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.

Matter:	Application to approve electroconvulsive therapy (ECT)
Attendees	
Patient:	Attended
Patient's Legal Representative:	Attended
Nominated Support Person:	Attended
Psychiatrist:	Attended
Other attendees:	Member of wellbeing team - Attended Clinical Nurse - Attended
Decision	
Date of decision:	2021
Decision:	The application for ECT is refused

An application was made to the Tribunal for the performance of electroconvulsive therapy (**ECT**) on the patient. A Treatment Authority had been made for the patient late last year as he was found to be exhibiting psychotic symptoms in the form of prominent paranoid and religious delusions and perceptual disturbances. It was determined at the time that the patient required involuntary treatment as he lacked insight and was acting on those beliefs.

The patient was reported to have improved initially following his commencing depot antipsychotic medication and he was discharged from hospital with what the treating team described as improving insight into his condition. His mental state following his discharge was described by the treating team as initially somewhat stable but it deteriorated when he began to exhibit acute psychotic symptoms again.

At the time of the hearing of this application, the patient remained an inpatient but had been having some supervised leave. The treating team state that while there has been some improvement in his mental state on antipsychotic medication, he continues to experience distressing symptoms. The application for ECT treatment was heard by the Tribunal with the patient and his legal representative present at the hearing and his nominated support person attending by phone.

Statutory Framework

Appendix A to these reasons is a summary of the provisions of the *Mental Health Act 2016* (**Act**) that are relevant when the Tribunal considers an application to perform ECT.

Summary of evidence and findings

What were the views, wishes and preferences of the person (and their parent if they are a minor)?

The patient provided the Tribunal with a self-report which was read out at the hearing by his legal representative. It included his understanding of what is involved with ECT treatment and a little bit about why he believes the treating team want him to have it. The patient made it clear at the hearing that he still does not want to have ECT treatment. He also indicated that he was agreeable to trial other medications for his illness, including clozapine**.**

The patient's nominated support person told the Tribunal in her evidence that she had thought a lot about the issue of ECT treatment. She spoke of her concerns about how it might affect him in the long term and in particular, she expressed concerns about the possible effect ECT might have on the patient's cognitive functioning. She made it clear in her evidence that her preference was for the treating team to trial other psychotropic medication options rather than moving straight to ECT at this time.

The patient's views and wishes, as well as the view expressed by his nominated support person, as his closest support, were very significant factors in the Tribunal's deliberations and decision.

Is the performance of the therapy on the person in the person's best interests?

The treating psychiatrist told the hearing that the patient's first presentation to mental health services was late last year with similar symptoms to those he is currently exhibiting. These were described in the doctor's application as psychotic with prominent paranoia and religious delusions and perceptual disturbances. The treating psychiatrist told the hearing that the patient was discharged after a few weeks with some ongoing symptoms. Subsequently, the symptoms worsened and a further hospital admission was needed. During this second admission, his depot medication was increased to the maximum level and other medication was added and increased to the maximum level**,** without significant improvement.

The treating psychiatrist told the hearing that although the patient has been in hospital for some time and has been receiving the maximum doses of the same medications he remains unwell. The treating psychiatrist added that the patient had lost significant weight and continues to experience distressing symptoms without improvement to his mental state, as he has not been responding to the large doses of antipsychotic medication.

The treating psychiatrist stated that while clozapine does present as an alternative pharmacological option, it would then be required life-long by the patient and could also result in significant side effects for him, whereas one course of ECT could in her opinion help improve the patient's response to the currently prescribed medication. This was the treating psychiatrist's preference for the patient rather than a change to a life-long need for clozapine which the doctor pointed out at the hearing can have its own significant side effects.

The treating psychiatrist did acknowledge the effectiveness of clozapine for a schizophrenic illness and that it was the recommended treatment for treatment-resistant schizophrenia but expressed her view that the side effects of clozapine outweighed the benefits. The treating psychiatrist told the hearing that, in any event, clozapine could not be started for a couple of months.

When asked about the effectiveness of ECT for someone of the patient's age, the treating psychiatrist stated that it has been prescribed for others of a similar age and can facilitate a better response to the medication which was currently being prescribed. When asked whether the treating team had concerns, when considering ECT, about the potential side effect of cognitive impairment for someone so young, the treating psychiatrist said that the impact would be localised around the time of the treatment (as opposed to lifelong) and that in any event, the patient's current cognitive functioning was already low in the context of his ongoing psychosis. Specifically, the doctor said that the patient needed constant repeating of information.

In summary, the treating psychiatrist's evidence was that while ECT might have some problematic side effects, it is more likely in her opinion to facilitate the patient's return to a normal level of functioning.

When asked whether the treating team had concerns about the impact of undertaking a course of ECT against the patient's wishes and those of his closest support person, the treating psychiatrist responded that while this was a relevant concern for the treating team, the potential benefits from a course of ECT could produce a much better outcome in the longer term without committing the patient to lifelong need for clozapine, which in any event could not even be started for a couple of months.

The patient's legal representative, after reading out the patient's self-report and wishes, made submissions on the patient's behalf to the Tribunal that:

(1) ECT should be a treatment option of last resort for schizophrenia and that other options have yet to be tried;
(2) that the last change of medication was relatively recent, and a longer period of time should be given to determine its suitability or otherwise, as the patient has not experienced further deterioration;
(3) that in these circumstances bearing in mind the wishes of the patient and his nominated support person, the Tribunal should be cautious in approving ECT.

The Tribunal further notes that the treating psychiatrist acknowledges clozapine as the recommended treatment for treatment-resistant schizophrenia, which the Doctor believes the patient has exhibited, but stated strongly that in her view, having to wait a couple of months to begin clozapine and the lifelong commitment and side effects involved, indicate to her that a course of ECT is more appropriate at this time, and could give a better outcome for the patient overall.

On the evidence before it, the Tribunal could not be satisfied that the use of ECT as treatment for the patient would be in his best interests at this time. It would mean moving straight to ECT without having worked with the patient's expressed wishes to trial a range of other available psychotropic medications, including clozapine, which is regarded as the most effective treatment for the patient's diagnosis of treatment resistant schizophrenia. Furthermore, currently proceeding with ECT would be directly against the patient's wishes and those of his closest support despite the patient's willingness to trial other available effective antipsychotic treatments.

Is there evidence supporting the effectiveness of the therapy for the person's particular mental illness?

The Tribunal notes that the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) guidelines for the treatment of first episode psychosis indicate that treatment should initially be with one of a variety of second-generation antipsychotic medications, at maximum tolerated doses and for period of at least six weeks. In cases with poor response to the initial treatment, the RANZCP guidelines recommend a trial of a second antipsychotic medication followed by a trial of olanzapine and then an early trial of clozapine for patients whose illness has still not responded.

The Tribunal noted that while RANZCP guidelines did indicate some limited evidence for the use of ECT as treatment for schizophrenia, its use was recommended in specific situations such as when a rapid clinical response is an urgent priority or in people with treatment-resistant schizophrenia who have an inadequate response to clozapine. The Tribunal noted that the evidence did not indicate that these situations were applicable to the patient's current circumstances.

The treating psychiatrist told the hearing that there has been some evidence supporting the use of ECT for schizophrenia and pointed out that a recent paper indicated that ECT can help the brain respond better to prescribed medication. The treating psychiatrist's view was that the brain would become more responsive after ECT and so the current antipsychotic medication could continue unchanged after the acute course of ECT was completed. The treating psychiatrist also acknowledged that clozapine is a recommended treatment (RANZCP) for treatment-resistant schizophrenia.

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

There has not been any prior use of ECT for the patient.

If the person is a minor, is there evidence supporting the effectiveness of the therapy for persons of the minor's age?

The Tribunal questioned the doctor specifically about the effectiveness of ECT for someone of the patient's age. The Tribunal was not satisfied that there was sufficient evidence submitted by the treating team to support the effectiveness of ECT for someone so young. The genuine concerns the patient and his nominated support person hold about possible cognitive side effects following ECT treatment, given his young age, remained a significant factor in the Tribunal's decision.

Human Rights

The Tribunal acknowledges the Human Rights Act 2019 (**HRA**). In particular, the Tribunal considers that the following human rights are potentially engaged and limited by the decision of the Tribunal: sections 17(c), 19 and 25.

However, the Tribunal is satisfied that any limitations of the patient's human rights as a result of its decision are lawful, proportionate to the circumstances and compatible with the HRA.

In respect of section 31 of the HRA, the Tribunal is satisfied that the rights of the patient have not been limited or compromised as the patient received a copy of the relevant material pertaining to the application within the prescribed statutory timeframe, he was represented by a lawyer and had the support of his nominated support person at the hearing and he was given the opportunity to provide his own views wishes and preferences at the hearing.

Conclusions of the Tribunal

On the evidence presented, the Tribunal was not satisfied that the criteria in section 503 of the Act were satisfied. In particular, the Tribunal was not convinced by the evidence presented that the performance of ECT is currently in the patient's best interests.

Significant factors in the Tribunal's decision were the patient's very clear wishes and those of his nominated support person, the fact that not all pharmacological options for treatment had been tried, proceeding to ECT at this stage in the patient's illness was not in keeping with the RANZCP schizophrenia treatment algorithm and the patient's stated willingness to try clozapine, a treatment reported most likely to be successful in cases of treatment resistant schizophrenia.

While the doctor had put a strong case for the use of ECT, in the circumstances where alternative medication treatment options remain untried and which the patient has clearly stated he is willing to trial, together with the evidence that the patient has been somewhat improved more recently and able to take some supervised leave, the Tribunal considered that ECT is not in his best interests at this time.

Accordingly, for these reasons the Application is refused.

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**) means: *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.*

507 Who may apply
A doctor may apply to the tribunal for approval to perform electroconvulsive therapy on another person if the doctor is satisfied:
(a) the person is an adult and is unable to give informed consent to the therapy; or
(b) the person is a minor.

509 Decision on application
(1) In deciding the application, the tribunal must give, or refuse to give, approval for electroconvulsive therapy to be performed on the person.
(2) 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.
(3) The tribunal may give the approval 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.
(4) If the tribunal gives the approval, the approval:
    (a) must state the number of treatments that may be performed in a stated period under the approval; and
    (b) may be made subject to the conditions the tribunal considers appropriate.