MENTAL HEALTH COURT

CITATION:	*In the Matter of FYS* [2023] QMHC 3
FILE NO/S:	MHC No. 0170 of 2023
PROCEEDING:	Appeal
DELIVERED ON:	22 September 2023
DELIVERED AT:	Brisbane
HEARING DATE:	15 September 2023; 18 September 2023
JUDGE:	Ryan J
ASSISTING PSYCHIATRISTS:	Dr F Iqbal
DETERMINATION:	**The appeal is dismissed.** **The decision of the MHRT made on 30 August 2023 is confirmed.**
CATCHWORDS:	HEALTH LAW – MENTAL HEALTH GENERALLY – GENERAL LAW AFFECTING PERSONS WITH MENTAL ILLNESS OR IMPAIRED CAPACITY – where the appellant is subject to a treatment authority for the involuntary treatment of his mental illness – where the Mental Health Review Tribunal approved 12 treatments of ECT for the appellant, over a period of 90 days – where the appellant appealed that decision – where the critical issue is the appellant's capacity to give informed consent to ECT in the context of his delusions – human rights considerations – evaluation of capacity to give informed consent *PBU & NJE v Mental Health Review Tribunal* (2018) 56 VR 141, applied *In the matter of ICO* [2023] QMHC 1, applied
COUNSEL:	K Prskalo KC for the Appellant S Robb for the Chief Psychiatrist
SOLICITORS:	Legal Aid Queensland for the Appellant Office of the Chief Psychiatrist for the Chief Psychiatrist

NOTE: This judgment is published pursuant to section 790 of the *Mental Health Act 2016* (Qld). It has been anonymised and redacted.

[1] This appeal against a decision of the Mental Health Review Tribunal raises as the critical issue the appellant's capacity to consent to treatment for his mental illness by way of electroconvulsive therapy (ECT).

The law

[2] The appeal is to be determined having regard to Australia's most significant human rights decision on mental health law: the decision of Justice Bell of the Supreme Court of Victoria in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564; 56 VR 141. That decision has been applied in this Court by its President, Wilson J, in *In the matter of ICO* [2023] QHMC 1.

[3] Because there has already been a delay in my dealing with this appeal, I will not discuss *PBU & NJE* in detail in these reasons. And indeed, I have the benefit of Wilson J's analysis of it in *ICO.*

[4] In addition to the decisions of *PBU & NJE* and *ICO*, I have been further assisted by the academic consideration of *PBU & NJE* in "Electroconvulsive therapy, law and human rights *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, Bell J" by Ian Freckelton QC.[1]

[5] As Bell J explained in *PBU & NJE*, in the context of involuntary treatment for mental illness, there has been a paradigm shift away from best-interests paternalism to the least-restrictive kind of treatment, which draws upon elementary human rights concepts. Where reasonable, the views and preferences of the person with a mental illness must be considered. And the treatment decision is not to be based upon purely medical grounds but rather – where appropriate – it is to encompass the holistic considerations of persons with mental illness in their entire personal and social setting.

[6] As Wilson J explained in *ICO,* the following human rights are engaged in a decision to approve treatment by way of ECT under the *Mental Health Act* 2016 (Qld) (MHA):

(a) the right to recognition and equality before the law;

(b) the right to privacy;

---

1 Psychiatry, Psychology and the Law, 2019 26(1), 1 – 20.

(c) the right to liberty and security of person;

(d) the right to humane treatment when deprived of liberty; and

(e) the right to access health services without discrimination.

[7] As Wilson J further explained, under the MHA, if a person subject to involuntary treatment for their mental illness has *the capacity* to give *informed consent* to ECT but does not consent to it, then the MHRT must respect their decision.

[8] If a person subject to involuntary treatment for their mental illness does *not* have capacity to give informed consent to ECT, then the test for approving treatment by way of ECT is the same for that person as it would be for any other adult without the relevant capacity.

[9] Bell J held that threshold for capacity is relatively low. The question is not whether the person is able to make a balanced, sensible, rational, or well-considered decision. A person with mental illness is not to be found lacking the capacity to give informed consent simply because their decision about ECT may be unwise. Self-determination is important for both dignity and health. Those with mental illness should have the same dignity of risk in relation to personal health-care decision making as other people.

[10] The presence in a person of: delusional thinking; irrational fears; or a lack of belief or insight into the person's illness, is capable of depriving the person of capacity, but it need not.

[11] After a thorough review of the relevant provisions of the MHA, as amended by the *Health and Other Legislation Amendment Act* 2022;[2] and considering relevant authority (including, but not only, *PBU & NJE*), Wilson J set out the principles relating, directly or indirectly, to informed consent in this context at [116] – [119] of *ICO*. I have, respectfully, paraphrased and re-ordered those principles to suit this appeal, below:

(a) One of the objects of the *Mental Health Act* 2016 (Qld) is to improve the health and wellbeing of a person who has a mental illness but does not have the capacity to consent to treatment for their illness.

---

2 Which, in effect, replaced a "best-interests" approach to this matter with a human rights-based approach.

(b) This object is to be achieved –

(i) in such a way as to *safeguard the human rights* of the person;

(ii) in the way which is least restrictive of the rights and liberty of the person; and

(iii) by the promotion of the recovery of the person, and the person's ability to live in the community, without the need for involuntary treatment and care.

(c) A person with a mental illness has the same human rights as a person without a mental illness.

(d) A person with a mental illness has the same right to respect for their human worth and dignity as a person without a mental illness.

(e) To the greatest extent practicable –

(i) a person (with mental illness) is to be encouraged to take part in making decisions which affect their life – especially decisions about their treatment and care; and

(ii) in making a decision about a person with mental illness, the person's views, wishes and preferences are to be taken into account.

(f) Capacity to give informed consent is to be tested in a non-discriminatory manner, to ensure that a person with mental illness is *not* deprived of their right to exercise their capacity on the basis of contestable value judgments relating to their illness, decisions, or behaviours. The test is not to be applied to produce social conformity at the expense of personal autonomy.

(g) The criteria set out in section 233(2) of the MHA must be applied neutrally – that is, there must be a neutral determination as to whether the person has the ability to: (a) understand the nature and effect of a decision relating to treatment; (b) freely and voluntarily make the decision; and (c) communicate the decision.

(h) In determining whether a person has the ability to understand the nature and effect of a decision relating to ECT the following matters are relevant:

(i) A person is presumed to have capacity to make decisions about the person's treatment and care.

(ii) The test for capacity to give informed consent to ECT is decision and time specific. It is different from the test of capacity which applies to the imposition of involuntary treatment.

(iii) Capacity to give informed consent to ECT must be established on the balance of probabilities. No party bears the onus of proof on the matter.

(i) Additionally, to have the capacity to give informed consent, a person must be *able to understand information relevant to the decision*, including the options and their consequences. Accordingly, section 234 of the Act requires the person be given a full explanation, in a form and language they are able to understand, *by the doctor proposing the treatment*, about the –

(i) purpose, method, likely duration and expected benefit of treatment; and

(ii) possible pain, discomfort, risks, and side effects associated with the treatment; and

(iii) alternative methods of treatment available to the person; and

(iv) consequences of not receiving treatment.

(j) This explanation provides the context for determining whether a person has the ability to understand the nature and effect of a decision about ECT. Therefore, the doctor's explanation and the person's response *should* be recorded, so that they can be considered and assessed.

(k) Capacity exists where a person has an *ability* to: identify the advantages and disadvantages of the available options; understand their consequences; *weigh the consequences*, and make a decision.

(l) Capacity to give informed consent does *not* require the person to give *careful consideration* to the advantages and disadvantages of treatment.

(m) Capacity to give informed consent does not require the person to make a rational and balanced decision. It is enough that the person is able to make and communicate their decision in broad terms.

(n) Those assessing capacity under section 233 must "*vigilantly ensure that the assessment is evidence based, patient-centred, criteria focused and non-*

judgmental, and not made to depend, implicitly or explicitly, upon identification of a so called objectively reasonable outcome".[3]

(o) Those assessing capacity under section 233 of the MHA must not reason that, if a person does not wish to receive ECT when objectively they *should*, then they do not have the ability to understand the nature and effect of a decision relating to ECT.

(p) Section 233 does not require an assessment of whether a person is capable of understanding that they have an illness, or symptoms of an illness, that affects their mental health and wellbeing.[4] However, such an assessment *may be relevant* to the question whether the person has the ability to understand the nature and effect of a decision relating to ECT.

(q) *A lack of insight may impact upon a person's ability to understand relevant information, but the presence or absence of insight is not a proxy for the presence or absence of decision-making capacity.*

(r) *A person's lack of insight into their mental illness may – as a relevant fact – support a conclusion that a person does not have the ability to understand the nature and effect of a decision relating to ECT. But the lack of insight is not a determinative, normative criterion.*

(s) *A person who lacks insight into, or does not accept or believe that they have, a mental illness, or that they need ECT, may nevertheless have the capacity to give informed consent.* Those assessing the capacity to consent must consider how the lack of insight et cetera affects the person's ability to understand the nature and effect of a decision relating to ECT.

(t) Acceptance, or belief in, or insight into, the diagnosis of mental illness and the need for treatment may vary significantly depending on the person and their situation.

(u) The presence of thought disorder or psychotic thinking which clouds a person's judgment, or delusions about treatment, may lead to the conclusion that a person does not have the relevant capacity.

---

3 *PBU & NJE* at [206(6)].

4 Compare the definition of "capacity to consent to be treated" in section 14 of the MHA.

(v) But if a person subject to involuntary treatment has the capacity to provide informed consent to ECT and decides not to receive ECT, then their decision must be respected.

(w) The decision to approve treatment by way of ECT for a person *without* relevant capacity is to be made having regard to –

(i) the person's views, wishes and preferences, to the greatest extent possible;

(ii) whether treatment by way of ECT has clinical merit;

(iii) whether it is appropriate in the circumstances;

(iv) whether evidence supports its effectiveness for the particular person's mental illness; and

(v) where the person has previously received treatment by way of ECT – its effectiveness for the person.

(x) The "best-interests" paradigm has been rejected in this context.

[12] Lack of the capacity to give informed consent is to be established according to the *Briginshaw* standard, having regard to the seriousness of the issue – namely the fundamental human rights of a person to self-determination; to be free of non-consensual treatment; and to personal inviolability.

The appellant and the background to this appeal

[13] The [redacted] appellant has a history of bipolar affective disorder (BPAD).

[14] [redacted]

[15] Upon hospitalisation in Queensland in the Mental Health Unit of a major public hospital, he required management in the high dependency unit for over a month because of his vulnerability and his risk of aggression towards others. The appellant's delusional content was considered more severe than upon his previous admissions.[5] His delusions were grandiose and paranoid.

---

5 Which had followed non-compliance with medications and a relapse of BPAD.

[16] The appellant had a limited response to psychotropics and, [redacted], the MHRT approved the administration to him of 12 sessions of ECT over 90 days. The appellant appealed that decision to this Court.

[17] ECT was administered to the appellant on 9 occasions [redacted] before his appeal was allowed. His symptoms reduced considerably, and he was able to be nursed in the open ward from [redacted].

[18] His appeal was allowed on [redacted]. On that date, the treating team identified that his circumstances had changed, and that clozapine was now a possible alternative treatment, which the appellant was prepared to receive.

[19] Although the appellant informed his treating team, and the Court, that he was prepared to take clozapine, there were some difficulties associated with his taking it. More significantly though, [redacted] clozapine is no longer a treatment option for the appellant.

[20] The clinical notes made before and after the appellant received ECT [redacted] reveal numerous attempts by hospital staff to discuss ECT with him. Speaking generally, the appellant was not often open to discussions about ECT and when he did engage in discussions about it, he was strongly opposed to it. However, the clinical notes do not always reveal the *content* of the discussions with the appellant about ECT.

[21] [redacted] the appellant was said to be unable to weigh up *complex* decisions regarding treatment, including ECT, due to the severity of his condition "*and as such lacks the capacity to consent*". (I pause here to note that the test of capacity does not require an ability to weigh *complex* decisions; and the severity of an illness *per se* does not equate to a lack of capacity to consent to ECT.)

[22] [redacted]

[23] [redacted], the appellant was advised that further ECT might lead to a faster discharge from hospital. The appellant [redacted] was unable to meaningfully engage in a conversation about his mental health.

[24] [redacted]

[25] The following was recorded about the appellant's consultation with his psychiatrist on 4 September 2023 –

> [redacted]

[26] [redacted]

[27] The most recent written clinical report explained that the appellant remained unwell under his current treatment regime:

> [redacted]

[28] [redacted] the MHRT approved another course of 12 sessions of ECT, over 90 days, for the appellant. This is the decision under appeal.

[29] At the hearing of the ECT application, the appellant told the MHRT, among other things, the following –

> [redacted]

[30] Also, he expressed some of the concerns set out in the document he relied upon at the stay application and the appeal (see below).

[31] He expressed delusional beliefs at the MHRT hearing, including in his written self-report.

[32] His treating doctor, and a doctor asked to provide a second opinion for ECT, found him to lack the capacity to consent to ECT.

[33] The MHRT found that the appellant's symptoms were "preventing him from understanding and weighing the risks and benefits of ECT, the risks and benefits of other treatments, and the consequences and risks of not receiving medication treatment or ECT". The MHRT found that the appellant lacked the capacity to give informed consent to ECT.

[34] The MHRT found that ECT was an appropriate treatment for the appellant [redacted]. Without ECT, the risks to the appellant included [redacted]. It was difficult to identify a treatment with more clinical merit than ECT, given [redacted].

The appeal

[35] The appellant's ground of appeal is: *I do not wish to receive ECT and I'm worried about memory side effects. I can maintain a healthy state of mind.*

[36] The MHRT's decision was stayed on 7 September 2023, pending the final hearing of the appeal.[6]

[37] In exercising jurisdiction on appeal, I am required to inquire into the matter and inform myself in relation to it in any way I consider appropriate. Appeals are by way of re-hearing. I may consider the evidence before the MHRT as well as any other evidence, including evidence which has emerged since the MHRT's decision.

[38] Drawing on Bell J's judgment: I have taken into account, in deciding this appeal, that the provisions of the MHA are predicated upon the central purpose of ensuring that persons with mental illness have access to and receive medical treatment, consistently with their right to health. Where – having regard to relevant principles – a person does not have the capacity to give informed consent and where there is no less restrictive way for the person to be treated (and treatment is appropriate et cetera), then the MHRT must grant an application for approval for ECT because under the Act, and subject to its safeguards, this is a necessary means of ensuring a person is given that treatment.

[39] Further, in deciding this appeal, I have borne in mind the following from Freckelton QC's interpretation of Bell J's decision:

> At the heart of Bell J's decision is a requirement for clinicians and bodies such as mental health tribunals and administrative tribunals on review to be rigorous in their analysis of legislation which impacts upon mental patients' rights. There is a risk that 'best interest' considerations and extra-legislative notions, such as insight and compliance, will intrude into decision-making without legislative warrant … [T]he dignity and autonomy of capacity for error should be extended to those with mental illness as it is to those without mental illness … [T]he presence of symptomatology of psychiatric pathology, such as paranoia, delusions or hallucinations, may deprive or substantially impair the capacity for informed consent but … this does not necessarily follow. The question is what the correlation is between symptomatology and capacity, whether or not the capacity is ultimately exercised irrationally – there should not be consequentialist drawing of inferences …

---

6 On 15 September 2023, the date on which the appeal was heard, I stayed the MHRT's decision until delivery of this judgment.

Evidence given at the hearing of the application for a stay of the decision

[40] [redacted]

[41] [redacted] At the hearing of the stay, the appellant's treating doctor informed the Court that those treating the appellant had been able to manage him on reasonable doses of benzodiazepines, mood stabilisers, and antipsychotics. She continued –

> [redacted]

Further evidence given, and arguments made, at the appeal hearing

[42] The appellant was represented by a King's Counsel from Legal Aid Queensland on this appeal.

[43] The update report of 13 September 2023, created for the purposes of this appeal, sets out the appellant's wishes as follows:

> [redacted]

[44] [redacted]

[45] [redacted]

[46] [redacted]

[47] The doctor clarified that her opinion was that he was unable to understand the information she provided to him about ECT because of his delusions and his mental state.

Submissions

[48] Counsel for the appellant submitted that there was evidence that the appellant could make decisions about treatment – he had decided to accept clozapine. He said that, if he had a choice, he would not receive any treatment, but he'd "100 per cent" prefer medications to ECT. He was accepting of treatment generally – just not of ECT for the reasons given in his written document.

[49] He was to be presumed to have capacity. All that was required was an understanding of the nature and effect of the decision about ECT – which he had demonstrated. His right to make a decision included his right to make a bad decision.

[50] She also submitted that I might find that there had not been full compliance with section 234 of the Act. She acknowledged that the update report dealt more fully with the question of informed consent than the other material before the Court – but it did not contain what the appellant had been told.

[51] Counsel for the Chief Psychiatrist submitted that the evidence could not support a finding that the explanation required by section 234 had not been given but there was no clear repository, in the clinical notes, including the update report, of the sort of information which Wilson J indicated the Court expected to see.

[52] She also observed the obvious difficulty which arose if a person was not willing to receive full information about ECT but that, in this case, the appellant had experienced it.

[53] While not taking a position on the outcome of the appeal, counsel for the Chief Psychiatrist identified the issue for the Court as whether the appellant's inability to accept what he was told about ECT [insofar as it might apply to him] and lack of insight into his illness affected his capacity. [redacted]

[54] [redacted] He could not weigh up and understand the nature and effect of the decision he was being asked to make because of the severity of his symptoms.

Advice

[55] [redacted]

[56] As to capacity, Dr Iqbal advised me that the evidence supported a finding that the appellant knew what ECT did and did not do. As the treating doctor explained, the appellant had been shown a certain movie about ECT and he had experienced it.

[57] However, Dr Iqbal advised me that while he could literally understand the other information he was given: the import of it was lost on him because of his illness.

Consideration of outcomes in comparable matters

[58] Appreciating that every matter is different, I nevertheless considered the outcomes in the cases of ICO, PBU and NJE.

[59] ICO experienced a deterioration in her mental health in the two years prior to the approval to treat her with ECT. She had declined functionally overall and suffered more severe symptoms over that period, during which she had never been in full remission. Her judgment was acutely impaired. ICO had no insight into her chronic mental illness or her need for treatment. She demonstrated no clear disorder of thought form, but her thought content consisted of paranoid and grandiose themes. She could not make rational and self-serving decisions. She believed she was "fine in the head" and suitable for discharge – even though she was clearly not.

[60] ICO had been provided with a good explanation of ECT and its benefits. ICO had been consistently clear that she did not want ECT. She described it as draconian and expressed concerns that, in effect, it was over-used.

[61] In her self-report to the Mental Health Review Tribunal (MHRT), ICO acknowledged that she had a mental illness but wanted a second opinion. During the MHRT hearing, the symptoms of ICO's illness were obvious. For example, she interrupted frequently, she had difficult following direction, and she was highly elevated.

[62] She did not want ECT because of her concerns that it would cause memory and cognition problems. She would prefer to have psychotherapy or psychoanalysis, rather than medications. Her plan was not to have ECT and to be eventually discharged.

[63] It was submitted that she had been weighing up the information given to her about ECT and that her reasons had some form or logic to them, or a connection to real life and were not delusional. Even though she had disordered thought, she understood the nature and effect of her decision. While others might think her decision was not rational – that was not the test.

[64] Wilson J acted on evidence to the effect that, while ICO could listen to information about ECT, she was not receptive to it because she did not believe that ECT would be good for her because she did not believe that she had mental illness – even though she would glibly say that she had paranoid schizophrenia.

[65] Wilson J accepted that ICO had no insight into the complexity of her chronic, relapsing mental illness and its effects on her moods, thoughts, and behaviours. Her lack of insight into her chronic mental illness or her need for treatment affected her ability to understand

the nature and effect of a decision to give consent for ECT. She did not have the ability, in general terms, to identify the advantages and disadvantages of the available options; or to understand their consequences; or to weigh their consequences and reach a decision.

[66] Having found ICO lacked capacity, her Honour went on to consider the matters in section 509(4) of the Act.

[67] On the evidence, her Honour was not satisfied that there were no other treatments available for ICO apart from ECT. Her Honour observed that applications for ECT should include comprehensive material about the medications which have been considered for a person, and used or not used, and the reasons for doing so. That was absent from the evidence and her Honour was not satisfied that ECT was appropriate in the circumstances.

[68] Her Honour indicated that further investigation into the appropriateness of treatment with clozapine or other anti-psychotics was required. It might be that the treating team concluded thereafter that there was no other alternative to ECT, in which case, another application could be made to the MHRT. Her Honour allowed the appeal and set aside the existing decision of the MHRT to approve ECT for ICO.

[69] Bell J found that the decisions of VCAT in the case of PBU and NJE were affected by various errors of law. His Honour quashed those decisions. By the time his Honour had done so, PBU and NJE were being treated in the community. Compulsory ECT was no longer sought and there was therefore no need for remitter orders. Bell J did not need to embark on an assessment of the capacity of either PBU or NJE.

Consideration

[70] The critical issue raised by this appeal is that of the appellant's capacity to consent to ECT when he has no, or very limited, insight into his mental illness and his need for treatment, and where the delusional symptoms of his illness are prominent.

[71] For the following reasons, I find that the appellant does *not* have the capacity to give informed consent to ECT.

[72] I began with the presumption that the appellant did have capacity.

[73] I acknowledged that where delusions are present, the capacity assessment must consider the relationship between the delusion and the capacity. The least restrictive principle is to be applied with recognition that persons with mental illness are dignified rights-bearers, not welfare cases. However, as Bell J said, "*As a patient's health, medical treatment and self-determination are interrelated, this can cut both ways: discriminatory denial of capacity and paternalistic medical treatment can undermine patients' dignity, autonomy and prospects of recovery in the long term; but subject to safeguards, compulsory medical treatment may presently be necessary as a last resort to improve those prospects and contribute to the realisation of patient autonomy and self-actualisation*" (my underlining).

[74] As this is an appeal by way of re-hearing, I was first to determine, in a neutral way, whether the appellant *currently* had the ability to understand the *nature and effect* of a decision relating to treatment: that is, whether he had an ability to: *identify the advantages and disadvantages of the available options* and their *consequences;* and to *weigh* those consequences.

[75] I was to ensure that I did not place the threshold for capacity too high. I was not assessing whether the appellant was able to make a balanced, sensible, rational, or well-considered decision.

[76] In this case, on the facts, the question of the appellant's capacity reduced to whether the appellant's lack of insight into his illness, or the presence in the appellant of delusional thinking, or both, had deprived him of the ability referred to above, and therefore his capacity.

[77] The relevant "capacity" requires an ability to understand the "nature" and "effect" of a decision about ECT.

[78] I interpreted a reference to the "nature" of a decision relating to ECT as a reference to the basic features of the decision.

[79] I interpreted a reference to the "effect" of a decision relating to ECT as a reference to the result or consequences of the decision.

[80] In my view, currently, the appellant has the ability to understand the *nature* of a decision about ECT. He understands he is being asked to consent to treatment by way of electro-convulsions under anaesthetic. He understands that, if he says he will have it, it will be administered to him as it has been administered to him in the past. He knows what ECT involves and its risks for his memory. Neither his illness nor his delusions interfere with his understanding of what is involved/the *nature* of electroconvulsive therapy.

[81] However, subject to one complication, I found that, on the evidence tendered at the hearing of the appeal on 15 September 2023, the appellant did not have the ability to understand the *effect* of a decision relating to ECT because his illness affected his ability to understand *the result or consequences of his decision*.

[82] What complicated my assessment of the appellant's ability to understand the effect of a decision relating to ECT was the application of the statement in *ICO* that the explanation required by section 234 provided the context for determining whether a person is able to understand the nature and effect of a decision about ECT.

[83] In the present case, as at 18 September 2023,[7] the explanation was incomplete, because although the appellant had been informed about a more protracted admission if he did not receive ECT, he had not been told [redacted].

[84] I had to consider whether the appellant's obvious *incapacity* to engage in a discussion about the *other consequences* of a decision regarding ECT (which had been explained to him), because of the prominence of his delusions and other symptoms and his lack of insight into his illness and the need for its treatment, could be used by me as a proxy for determining whether the appellant had the capacity to give informed consent in the absence of the full explanation required. Expressing it another way, I had to consider whether the appellant ought to be given a last chance to demonstrate capacity in the face of information that he had not been given previously, [redacted].

[85] Bearing in mind all that has been said in these reasons, and the judgments referred to therein, about the human rights of a person such as the appellant, and the significance of the decision which I am making in this case; and without dissent from the appellant's counsel, I adjourned the appeal to allow the appellant's doctor to inform him of that

---

7 The day I intended to give my decision in this matter.

consequence of not receiving ECT (*cf* section 234(d)). I considered that I could not simply discount the *chance* that the appellant could demonstrate capacity when informed of a consequence of not receiving ECT which might be meaningful to him in a concrete way.

[86] On 20 September 2023, the appellant's doctor had a conversation with him about ECT. She has produced detailed notes of what she told the appellant and his reaction to it. It was apparent from the notes that, because of his illness, the appellant was unable to tolerate the conversation [redacted].

[87] [redacted]

[88] [redacted]

[89] By 20 September 2023, his illness and its symptoms had disabled him from understanding *any* effect of his decision about ECT; and any attempt at a full explanation was futile. The appellant's *response* to the explanation given to him on that date – that is, his inability to sit through it [redacted]– proved, to the requisite standard, evidence of his inability to understand the effect of a decision relating to ECT.

[90] Accordingly, I found that he was not an adult able to give informed consent to ECT. Thus, section 509(3) of the MHA applied and I was required to consider the matters listed in section 509(4), as the MHRT had done.

[91] [redacted]

[92] I am therefore satisfied as required by section 509(4). It follows that the appellant's appeal is dismissed and the decision of the MHRT is confirmed. For completeness: the stay of the MHRT decision ceased upon the pronouncement of my orders and the publishing of these reasons.