Statement of Reasons

This is an edited version of the statement of reasons issued pursuant to the section 756 of the *Mental Health Act 2016*. The patient and person 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.

Patient details	
Matter:	Application to approve electroconvulsive therapy
Attendees	
Patient:	Attended
Patient's Legal Representative:	Attended
Psychiatrist:	Attended
Other attendees:	A nurse unit manager A registered nurse A senior care coordinator The patient's mother A security officer
Decision	
Decision:	To refuse the application for electroconvulsive therapy
Documents before the Tribunal at hearing:	Application for regulated treatment Treatment authority Second opinion

The patient had been admitted presenting with grandiose, elevated and irritable behaviour over the previous week. At admission, he had not slept for days in the context of using increased doses of medical marijuana and wishing to start his own business. He was brought to the hospital by the police after displaying aggressive behaviour and expressing suicidal ideation. The Treatment Authority records that his mental illness was either Mania or a Drug Induced Psychosis. This was the patient's first admission to a mental health inpatient unit.

Following admission, the patient was very difficult to engage due to his irritability, lack of insight, and prominent frustration as he believed that he did not have a mental illness and wished to be discharged. During the period of his admission, he had been presenting with pressured speech and grandiose ideations. The presence security officers in the psychiatric intensive care unit had been required at all times due to the patient's behaviour. He had presented as consistently insightless into his mental illness and had damaged property at the hospital.

The application for electroconvulsive therapy (**ECT**) was made on the basis that the treating psychiatrist was of the view that the patient does not have capacity to give informed consent to ECT.

At the hearing, the treating psychiatrist repeated his view that the patient was insightless into his mental illness and the need for treatment, and that the patient had not been able to engage in any meaningful conversations regarding the illness with the treating team.

The psychiatrist's view was that the patient's lack of insight into his mental illness and disorganised and harmful behaviours, including damaging property and a high degree of irritability had meant that he was unable to properly engage in a discussion regarding treatment options and lacks capacity to consent to ECT.

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.

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

What were the views, wishes and preferences of the person?

The patient attended the hearing and was very vocal in his views regarding ECT and the treatment that he had received whilst an inpatient. He was irritable and interrupted on a number of occasions to respond to statements made by the treating psychiatrist in the course of the psychiatrist's presentation to the Tribunal. The patient expressed the view that he did not have the mental illness as described by the treating psychiatrist. He expressed his belief that the reason the high levels of medications that he had been prescribed since coming to hospital was not working was that he has a diagnosis of ADHD and has a "higher focus".

The patient stated that his inpatient admission was in the context of being sleep deprived for three weeks because he was starting a business. He expressed anger for being "incarcerated" (involuntarily hospitalised) with nothing to do for two weeks. With regards to the medication he had been prescribed, the patient expressed that it makes him feel unwell. He went on to say that he believed he could die from the medication.

The patient stated that he had developed his own plan on how to access support for his mental health, explaining that his own treatment plan included a variety of lifestyle and psychosocial interventions, including DBT and CBT. He expressed the view that ECT was a "very archaic" and an inhumane way of treating a patient. He did not understand how it was allowed to happen. He repeated a number of times that he just wanted to go home and engage in his own treatment plan which he had written out

and read aloud to the Tribunal.

The patient repeated a number of times that he had been misdiagnosed as having Mania, stating instead that he had ADHD, and expressed views to the Tribunal that he believed that the treating psychiatrist did not “like me as a person, and it’s personal”. He complained about being assaulted by security guards.

There was no evidence that the patient had an Advance Health Directive.

There was no other evidence before the Tribunal, including any from evidence from the treating team, as to whether the family had expressed any views regarding ECT.

Was the person able to give informed consent to ECT?

The patient was admitted 16 days before the hearing and 9 days before the application for ECT was made to the Tribunal. The Tribunal was satisfied that, based on the symptoms as described by the treating team and the presentation of the patient at the hearing, he had a mental illness and that the patient lacked capacity to give informed consent to treatment, including ECT.

In addition, the patient expressed his belief at the hearing that he does have a mental illness and that he could be properly cared for without the use of psychiatric medication.

Does ECT have clinical merit and was it appropriate the in the circumstances?

The treating psychiatrist gave evidence that in his view the treatment of the patient’s illness with ECT had clinical merit. The application stated that ECT is a “gold standard treatment for severe affective disturbances”. The psychiatrist gave evidence at the hearing that the intention of the ECT treatment was to address both psychotic and mood symptoms and that the ECT was to obtain rapid improvement in these symptoms. The patient was experiencing a severe manic episode and had been hospitalised for two weeks at the time of the hearing. The patient continued to display active symptoms of his mental illness.

This was the patient’s first admission to a mental health facility and in the course of his admission the patient had been prescribed a number of medications at high dosage. Serum levels had been completed in the course of the admission, which reportedly demonstrated the presence of these medications in the patient’s blood.

The ECT application contained little detail regarding any collateral history or background information on the patient. The psychiatrist expressed at the hearing that no useful information had been provided by the family regarding collateral, only limited background from the patient himself and his father.

The second opinion completed by a psychiatrist was however able to provide more background information, including that there was a family history of ADHD and a suspicion by the school that the patient may have had ADHD as a child. The patient had enduring issues with anger management, dysregulation and externalising behaviours. The patient had reported in the course of the second opinion assessment that he had social anxiety which fuels his cannabis use and intermittent depressive symptoms but had not in the past seen psychiatrists or had any treatment for mental illness. There had been some developmental trauma with exposure to family violence and sexual activity noted by the author of the second opinion, with a recommendation to the treating team to obtain corroborative evidence of this history.

The second opinion report indicated that the patient had a history of alcohol dependence, including a past history of daily cannabis and heavy alcohol use.

The second opinion records the presenting psychiatric symptoms in the same terms as the evidence

available elsewhere, including a short history of elevated mood accompanied by an increase in goal-directed activity. At the time of the second opinion, no urine drug screens nor any blood tests had been completed. There had only been one ECG recorded.

Significantly, the second opinion recorded that on review, whilst initially wary of the assessing psychiatrist and the accompanying psychiatry registrar, the patient was noted to be "co-operative with review".

The second opinion report records the details of the conversation with the patient. Under the mental state examination, the psychiatrist noted that the thought disorder had resolved. The patient remained preoccupied with [delusions] and was frustrated that his admission was preventing his progress. He had an inflated sense of intelligence and ability. The second opinion records that the patient presented with a likely mixed state manic episode which was challenging to manage. The psychiatrist felt there had been only a partial response to multiple psychotropic medications including high dose antipsychotic. The psychiatrist also considered a Drug Induced Mania as a differential diagnosis but felt that this was less likely given the gradual onset of the Mania. She commented that she was unsure about whether there was a family history of Bipolar Affective Disorder and recommended gathering of collateral information regarding this.

The second opinion noted that there had been an improvement in the patient's presentation during the preceding five days but that he still required continued seclusion due to aggressive outbursts.

The Tribunal was satisfied in the evidence that the use of ECT for treatment of refractory psychotic and major affective disorders is clinically appropriate, based on the research and studies available, including the RANZCP Clinical Practice Guidelines referenced by the treating psychiatrist. The Tribunal was satisfied that there was likely to be clinical merit in the use of ECT in a general sense for this acute presentation.

The Tribunal must also be satisfied however that in addition to the application for ECT having clinical merit, that ECT treatment is appropriate in the specific circumstances of this patient's presentation.

The second opinion included a number of recommendations for the treating team to consider. The second opinion assessment and report was undertaken after the application for ECT had been made. As a result, the plan which had been suggested had not been implemented.

The plan that was suggested was in summary:

1. Manage the patient's challenging behaviours in order to try to reduce seclusion episodes by accommodating his requests wherever possible.
2. Suggestion to increase one particular medication.
3. Another medication required more time to reach steady state but could potentially be increased.
4. Suggested a full set of blood pathology work-up.
5. Query the ability to tolerate high potency antipsychotic. Suggested repeat ECG and cardiology review given his lack of adequate response to a third medication.
6. If able to be tolerated from a cardiac perspective, a switch from that third medication to a fourth may be a reasonable option.

The second opinion plan also included the following final statement:

- "If his mental state does not improve despite maximal medical therapy, then I would support application for ECT given his ongoing risk to self and others prolonged restricted state in MHICU which is clearly causing distress."

The evidence provided at the hearing was that the patient had been reviewed by cardiology and the presenting psychiatrist confirmed that they would obtain cardiology sign off prior to proceeding with ECT.

The treating psychiatrist gave evidence that he felt that there had been an adequate trial of the medication, in particular mood stabilisers, and that he would have expected some improvement within one week.

At the time of the hearing, the patient had only been admitted for a short period of time (two weeks), noting his lack of cooperation with the treating team and meaningful engagement. The patient mentioned a number of times that he wished to be discharged to engage in his self-developed treatment plan.

The Tribunal were concerned regarding the lack of collateral evidence available at the hearing regarding family history and the patient's personal background history. Furthermore, this was the patient's first ever acute mental health presentation and the treatment recommendations suggested in the second opinion doctor had not been attempted. The evidence at the hearing was that if ECT were not approved it is likely that the treating team would swap out a medication to try a different antipsychotic, and that if that was not effective, they would discontinue it. They felt that taking these actions would likely extend the duration of the patient's inpatient admission.

It was noted that the patient had been using cannabis, although in the form of medicinal marijuana, prior to his admission.

Having regard to the second opinion and the recommendations in it, the fact that the second opinion recommendations had not been attempted, and the short period of time since the patient's (first ever) admission, the Tribunal were not satisfied that ECT was appropriate in these circumstances.

Does evidence support the effectiveness of ECT for the person's particular mental illness?

The treating team were of the view that the patient was suffering from a severe manic episode with psychotic symptoms. The mental illness noted in the Treatment Authority (made on admission) was manic episode vs Drug Induced Psychosis. Regardless, the patient's acute symptoms were evidently a combination of manic symptoms and psychotic symptoms.

There is evidence in the literature that supports the use of ECT as an effective treatment in severe and treatment-refractory affective disorders (Major Depressive Disorders, Bipolar Affective Disorder, manic episodes) and refractory psychotic disorders.

The treating psychiatrist referenced the RANZCP Clinical Practice Guidelines and APA Guidelines in the application for ECT report and in oral evidence at the hearing. Whilst no further specific details were provided in evidence other than the statement that ECT is "the gold standard treatment for severe affective disorders", the Tribunal were satisfied that what is known of the literature that ECT does hold a place in the treatment of severe manic episodes (with or without psychotic features) where the patient's symptoms have failed to respond to first-line evidence-based treatment (pharmacological) options, or there is some other contraindication to medication.

If ECT has previously been performed on the person, was the Tribunal satisfied of the effectiveness of the therapy for the person?

This was the patient's first admission to a mental health inpatient unit and he had not previously had ECT performed on him.

Human Rights

The Tribunal is cognisant that section 48 of the *Human Rights Act 2019* requires that the statutory provisions must be interpreted to the extent possible that is consistent with their purpose, in a way compatible with human rights.

The Tribunal felt that the following human rights had been engaged by the making of this decision:

- section 15 – Equality. By reason of the patient having a mental illness, he is subject to the application and the making of a decision. This is solely because of that mental illness. Other persons who do not have a mental illness are not subject to the same provisions, therefore this right is engaged.

- section 17(c) – The granting of an approval requires the patient receive treatment involuntarily. This engages the patient's human right not to be subject to treatment without their informed consent. The patient does not have an awareness of the current severity of his mental illness and is unable to weigh up the risks vs benefits of having or not having ECT as part of the treatment plan for his mental illness.

  In considering the application of section 17(c), and as outlined above, the Tribunal were of the view that whilst ECT may have clinical merit, the Tribunal did not believe that it was appropriate in the patient's current circumstances based upon the evidence provided in the application report and oral evidence at the hearing. Suggested alternatives to ECT have not yet been trialled, the patient had been in hospital for only two weeks, and this is his first ever acute mental health presentation and admission. It is to be noted that the patient had been using medicinal cannabis prior to admission. Further, the patient has a strong opposition to ECT as clearly articulated in the hearing today.

- section 31 – This human right has been engaged by the non-publication of the proceedings, but by not publishing the proceedings, the Tribunal is satisfied that the human rights to privacy and reputation as provided by section 25 of the *Human Rights Act* are promoted. The patient's personal information was only shared with the parties involved in the hearing. The sharing is necessary to conduct a fair and balanced hearing and for the members to make an informed decision. This could not be achieved without access to personal information regarding the patient including matters pertaining risk to self and others.

The Tribunal was further satisfied that the limitations on human rights because of the decision are lawful, proportionate to the circumstances and compatible with the *Human Rights Act* because the criteria of the relevant tests under the *Human Rights Act* were met and the *Mental Health Act 2016* provided the authority to make the decision, meeting the requirements of both the *Human Rights Act* and the *Mental Health Act*.

In the circumstances, the Tribunal considered that the limitations were demonstrably justified as that term is used in the *Human Rights Act*.

Conclusions of the Tribunal

The Tribunal were not satisfied that all the applicable criteria within section 509 of the *Mental Health Act 2016* were met. Whilst the Tribunal was of the view that ECT may have clinical merit, the Tribunal were not satisfied that ECT was appropriate in the current circumstances.

For these reasons, the Tribunal has decided to refuse the application to perform ECT.

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 who is:
    (i) subject to a treatment authority, forensic order or treatment support order; or
    (ii) 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 person is an adult:
        (i) whether the adult is able to give informed consent to the therapy; and
        (ii) to the greatest extent practicable, any views, wishes and preferences the adult has expressed about the therapy, whether in an advance health directive or otherwise; or
    (b) if the person is a minor:
        (i) the views of the minor's parents; and
        (ii) the views, wishes and preferences of the minor.
(3) Subject to subsections (4) to (6), the tribunal may give the approval only if the tribunal is satisfied the person is:
    (a) an adult who is not able to give informed consent to the therapy, whether or not the adult is subject to a treatment authority, forensic order or treatment support order; or
    (b) an adult who is:
        (i) able to give informed consent to the therapy; and
        (ii) subject to a treatment authority, forensic order or treatment support order; or
    (c) a minor.
(4) If subsection (3)(a) applies, the tribunal must also be satisfied:
    (a) the therapy has clinical merit and is appropriate in the circumstances; and
    (b) evidence supports the effectiveness of the therapy for the adult's particular mental illness;
    (c) if the therapy has previously been performed on the adult – of the effectiveness of the therapy for the adult.
(5) If subsection (3)(b) applies, the tribunal must also be satisfied:
    (a) the applicant has given the adult the explanation required under section 234; and
    (b) the adult has given informed consent to the therapy under chapter 7, part 10.
(6) If subsection (3)(c) applies, the tribunal must also be satisfied:
    (a) the therapy has clinical merit and is appropriate in the circumstances; and
    (b) evidence supports the effectiveness of the therapy for:
        (i) the minor's particular mental illness; and
        (ii) persons of the minor's age; and
    (c) if the therapy has previously been performed on the minor – of the effectiveness of the therapy for the minor; and
    (d) the performance of the therapy on the minor is in the minor's best interests.
(7) 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.