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
Attendees	
Patient's Legal Representative:	Attended
Psychiatrist:	Attended
Registrar:	Attended
Decision	
Decision:	Approved – 12 treatments over 90 days

The patient is a man who lives in a share house with others. He is divorced and has two adult children with whom he has some, but generally limited, contact. His employment has now ceased. The patient suffered a major depressive episode with active suicidal ideation after his brother died. The patient was admitted for a period however failed to engage with follow up on discharge. The patient was later taken to hospital by Queensland Ambulance Services (QAS) after they were called to his home secondary to concerns that he was acting bizarrely, pacing around the house, not talking and starving himself. He was admitted under involuntary treatment, commenced on Risperidone and offered ECT, which he refused. He was discharged and remained engaged, though his engagement is reported to have been superficial and his interactions described as guarded.

The patient is currently subject to a Treatment Authority with the view of supporting treatment of the patient for psychotic depression. The Treatment Authority was considered necessary after the patient was re-referred for treatment following concerns raised by his flat mates that he was isolating himself in his room and not eating adequately. He was admitted to hospital and has continued to present with poor oral intake, broken sleep and rumination over regrets and matters for which he feels guilt. He is reported to have lost approximately 10 kilograms and be suffering mild to moderate malnutrition, dehydration and ongoing suicidal ideation. The patient has also suffered an acute kidney injury due to his level of dehydration and has required much prompting to increase his oral intake and avoid IV fluids. He is noted to have a latency in his speech and responses and is diagnosed as having psychotic depression with features of catatonia. Though the patient responded well to Sertraline during a previous presentation he is currently not responding adequately, with very little improvement in the two weeks he has been admitted, resulting in ongoing distress and danger related to prolonged mental and physical decline. The treating team subsequently made the application for ECT to which this SOR relates as a means of expediting the patient's treatment in the most effective manner for treating his current illness.

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.

Summary of evidence and findings

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 elected not to attend the hearing and therefore his views, wishes and preferences with respect to the application for ECT were communicated by the treating team and through his legal representative.

The treating team indicated that though the patient initially demonstrated an interest in ECT, due to his poverty of speech and difficulty communicating, his views, wishes and preferences could not be adequately communicated for the purpose of informing his consent or otherwise for the procedure. In terms of ongoing discussion, the patient has indicated to the treating team that he has some concerns regarding brain damage he feels he currently suffers (a delusional belief) and that ECT may further exacerbate that damage. The team indicated that given the patient's current delusional beliefs it would not be possible for him to weigh the consequences of treatment options. He has remained ambivalent and unable to adequately express his views in a meaningful way.

In relation to the views of the patient's adult children, they are described by the treating team to be somewhat estranged and therefore, in accordance with the patient's wishes, they have not been consulted with respect to the application for ECT.

The legal representative for the patient submitted that the patient had instructed her that he would prefer more time to trial the medication as he has concerns regarding potential side effects of ECT given his age, especially the risk of short-term memory loss. The patient's instructions were that he wishes to have more time to trial medication alone rather than trial ECT.

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?

The patient does not have an Advanced Health Directive for the purpose of consenting to treatment such as ECT.

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

The patient is suffering a very severe relapse of psychotic depression. He was admitted suffering malnutrition and dehydration as a result of his severe depression and had been isolating himself in his room with very poor self-care, depressed affect and psychomotor retardation. As a consequence of the dehydration he suffered an acute renal injury. He is described by his treating psychiatrist to be in a very distressed state with fluctuating catatonic features including being mute at times, having a long latency in speech when communicating and having very poor independent oral intake (currently

receiving significant support and prompting from nursing staff). In oral evidence, the treating psychiatrist indicated that ECT is the preferred treatment for psychotic depression and this is heavily supported by literature. Though Sertraline was used successfully in a prior episode, it has had little effect for the current presentation. While the Sertraline dose is still being increased, it must be done slowly because of the older age of the patient. The length of time it may take to improve on medication alone puts the patient at high risk of further medical and psychiatric deterioration. The registrar also indicated that it may take several weeks, if at all, to formulate a successful medication regime for the patient. The patient is in a highly distressed state and ECT is the safer and more rapid treatment that will provide relief and improvement for the patient.

The evidence of the treating team was supported by the second opinion which indicated that given the "*marginal intake, physical decline, immobility and thrombosis risk from marked psycho-motor retardation, recent and perhaps ongoing suicidal ideation and plans…….ECT is the treatment of choice for him and is likely to be more effective and effective more quickly than persisting with medications alone*."

The patient's legal representative queried a recent (subjective) improvement in mood reported by the patient, however the treating team indicated that objectively, the patient has made very little improvement. He tends to be worse in the mornings, consistent with catatonic depression and he continues to vary from mute to having limited spontaneity to being more verbal. His mental state was accordingly described as fluctuant.

The patient's legal representative also queried whether the increase in weight indicated an improvement in the patient's current presentation however the treating team indicated that the patient continues to have poor independent oral intake. The weight gain is likely the result of restoration of fluids after his initial dehydration.

Finally, the patient's legal representative also queried whether or not the patient reported improvement in mood was due to the commencement of Lorazepam and whether or not a longer trial would continue to provide improvement. The treating team indicated that the Lorazepam is not a treatment for the mood component of the illness, rather it is a treatment for the catatonic symptoms and accordingly there has been some improvement in these symptoms since the treatment commenced.

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 never undergone ECT treatment in the past.

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

The Tribunal decided to approve the application to perform ECT for the patient because they considered, on the evidence, that it was in the patient's best interests. The evidence the Tribunal found compelling was the severity of the distress currently being experienced by the patient and the high risk that without timely intervention, the patient faced the risk of further deterioration in both medical and psychiatric condition. The patient presented initially with malnutrition and dehydration resulting in a renal injury as a result of his severely depressed state. While the Tribunal accepted that further trials of alternative medication regimes could be considered, it felt, on balance, that further medication trials may take weeks and would therefore unnecessarily prolong the distress that the

patient was suffering. Furthermore, the difficulties associated with trialing different medications and different doses may pose risks of their own in someone who is currently physically compromised and elderly in age.

The Tribunal also considered the submission of the patient's legal representative that an adjournment should be granted to allow further time for the current medication to be trialed. The panel were not compelled by this argument because of the high risk of further deterioration and the objective assessment by the treating team that very little improvement was noted to date on the current medication regime. Improvement that was noted was identified as being for the symptoms of the catatonia rather than the depressed mood.

Further compelling the decision that ECT is in the best interests of the patient was the evidence of the effectiveness and rapidity of treatment for this particular illness. The Tribunal heard that the patient had been self-isolating for some months, with poor oral intake, poor self-care and little social interaction. He is described as having an extremely depressed affect and has previously presented in a similar manner with active suicidal intent. The Tribunal was therefore persuaded by the evidence that ECT is both efficacious and safe and that it poses the best opportunity to rapidly improve the patient's mental state, thereby limiting the duration and extent of his ongoing distress as well as the physical risks associated with his poor mental state.

The Tribunal heard and accepted evidence that given the patient's current mental state he is not considered to have capacity to consent to treatment. On this basis, and for the effective and rapid resolution of the distressing symptoms of the patient's severe depression, the Tribunal decided that ECT is in his best interests.

Conclusions of the Tribunal

The Tribunal was persuaded by the evidence indicating that ECT would provide rapid relief from very severe symptoms of a major depressive illness. The Tribunal accepted that the patient has been suffering from the symptoms of this illness quite acutely for some months, leading him to isolate and restrict his oral food and fluid intake to the point that he was malnourished and dehydrated. The Tribunal therefore felt that it was in the patient's best interests to interrupt the current progression of his illness with ECT in order to facilitate an effective and safe treatment that would assist to resolve his distress swiftly.

While the Tribunal considered the submissions of the patient's legal representative with respect to a longer trial of medication and more time to trial alternative medications, the panel were not persuaded that this would be the safest and most efficacious way to treat the patient. They did not therefore, feel that it was in his best interests to delay the commencement of ECT. The Tribunal approved the application for 12 treatments over 90 days being satisfied that this reflected a standard course of treatment and that it reflected an appropriate period to administer that course.

For these reasons, the Tribunal decided to approve the application to perform Electroconvulsive Therapy. Such approval was given for 12 treatments of Electroconvulsive Therapy over a period of 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.