12 months and it helped her a lot.

The patient's legal representative said that the patient feels his mental state has significantly improved since he commenced ECT and he feels more hopeful about life. He also has noticed that he feels worse since the ECT has stopped. Whilst he thinks his antidepressant has helped, he believes ECT will speed up the process and he wants it to commence ASAP. The legal representative for the patient had spoken to the patient's mother who was also supportive of continued ECT treatment and believes he was sounding clearer after the acute treatments.

The treating psychiatrist confirmed the patient's diagnosis of schizophrenia and psychotic depression. When he was first admitted, the patient was very distressed about his criminal charges and was actively suicidal. Whilst the initial course of ECT had improved the paranoid ideation and ideas of reference, the patient had become suicidal again. The treating psychiatrist confirmed that there had been some cognitive decline and that the team would be mindful of that during the ECT treatments and consider cognitive sparing techniques. He also attributed some of the cognitive decline to the patient's psychosis itself.

2. **Did the adult have an advance health directive expressing their views, wishes or preferences regarding ECT? If so, what were these and what weight did the Tribunal give to these in deciding the application to perform ECT?**

N/A

3. **What evidence supports the effectiveness of the therapy for the person's particular mental illness?**

The treating psychiatrist identified that whilst there was still room to optimise the patient's medication, he felt the ECT was indicated to achieve a more rapid resolution given his current state of agitation and suicidality. He referred to the RANZCP guidelines being supportive of the use of ECT in persons with psychosis and acute suicidality.

The second opinion of another psychiatrist who has seen the patient was referenced and noted that it is supportive of the patient receiving another course of ECT. Of note, the second opinion provides evidence of the patient still reporting that he was depressed, and that he felt that the first course of ECT had helped him and he would like it more frequently, preferably three times per week so that it could finish as soon as possible. The patient told the second opinion psychiatrist that his energy levels and concentration had improved in recent weeks however he still had thoughts of wanting to kill himself. The evidence of the second opinion psychiatrist also confirmed that the patient remains actively suicidal and the use of ECT was appropriate in the circumstances and in keeping with the RANZCP guidelines for depressive disorder (with psychotic features) when the risk of suicide is high and a more rapid response is required than can be provided by medications alone. She additionally confirmed that the patient currently did not have capacity to consent to treatment.

The patient's legal representative asked the treating psychiatrist if there was something that ECT could do that being on a depot and antidepressants could not do. The treating psychiatrist said that a faster response was required given the suicidality. He continued that antidepressants can take 4-

6 weeks to work whereas ECT can take 1-3 treatments to gain effect. He also stated that the risks and benefits had been explained to the patient when he was admitted. The team registrar had spoken to the patient's mother also and confirmed her response had been good to ECT. He noted that a familial ECT (positive) response is important.

The treating psychiatrist stated that there were no contraindications to the patient receiving another course of ECT.

4. If the person is a minor, what evidence supports the effectiveness of the therapy for persons of the minor's age?

N/A.

5. Has ECT previously been performed on the person? If so, what was the effectiveness of the therapy for the person?

The patient has received an acute course of ECT over the past month with a partial response – namely a reduction in his depressive symptoms, some improvement in his mood, reduced visual and auditory hallucinations and less morose thoughts. He also described to his legal representative that he was feeling more hopeful, was sleeping better and his appetite had improved. Of more concern are the residual symptoms including entrenched persecutory delusions and ongoing suicidal thoughts that were not responding to current therapy (medication) and required more immediate treatment.

6. Is the performance of ECT in the best interests of the person? Why or why not?

The patient is currently acutely unwell and requires constant and ongoing visual observations to manage his risk of self-harm. Despite significant efforts with what must be very intrusive and persistent monitoring, a prior course of ECT, and a review and up-titration of his medication, the patient remains actively suicidal.

Whilst on the one hand, the patient has provided his own evidence that he feels the prior course of ECT was of some benefit to him and he was able to convey to the Tribunal that his mother had also had a positive response to ECT, it is accepted that currently, he does not have the capacity to provide informed consent for the treatment. Accordingly, it is important for the Tribunal to weigh up whether the treatment is in the patient's best interests. In this regard, the Tribunal considered the following evidence to be persuasive:

- a partial positive, therapeutic response to a previous course of ECT
- a family history indicating positive responses to ECT
- supportive evidence from both the treating psychiatrist and the second opinion psychiatrist, that ECT was indicated (both citing the RANZCP Guidelines) for major depression with psychotic features, particularly when the risk of suicide is high, and a more rapid response is required than can be provided by medication alone
- no contraindications identified by the treating team
- a history of a serious prior (and one recent) attempted suicide
- alternative treatments existing (and being utilised) by way of a revised and up-titrated medication regime, however, evidence that ECT should potentiate the patient's current treatment resulting in a quicker response and recovery (which the patient has expressed as desirous)
- he feels worse since his originating course of ECT stopped
- the current symptoms and circumstances of the patient which include constant visual monitoring in order to keep him safe.

The Tribunal weighed this evidence with the patient's own evidence that he had some headaches and some memory loss following the first series of treatments with ECT. The treating psychiatrist

provided evidence that the patient had cognitive impairments prior to his most recent cognitive testing and the team will continue to monitor and test for any deterioration. The team will consider using cognitive sparing techniques with the next round of treatment as they are aware of the patient's concerns, however, it is their view that the current level of psychosis and disorganisation is likely to be contributing to the reported cognitive issues.

Conclusions of the Tribunal

Whilst the patient currently lacks capacity to give informed consent for the approval of the treatment, he was able to give some cogent insight into what his current circumstances were and how he felt the ECT had helped him in the past and what he also felt it might achieve for him moving forward. He was able to articulate that he wished to have another course of ECT and that he felt it would benefit him in his current and future circumstances. This evidence was highly regarded by the Tribunal.

These views, wishes and preferences aligned with the submissions that were provided by the patient's legal representative who concluded that in the circumstances, it would be in the patient's best interests to have a second course of ECT approved by the Tribunal.

The application, second opinion, and the evidence of the treating psychiatrist provided the Tribunal with the most persuasive evidence that ECT was warranted in all the circumstances and supported by a very recent evidence base.

Accordingly, the Tribunal concluded that the application for ECT be approved for 12 treatments over 90 days.

Presiding Member

APPENDIX A
Statement of the law regarding applications to perform Electroconvulsive Therapy

The main objects of the *Mental Health Act 2016* (**Act**) are set out in section 3(2) and must be achieved in the way outlined in sections 3(2) and 3(3).

The term **electroconvulsive therapy** (**ECT**) is defined in Schedule 3 to the Act (**Dictionary**) as meaning "*the application of electric current to specific areas of the head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent for the treatment of a mental illness."*

Section 235 provides that a person must not perform ECT on another person other than under the Act. Section 236(1) authorises a doctor to perform ECT on a patient at an authorised mental health service (**AMHS**) if:

(a) the patient is an adult and has given informed consent to the treatment; or
(b) the patient is an adult, who is unable to give informed consent to the treatment, and the tribunal has approved under section 509 the performance of the therapy on the adult; or
(c) the patient is a minor and the Tribunal has approved under section 509 the performance of the therapy on the minor.

Section 233 sets out the requirements for informed consent and section 234 provides that before informed consent can be given, the doctor proposing to provide the treatment must give the person a full explanation. The contents of that explanation are detailed in section 234.

Section 237 permits a doctor to perform ECT on an involuntary patient subject to a Treatment Authority, Forensic Order or Treatment Support Order at an AMHS in circumstances of emergency, that is, where a doctor and the senior medication administrator of the patient's treating health service have certified in writing that performing ECT on the patient is necessary to save the patient's life or to prevent the patient from suffering irreparable harm. It is also necessary for an application to perform ECT to have been made to the Tribunal at the time the emergency ECT is administered and that the application is undecided at that point in time.

Section 509(2) provides:

In deciding whether to give, or refuse to give, the approval, the tribunal must have regard to:
(a) if the application relates to an adult who is unable to give informed consent to the therapy - any views, wishes and preferences the adult has expressed about the therapy in an advance health directive; or
(b) if the application relates to a minor:
(i) the views of the minor's parents; and
(ii) the views, wishes and preferences of the minor.

Under section 509(3), the Tribunal may give approval to perform ECT only if the Tribunal is satisfied:

(a) the performance of the therapy on the person is in the person's best interests; and
(b) evidence supports the effectiveness of the therapy for the person's particular mental illness; and
(c) if the therapy has previously been performed on the person – of the effectiveness of the therapy for the person; and

(d) *if the person is a minor – evidence supports the effectiveness of the therapy for persons of the minor's age.*

If the Tribunal approves the performance of ECT, the approval must state the number of treatments that may be performed in a stated period and the approval may be made subject to the conditions the Tribunal considers appropriate.