MENTAL HEALTH COURT

CITATION:	*In the matter of ICO* [2023] QMHC 1
PROCEEDING:	Appeal
FILE NO:	MHC No. 0031 of 2023
DELIVERED ON:	10 May 2023
DELIVERED AT:	Brisbane
JUDGE:	Wilson J
ASSISTING PSYCHIATRISTS:	Dr J Sundin Dr F Iqbal
DETERMINATION:	**1. The appeal is allowed.** **2. The Mental Health Review Tribunal's decision dated 15 February 2023 to approve 12 treatments of electroconvulsive therapy (ECT) over a period of 60 days, which was to commence on the 15 February 2023, is set aside and substituted with the decision that the application for ECT is refused.**
CATCHWORDS:	HEALTH LAW – MENTAL HEATLH GENERALLY – GENERAL LAW AFFECTING PERSONS WITH MENTAL ILLNESS OR IMPAIRED CAPACITY – where the Mental Health Review Tribunal approved that the appellant have 12 treatments of electroconvulsive therapy over a period of 60 days – where the appellant appealed this decision of the Mental Health Review Tribunal – where a stay was granted until the full appeal could be heard – where section 509 of the *Mental Health Court Act 2016* (Qld) is considered – whether the appellant has capacity to give informed consent *Attorney-General for the State of Queensland v GLH* [2021] QMHC 4, cited *Adamson v Enever & Anor* [2021] QSC 221, cited *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141 *R v Cooper* [2009] 1 WLR 1786, cited *TSC v Department of Health and Wellbeing* [2021] SASCA 93 *YLY v Mental Health Tribunal (Human Rights)* [2019] VCAT 1383

Charter of Human Rights and Responsibilities Act 2006 (Vic)
Guardianship and Administration Act 2000 (Qld)
Health and Other Legislation Amendment Bill 2021 (Qld)
Health and Other Legislation Amendment Act 2022 (Qld)
Human Rights Act 2019 (Qld), s 13, s 15, s 25, s 29, s 30, s 37, cited
Mental Health Act 2016 (Qld), s 3, s 5, s 7, s 9, s 14, s 18, s 232, s 233, s 234, s 421, s 509, s 539, s 544, s 546, s 639, s 685, cited
Mental Health Act 2014 (Vic),s 68, cited
Mental Health Act 2009 (SA), s 5A, cited
Public Health Act 2005 (Qld), Chapter 4A, cited

Explanatory notes to the Health and Other Legislation Amendment Bill 2021

COUNSEL: G E Devereaux for the appellant
S J Hamlyn-Harris for the Chief Psychiatrist

SOLICITORS: Legal Aid Queensland for the appellant
Office of the Chief Psychiatrist

[1] On 15 February 2023, the Mental Health Review Tribunal (**the tribunal**) approved that the appellant have 12 treatments of electroconvulsive therapy (**ECT**) over a period of 60 days, which was to commence on 15 February 2023.

[2] On 1 March 2023, the appellant filed a notice of appeal in relation to this decision with her grounds of appeal being:

> "I do not feel like I need ECT, nor do I want it. I feel it is draconian and I am concerned about the memory and cognition problems associated with the treatment. I want another opinion."

[3] The appellant also applied for a stay of the tribunal's decision on the basis of:

> "I am worried if I have the treatment prior to the appeal hearing I will be impaired … the side effects and not able to participate fully."

[4] Pursuant to section 544 (1) of the *Mental Health Act* 2016 (Qld) (**the Act**), the Mental Health Court may stay the decision of the tribunal appealed against to secure the effectiveness of the appeal.

[5] I heard the stay application on 7 March 2023 and Dr Harden, who was assisting me, advised that there was no clinical risk to the appellant if ECT was stayed until the appeal could be determined. I granted the stay.

[6] The substantive appeal was then listed for 29 March 2023. However, on that date the appellant's legal representatives applied for an adjournment to get an independent second opinion. Dr McVie and Dr Sundin advised me that there was no clinical risk to the appellant if the adjournment was granted.

[7] Accordingly, I granted the adjournment and ordered an independent psychiatrist to provide an additional report. Thus, Dr Scott assessed the appellant on 6 April 2023 and provided a report having regard to sections 233 and 509 of the Act.

[8] This appeal raises two issues:

(a) Whether the appellant can give informed consent in relation to ECT; and

(b) Whether ECT is appropriate in the circumstances.

[9] The appellant submits that:

(a) Evidence demonstrates that the appellant has capacity to provide informed consent pursuant to section 233 of the Act; and

(b) Alternatively, ECT is not appropriate in the circumstances (as required by section 509 (4) (a) of the Act) because there remains an alternative to ECT that should be explored, being another trial of clozapine.

[10] The appeal was heard on 28 April 2023 where I was assisted by Dr Sundin and Dr Iqbal. At the hearing Dr Scott gave evidence and the legal representatives for the appellant and the Office of the Chief Psychiatrist both provided oral submissions which complimented their written submissions.

[11] The stay of the tribunal's decision was extended until my judgment in this matter.

Appeals from the tribunal to the Mental Health Court

[12] The appeal to the Mental Health Court is brought under section 539 of the Act.[1]

[13] Under section 546 (2), the appeal is by way of rehearing, which means that the Mental Health Court is to hear the matter afresh on all the evidence (including any updated material provided since the tribunal's decision) before the Court. It is not necessary for the appellant to show error on the part of the tribunal.

[14] In deciding the appeal, the Mental Health Court may:

(a) confirm the decision appealed against; or

(b) set aside the decision appealed against and substitute another decision; or

(c) set aside the decision and return the matter to the tribunal with the directions the Court considers appropriate.[2]

[15] Section 639 (2) of the Act provides that, in exercising its jurisdiction, the Court must inquire into the matter before it and may inform itself in relation to a matter before it in any way it considers appropriate.

The appellant's mental health history

[16] From 24 March 2022, the appellant was managed by a New South Wales mental health service and was medicated with depot zuclopenthixol 200 mgs fortnightly and depot olanzapine 405 mgs monthly. On 20 April 2022, when the appellant was discharged from the service, the discharge summary documented:

> "… 37-year-old woman with longstanding treatment resistive schizoaffective disorder currently relocated to emergency accommodation in [New South Wales] after being asked to leave her parents holiday house where they were all residing together after evacuation from their separate homes during the recent floods.
>
> … managed by a CTO [community treatment order] that expires 2nd May 2022.
>
> She has a history of undiagnosed eating disorders and poor compliance with orals [medications] … she can become unwell even when compliance is monitored. She has a history of multiple admissions due to relapse in the context of medication non-compliance and stressors in the community.

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1 Read with Schedule 2 of the *Mental Health Act 2016* (Qld).
2 Section 546 (3) of the *Mental Health Act 2016* (Qld).

> When unwell symptoms include poor self-care, malnourishment, obvious responding to internal dialogue, misinterpreting interactions, rude, argumentative, irritable, dismissive, threatening, refusal to engage with MH, suspicion and guardedness, paranoid and delusions including diabetes and Aboriginality and increased sexual related themes including public nakedness and accusations of paedophilia and sexual abuse/inappropriateness by her father. She has been known to send 100+ inappropriate and abusive text messages to family and case managers. She reports to get cathartic release from sending text messages and regards it as a form of therapy.
>
> … presentations are highly interchangeable from one fortnight to the next, ranging from pleasant and engaging to delusional, rude and abusive.
>
> … limited insight into her mental illness and does not share treating teams opinion that a CTO is required or necessary.
>
> … vague and evasive when describing her symptoms when she is unwell …"

[17] The appellant relocated from New South Wales to regional Queensland in search of cheaper housing. A Queensland mental health service attempted to contact the appellant in April 2022 following her arrival in Queensland. However, at the time the appellant refused to engage with this service and declined further contact. The referral was subsequently closed.

[18] On 8 September 2022 the police brought the appellant into hospital under an Emergency Examination Authority[3] after she was found walking the streets in the rain naked, thought disordered and refusing to engage with services.

[19] The appellant was uncooperative in the emergency department with an escalation of her behaviour, and she attempted to leave hospital. An intramuscular tranquillizer was administered, and she was transferred to the High Dependency Unit.

[20] The appellant was placed under a treatment authority. Section 18 of the Act explains the circumstances of when a person can be placed under a treatment authority:

> "**18 Treatment authorities**
>
> (1) A treatment authority is a lawful authority to provide treatment and care to a person who has a mental illness who does not have capacity to consent to be treated.
>
> (2) A treatment authority may be made for a person if an authorised doctor considers the treatment criteria apply to the

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3 Pursuant to Chapter 4A of the *Public Health Act 2005* (Qld).

person and there is no less restrictive way for the person to receive treatment and care for the person's mental illness, including, for example, under an advance health directive.

(3) Key elements of the treatment criteria are that the person does not have capacity to consent to be treated and there is a risk of imminent serious harm to the person or others.

(4) The category of a treatment authority is—

(a) community, if the person's treatment and care needs can be met in the community; or

(b) inpatient, if the person's treatment and care needs can be met only by being an inpatient.

(5) If the category of a person's treatment authority is inpatient, the person may receive limited community treatment, for a period of not more than 7 consecutive days, if authorised under this Act."

[21] On 8 November 2022, Dr G provided a second opinion to the treating team regarding medication optimisation. In this report it was noted that:

> "On review today, she was hostile, disengaging, angry, and quite paranoid. She exhibited paranoid delusions that we are illegal and should not be in this country. her thoughts showed some of loosening of association; her affect was hostile, angry; oriented; poor insight and judgement."

[22] Dr G's report sets out the appellant has treatment refractory psychotic and mood symptoms and that the following medication options were discussed with the treating team:

> "…
>
> 2. EPSE was discussed and could contribute to agitation and hostility
>
> 3. Clozapine Re challenge was considered but was not appropriate at this stage
>
> 4. Optimisation of lithium dose to 500mg BD with repeat lithium levels
>
> 5. Optimisation of olanzapine with additional of oral dose 5mg BD
>
> 6. Consider to increase Zuclopenthixol to 300mg F/N if no improvement
>
> 7. Consider Augmentation with ECT if symptoms persist"

[23] Dr A made an application for ECT to the tribunal on 3 February 2023 and provided a clinical report which set out the appellant's treatment and response to medication.

[24] It was noted that clozapine treatment, which is recommended for treatment resistant schizophrenia, had been trialled in the past but was discontinued due to severe leucopenia. Dr A stated that ECT would be the alternative evidence-based treatment option for the appellant.

[25] Dr A referred to a meeting with the appellant's family which confirmed the appellant's long standing mental health history, noting that:

(a) since her first presentation at around age nineteen, the appellant has had episodic attacks requiring hospital admissions at times;

(b) her overall functioning over the years have been gradually declining;

(c) the appellant has been having more frequent unwell episodes, with increasing severity;

(d) the appellant probably has never been completely well in last two to three years; and

(e) ECT was proposed as potential treatment option in New South Wales some years ago but did not eventuate.

[26] The family agreed that ECT should be considered as part of the appellant's treatment options and was supportive of her continuing care in a tertiary facility.

[27] Dr A's clinical assessment at the time of the ECT application was that despite being in a structured and supportive environment, on two depot antipsychotics and mood stabiliser with good serum level, the appellant's mental state continued to fluctuate with positive symptoms regularly observed. Her self-care, social interaction and engagement with treating team remain poor.

[28] At the time of the ECT application, the appellant had been stepped down from the High Dependency Unit to another ward. A referral to a tertiary facility was made and declined in January 2023. There was concern that the appellant could not be managed in an open ward with her current level of psychosis.

[29] Dr G provided a second opinion in relation to ECT for the appellant on 10 February 2023. He stated that since his previous opinion on 8 November 2022 the appellant's mental state had not changed or improved.

[30] When Dr G reviewed the appellant, he found her lying on her bed, refusing to talk, showing paranoid themes and formal thought disorder, with no insight.

[31] Dr G's impression was that:

> "[The appellant] has treatment resistant psychotic illness. ECT is a good treatment to augment the effects of medications. I support the team plan for ECT. My opinion has not changed from previous assessment."

[32] The application for ECT was allowed by the tribunal on 15 February 2022.

[33] Dr C provided an updated report dated 6 March 2023 which stated:

> "[The appellant] has been admitted to MHU [X] hospital since October 2022. [The appellant] is being treated involuntarily under the MHA.
>
> [The appellant] has been psychotic and disorganised during her admission in the ward.
>
> [The appellant] has had a long history of mental health concerns starting from around 19 years of age.
>
> [The appellant] has had several admissions in the past while living interstate. There hasn't been any period of time when [the appellant] has responded adequately, to the treatments provided. This has been confirmed following a discussion with her mother and sister.
>
> [The appellant] is currently on 2 antipsychotics and Lithium.
>
> [The appellant] hasn't shown any response to this regime. Second opinion had been sought which recommended medication changes and if not responding ECT.
>
> [The appellant] has had adverse reaction to Clozapine (Leucopenia) when trialled previously.
>
> [The appellant] has had significant risks in the past due to her psychosis and disorganisation.
>
> [The appellant] is not fit enough to be managed in a support independent living arrangement or other forms of accommodation, outside of the MHU.
>
> Under these circumstances the ECT is being considered as a last treatment option which hasn't been trialled before. The family doesn't report any ECT treatments in the past.
>
> The MHRT application for ECT was approved but on the day of the first treatment, [the appellant] stated to the ECT team that she is "appealing" the decision by MHRT.
>
> The ECT team discussed this with the treating consultant and the treating consultant (Dr C) decided to put a hold on the ECT till the appeal process is completed.
>
> [The appellant] is deemed to have low risk while in the inpatient unit.

> [The appellant] has been able to make a formal appeal.
>
> [The appellant] continues to be psychotic and disorganised.
>
> [The appellant] hasn't received any ECT since then as the treating team doesn't consider the ECT to be an urgent intervention. But considering the non-response to pharmacological treatment options, the treating team continues to recommend a trial of ECT."

[34] Dr C provided another report on 27 March 2023. He stated the appellant's mental state on 23 March 2023 was:

> "Wearing dress, not unkempt
>
> Appeared alert and oriented, detailed cognitive assessment not attempted
>
> Mood elevated, easily agitated
>
> Guarded initially then becoming agitated when discussing ECT
>
> Pressure of speech when discussing her appeal
>
> Thought disordered
>
> No AH
>
> No insight"

[35] Dr Scott then provided an independent report dated 14 April 2023. During Dr Scott's assessment with the appellant on 6 April 2023, she reported that in January 2006, she was first diagnosed with what she described as "textbook paranoid schizophrenia" and subsequently between 2006 to 2012, she had three inpatient admissions.

[36] When the appellant was asked to describe the features of her schizophrenia, she stated that: "paranoia, feeling like there were cameras everywhere, watching me".

[37] When the appellant was asked to further describe the features of her schizophrenia, the appellant stated: "... putting myself out there, having interpersonal problems, not getting enough sleep, poor concentration …"

[38] The appellant told Dr Scott that she had become estranged from her parents:

> "I needed to get away from them. I'm not sure they are my real parents. I'd like to access my government records and find out the truth … as a kid I lost weight. I was only 43 kgs. My mother was a nurse and she put baby oil on my face and cleaned me with methylate spirits, why would she do that ? … my father … is a paedophile … on 24 October 2005, he molested me, he touched my left breast. He used to get close to my older sister too … I'm not lying. I never lie. When I

> told my mother what my father had done, she just said 'Well at least he didn't rape you …' My mother might have been from the 'stolen generation.' I think my ancestry is Irish-Aboriginal. In 2015, it came to me, I realised that [MM] was actually my real father. He raised me. He was Irish, he had been recruited when he was only aged four as a sniper in World War II. He was the first soldier to shoot Hitler …"

[39] The appellant told Dr Scott that after she left New South Wales, she stopped taking her prescribed oral olanzapine and that:

> "I think I did well off the medication. I had more energy and I was thinking clearly. I also understood that my mother had Munchausen by proxy…"[4]

[40] The appellant explained:

> "I had a 'sugar fit' when I was anorexic. My mother told the psychiatrist I had an epileptic fit. The psychiatrist put me on anti-epilepsy medication which I didn't need to be on ..."

[41] In relation to the incident which predicated her admission into hospital in September 2022, the appellant told Dr Scott that she had been living in a cabin in the caravan park when she was disturbed by the snoring of the woman living next door:

> "I wasn't getting enough sleep. Her snoring was so loud. It reminded me of my mother. One night I had had enough and came out and banged on her door. I wasn't wearing any clothes at the time and I accidentally locked myself out. After I didn't get any response, I just walked off. It was raining but I didn't care. I was walking in the street naked and the police picked me up and took me to the hospital. I was provoked and angry because no one would listen to me. Then there was a teleconference and I was taken from [X] to the [X] Hospital …"

[42] The appellant told Dr Scott that she would prefer to cease all medication:

> "I think I'd do well off all medication. I'd like to have psychotherapy or psychoanalysis instead of taking medications which all have side effects …"

[43] When the appellant was asked whether any therapies had been shown to be effective as "stand-alone" treatment for schizophrenia, the appellant referred to a book entitled *Psychotherapy of Schizophrenia: The Treatment of Choice* (which was written by Bertram Karon and Gary van den Bos and first published in 1977).

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[4] Dr Scott explains that Munchausen by proxy is a factitious disorder imposed on another when someone, usually a parent or carer, falsely claims that another person, usually a child, has physical or psychological signs or symptoms of illness, or causes injury or disease in another person with the intention of deceiving others and to procure unnecessary investigations or medical procedures.

[44] Dr Scott set out the results of his mental examination of the appellant in his report:

> "During the assessment on 6 April 2023, [the appellant] presented as a slim woman with a pale complexion who looked younger than her chronological age. She had long dark hair tied back. She was casually dressed and wore no make-up. Her self-care was good. [The appellant] was alert and orientated. She was pensive and maintained good eye contact and manifested a mostly serious expression. She demonstrated no abnormal movements. She was not hypervigilant, agitated or guarded and a shallow rapport was able to be established. She was an entirely co-operative historian.
>
> [The appellant's] soft speech was of normal volume and form and was not pressured. Her vocabulary was sophisticated and she gave the impression of above average intelligence. [The appellant] denied feeling anxious, angry or depressed and self-rated her mood "7 out of 10" (10 being the best). Her affect was only mildly dysphoric, appropriate to her thought content and normally reactive.
>
> [The appellant] demonstrated no clear disorder of thought form (the connectedness of her thoughts) during the assessment. Her thought content consisted of paranoid and grandiose themes (as described above) and her comments about her parents particularly her father were likely to be delusional. [The appellant] may have been self-censoring her account for the purposes of the court-ordered assessment. [The appellant] denied any violent or intentional self-injury ideation. She specifically denied any abnormal percepts or passivity phenomena and she did not appear pre-occupied or distracted during the assessment.
>
> At the time of the assessment on 6 April 2023, [the appellant's] judgement was chronically impaired. She demonstrated no insight into her chronic mental illness or her need for treatment."

[45] Dr Scott stated that having regard to the appellant's longitudinal history, recent inpatient assessments and the findings of his mental state examination on 6 April 2023, the appellant has chronic paranoid schizophrenia. In Dr Scott's opinion, it is less likely that she has schizo-affective disorder. Her chronic psychotic disorder is marked by an irritable mood and paranoid and grandiose delusions.

[46] At the hearing Dr Scott gave evidence consistent with his report and stated:

(a) At the time of his assessment on 6 April 2023, the appellant's agitation and her arousal, her psychomotor activity, was certainly better than many of the assessments documented.

(b) Dr Scott noted that the appellant presented better than she had previously to others, until he inquired about her thought content.

(c) The appellant's thought content, which is the most important aspect of her mental state examination, was fairly consistent with someone who was psychotic.

(d) The appellant's judgment is acutely impaired. She cannot make rational and self-serving decisions and is likely to come to harm, be homeless and be in a very vulnerable situation.

(e) Presently the appellant is not well enough to leave the hospital. The appellant was certainly not well enough to be discharged into the community. The appellant is not even allowed to have escorted leave within the hospital grounds and is locked inside the Mental Health Unit.

(f) Dr Scott agrees that there has been a clear deterioration in the appellant's mental health in the last two years. There has been an overall functional gradual decline with more frequent and more severe symptoms over a two-year period where she has never had a full remission.

[47] Dr Scott explained at the hearing that schizophrenia is a chronic relapsing illness. Dr Scott further explained that the more a person experiences periods of untreated psychosis or sub-optimally treated psychosis will result in more cognitive and functional decline.

[48] Further Dr Scott explained that where a patient, who has long periods of untreated psychosis, becomes immured and more or less habituated to that lower functioning, then their ability to imagine an improved mental state is diminished.

[49] Dr Scott stated that treatments, like ECT, can try and avoid such deterioration for patients.

The appellant's views, wishes and preferences

[50] I have taken the appellant's views, wishes and preferences into account.

[51] The appellant has been consistently clear that she does not want ECT.

[52] Dr A's clinical report dated 3 February 2023 states that the appellant does not wish to have ECT:

> "She believes she is "fine in the head" and is suitable for discharge, although she was observed to be actively responding to unseen stimuli on the ward and seemed guarded.
>
> Multiple attempts were made by treating team on "better days" to discuss treatment
>
> [The appellant] maintained that she does not wish to have ECT."

[53] The tribunal set out the appellant's view, wishes and preferences and stated that:

> "The patient was very clear in her self-report to the Tribunal that she acknowledged she has a mental illness but that she wanted a second opinion. The tenor of the self-report was that she opposed treatment with ECT. Throughout the course of the hearing, she interrupted frequently noting to have pressured and rapid speech and was tangential. She had difficulty following direction and generally was highly elevated. She tried to explain how she was Munchausen by proxy and had early onset Alzheimer's. She opposed to ECT saying "I already have Alzheimer's and could be problem for me". Again, in the course of the hearing, the patient stated on a number of occasions that she was the golden-girl, was highly intelligent and did not use drugs or alcohol. She persisted with her opposition to an approval.
>
> In a discussion regarding an Advanced Health Directive there was no evidence that the patient had an Advanced Health Directive and the patient mentioned that if she did, she wanted it revoked. She was not sure whether she had one but does not want her family involved."

[54] The appellant reiterated her strong opposition to having ECT to Dr Scott. She is concerned that the ECT would affect her memory and cognition:

> "I think ECT is draconian. I don't want to have that done to my brain. I look at people here who've had it and they look vacant, catatonic … I've noticed that a lot of patients here in this mental health unit get ECT which concerns me. I think there is an over-representation of psychiatrists who order ECT for patients here. I'm highly intelligent. [The appellant referred to her academic achievement] …"

[55] Dr Scott explained to the appellant that there is considerable research showing that ECT treatment for her particular mental illness was effective and that long-term side effects like memory loss were usually not significant. However, the appellant reiterated that she would not consider having ECT.

[56] At the hearing, Dr Scott confirmed that the appellant told him that she had not been provided a good explanation of ECT by her treating team. However, he noted that this was not consistent with the clinical notes which suggest that, on a number of

occasions, her treating team have discussed ECT with the appellant and tried to reassure her about the likelihood of complications of ECT.

What is required before ECT can be performed?

[57] ECT is a regulated treatment that can be effective for some types of mental illness, including severe depressive illness. It involves the application of a minimal electric current to specific areas of a patient's head to produce changes in the brain's electrical activity.[5]

[58] As ECT is a regulated treatment under the Act[6] sections 235 to 237 define the circumstances in which it can be performed.

[59] Section 509 of the Act sets out the criteria (**the section 509 criteria**) that must be satisfied before the tribunal can give approval for the performance of ECT:

> "**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—

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5 Explanatory notes to the *Health and Other Legislation Amendment Bill 2021*, at page 5.

6 Section 232 of the *Mental Health Act 2016* (Qld).

(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; and

(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."

[60] It follows from section 509 that if the person is able to give informed consent, but does not consent, then ECT cannot be approved. That is the position that the appellant advances in this case.

[61] The requirements for informed consent are set out in section 233 of the Act:

"**233 Requirements for informed consent**

(1) A person gives ***informed consent*** to the person's treatment by regulated treatment only if—

(a) the person has capacity to give consent to the treatment; and

(b) the consent is in writing signed by the person.

(2) For subsection (1)(a), the person has capacity to give consent to the treatment if the person has the ability to—

(a) understand the nature and effect of a decision relating to the treatment; and

(b) freely and voluntarily make the decision; and

(c) communicate the decision.

(3) A person can give informed consent in an advance health directive."

[62] Importantly, before a person gives informed consent to ECT they must be given a full explanation about the nature and effect of the treatment.

"234 Explanation to be given

Before a person gives informed consent to the person's treatment by regulated treatment, the doctor proposing to provide the treatment must give the person a full explanation, in a form and language able to be understood by the person, about—

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

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

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

(d) the consequences of not receiving treatment."

[63] Accordingly, this explanation, which must be provided by the doctor, provides context as to whether the person has the ability to understand the nature and effect of a decision relating to ECT treatment as set out in 233 (2) (a) of the Act.

[64] The section 509 criteria are the result of significant amendment by the *Health and Other Legislation Amendment Act 2022* (No 1 of 2022) and the explanatory notes set out the position prior to 1 July 2022:[7]

> "The Mental Health Act provides that a medical practitioner requires the MHRT's approval to perform ECT on an adult who is unable to give informed consent to the treatment. Before approving the performance of ECT, the MHRT must:
>
> - consider the views, wishes and preferences expressed by the person about the therapy in an Advance Health Directive, and
> - be satisfied:
>   - the therapy is in the person's best interests;
>   - there is evidence supporting the effectiveness of the therapy for the person's particular mental illness; and
>   - if the therapy has previously been performed on the person, the therapy has been effective for the person.
>
> The current test does not require the MHRT to take into account the views, wishes and preferences of an adult who is unable to give informed consent to the treatment unless they are expressed in an Advance Health Directive. It also does not require the MHRT to specifically consider the adult's capacity to provide informed consent to the therapy. Additionally, the 'best interests' test is considered a less rights-based approach which may not promote a person's participation in making decisions about their treatment compared with other approaches that require consideration of the person's views, wishes and preferences together with an 'appropriateness' element such as a 'clinical merit' test."

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7 Explanatory notes to the *Health and Other Legislation Amendment Bill 2021*, at pages 5 – 6.

[65] The explanatory notes then go on to make it clear that the object of the present statutory scheme is to enhance the protections for persons with mental illness who cannot consent to ECT or who may have specific vulnerabilities in relation to providing consent which warrants additional oversight.[8]

[66] The section 509 criteria now adopt a more rights-based approach, including by removing the 'best interests' test for adults and specifically requiring consideration of an adult's capacity to provide informed consent, where relevant.[9]

[67] As the explanatory notes explain that this will also better support decision makers in complying with their obligations under the *Human Rights Act 2019* (Qld) **(HRA)**.[10]

[68] The section 509 criteria will also better support a person to participate in decisions and are considered to promote a person's right to recognition and equality before the law.[11]

[69] The appellant is presently an involuntary patient under the Act under a treatment authority. However, this does not alter the requirements of informed consent as provided by section 233 of the Act.

[70] It should be noted that the legislature has purposely distinguished between the meaning of capacity in relation to receiving treatment under the Act, and the capacity to give consent to ECT.

[71] The meaning of capacity to consent to be treated under the Act (for non-regulated treatments) is not the same as capacity to give consent to ECT, and the former is set out in section 14 of the Act:

> "**14 Meaning of capacity to consent to be treated**
>
> (1) A person has ***capacity*** to consent to be treated if the person—
>
> (a) is capable of understanding, in general terms—
>
> (i) that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing; and

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8 Explanatory notes to the *Health and Other Legislation Amendment Bill 2021*, at page 6.
9 Explanatory notes to the *Health and Other Legislation Amendment Bill 2021*, at page 6.
10 Explanatory notes to the *Health and Other Legislation Amendment Bill 2021*, at page 6.
11 Human Rights Statement of Compatibility to the *Health and Other Legislation Amendment Act 2022* (Qld), at page 4.

(ii) the nature and purpose of the treatment for the illness; and

(iii) the benefits and risks of the treatment, and alternatives to the treatment; and

(iv) the consequences of not receiving the treatment; and

(b) is capable of making a decision about the treatment and communicating the decision in some way.

(2) A person may have capacity to consent to be treated even though the person decides not to receive treatment.

(3) A person may be supported by another person in understanding the matters mentioned in subsection (1)(a) and making a decision about the treatment.

(4) This section does not affect the common law in relation to—

(a) the capacity of a minor to consent to be treated; or

(b) a parent of a minor consenting to treatment of the minor."

[72] The Act acknowledges that capacity may fluctuate, which is a factor to take into account when determining when a treatment authority must be revoked:

"**421 Requirement to revoke treatment authority**

(1) On a review of a treatment authority, the tribunal must revoke the authority if the tribunal considers—

(a) the treatment criteria no longer apply to the person subject to the authority; or

(b) there is a less restrictive way for the person to receive treatment and care for the person's mental illness.

(2) However, subsection (1) does not apply if the tribunal considers the person's capacity to consent to be treated for the person's mental illness is not stable.

Example of when a person's capacity to consent is not stable—

the person gains and loses capacity to consent to be treated during a short time period."

[73] However, the test for capacity that is applied to regulated treatments, including ECT, is decision and time specific and is distinct from the test for capacity that applies to involuntary treatment provided under a treatment authority.[12]

[74] Therefore, as the explanatory notes make clear, the Act provides that a person may be placed on a forensic order or treatment support order by the Mental Health Court following an unlawful act, on the basis the order is necessary to protect the safety of the community. However, a person under a treatment authority may be assessed as having capacity to consent to ECT even though they may be assessed, at the same time, as not having capacity to consent to other non-regulated treatments, such as psychotropic medications:[13]

> "The Mental Health Act provides that a person may be placed on a forensic order or treatment support order by the Mental Health Court following an unlawful act, on the basis the order is necessary to protect the safety of the community. A forensic order or treatment support order provides for, among other things, the involuntary treatment and care of a person with a mental illness. While persons on these orders may lack capacity, this is not a particular consideration of the Court when making the order.
>
> …
>
> Although patients on forensic orders or treatment support orders may therefore have capacity to make treatment decisions, including decisions about ECT, the high level of monitoring and specific requirements attached to the treatment provided under their orders may make them susceptible to providing consent under the mistaken belief they are required to undergo ECT as a condition of their order.
>
> To provide additional protection to people subject to involuntary orders, and improve safeguards for the rights of individuals under the Human Rights Act, it is proposed that for persons subject to a treatment authority, forensic order or treatment support order, the MHRT should be satisfied that the person has both been given appropriate information about ECT and has given informed consent."

[75] As the explanatory notes also make clear, if a person under an involuntary order has the capacity to provide informed consent and declines to undergo ECT, the tribunal will be required to respect their decision. If a person on an involuntary order does not have capacity, the test for approving the performance of ECT will be the same for other adults who do not have capacity to provide informed consent.[14]

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12 Explanatory notes to the *Health and Other Legislation Amendment Bill 2021*, at page 6.
13 Explanatory notes to the *Health and Other Legislation Amendment Act*, at page 7.
14 Explanatory notes to the *Health and Other Legislation Amendment Act*, at page 7.

The *Mental Health Act 2016* (Qld) and the *Human Rights Act 2019* (Qld)

[76] Relevantly, in relation to this appeal, one of the main objects of the Act is to improve and maintain the health and wellbeing of persons who have a mental illness who do not have the capacity to consent to be treated.[15] This to be achieved in a way that:

(a) safeguards the rights of persons; and

(b) is the least restrictive of the rights and liberties of a person who has a mental illness; and

(c) promotes the recovery of a person who has a mental illness, and the person's ability to live in the community, without the need for involuntary treatment and care.[16]

[77] The Act recognises the least restrictive practices should always be adopted in respect of patients. The least restrictive way is if it adversely affects the person's rights and liberties only to the extent required to protect the person's safety and welfare or the safety of others.[17]

[78] Any person performing a function or exercising a power under the Act must have regard to[18] a number of principles which apply in relation to a person who has, or may have, a mental illness[19] which relevantly for this appeal include:

> "**(a) Same human rights**
>
> - the right of all persons to the same basic human rights must be recognised and taken into account
> - a person's right to respect for his or her human worth and dignity as an individual must be recognised and taken into account
>
> **(b) Matters to be considered in making decisions**
>
> - to the greatest extent practicable, a person is to be encouraged to take part in making decisions affecting the person's life, especially decisions about treatment and care

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15 Section 3 (1) (a) of the *Mental Health Act 2016* (Qld).
16 Section 3 (2) of the *Mental Health Act 2016* (Qld).
17 Section 3 (3) of the *Mental Health Act 2016* (Qld).
18 Section 7 of the *Mental Health Act 2016* (Qld).
19 Section 5 of the *Mental Health Act 2016* (Qld).

- to the greatest extent practicable, in making a decision about a person, the person's views, wishes and preferences are to be taken into account
- a person is presumed to have capacity to make decisions about the person's treatment and care and other matters under this Act

(c) Support persons

- to the greatest extent practicable, family, carers and other support persons of a person who has a mental illness are to be involved in decisions about the person's treatment and care, subject to the person's right to privacy

(d) Provision of support and information

- to the greatest extent practicable, a person is to be provided with necessary support and information to enable the person to exercise rights under this Act, including, for example, providing access to other persons to help the person express the person's views, wishes and preferences

(e) Achievement of maximum potential and self-reliance

- to the greatest extent practicable, a person is to be helped to achieve maximum physical, social, psychological and emotional potential, quality of life and self-reliance

(f) Acknowledgement of needs

- a person's age-related, gender-related, religious, communication and other special needs must be recognised and taken into account
- a person's hearing, visual or speech impairment must be recognised and taken into account

(g) Aboriginal people and Torres Strait Islanders

- the unique cultural, communication and other needs of Aboriginal people and Torres Strait Islanders must be recognised and taken into account
- Aboriginal people and Torres Strait Islanders should be provided with treatment, care and support in a way that recognises and is consistent with Aboriginal tradition or Island custom, mental health and social and emotional wellbeing, and is culturally appropriate and respectful
- to the extent practicable and appropriate in the circumstances, communication with Aboriginal people and Torres Strait Islanders is to be assisted by an interpreter

(h) Persons from culturally and linguistically diverse backgrounds

- the unique cultural, communication and other needs of persons from culturally and linguistically diverse backgrounds must be recognised and taken into account
- services provided to persons from culturally and linguistically diverse backgrounds must have regard to the person's cultural, religious and spiritual beliefs and practices
- to the extent practicable and appropriate in the circumstances, communication with persons from culturally and linguistically diverse backgrounds is to be assisted by an interpreter

…

(j) Maintenance of supportive relationships and community participation

- to the greatest extent practicable, the importance of a person's continued participation in community life and maintaining existing supportive relationships are to be taken into account, including, for example, by providing treatment in the community in which the person lives.

(k) Importance of recovery-oriented services and reduction of stigma

- the importance of recovery-oriented services and the reduction of stigma associated with mental illness must be recognised and taken into account.

(l) Provision of treatment and care

- treatment and care provided under this Act must be provided to a person who has a mental illness only if it is appropriate for promoting and maintaining the person's health and wellbeing.

(m) Privacy and confidentiality

- a person's right to privacy and confidentiality of information about the person must be recognised and taken into account."

[79] In my view, the objects and principles of the Act are compatible with HRA despite being expressed in slightly different terms.[20]

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20 See *Attorney-General for the State of Queensland v GLH* [2021] QMHC 4.

[80] I note that section 13 of the HRA sets out that a human right "may be subject under law only to reasonable limits … in deciding whether a limit on a human right is reasonable and justifiable, a number of factors may be relevant". One of those factors is whether there are any less restrictive and reasonably available ways to achieve that purpose.[21] Such a position is also built into the how the Act's objects are to be achieved.[22]

[81] In making a decision to approve ECT a number of human rights are engaged including:

(a) the right to recognition and equality before the law;[23]

(b) the right to privacy;[24]

(c) the right to liberty and security of person;[25]

(d) the right to humane treatment when deprived of liberty;[26] and

(e) the right to access health services without discrimination.[27]

[82] Further section 17 (c) of the HRA provides that a person must not be subjected to medical or scientific experimentation or treatment without the person's full, free and informed consent.

[83] These considerations raised by the HRA are consistent with the Act's objects and the principles that must be applied when performing a function or power under the Act.

What does the ability to understand the nature and effect of a decision relating to ECT mean?

[84] This appeal concerns whether the appellant is able to give informed consent to ECT as required by section 509 (2) (a) (i).

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21 Section 13 of the *Human Rights Act 2019* (Qld).
22 Section 3 (2) of the *Mental Health Act 2016* (Qld).
23 Section 15 of the *Human Rights Act 2019* (Qld).
24 Section 25 of the *Human Rights Act 2019* (Qld).
25 Section 29 of the *Human Rights Act 2019* (Qld).
26 Section 30 of the *Human Rights Act 2019* (Qld).
27 Section 37 (1) of the *Human Rights Act 2019* (Qld).

[85] Section 233 of the Act sets out the requirements for informed consent and an issue for this appeal is whether the appellant has the ability to understand the nature and effect of a decision relating to ECT.

[86] The Chief Psychiatrist submits that to have the "ability to ... understand the nature and effect of a decision relating to the treatment" in terms of section 233 (2) (a), a person:

(a) must be able to understand that they are making a decision about whether or not to have ECT as a treatment option (the nature of the decision); and

(b) must be able to have at least some basic understanding that ECT is being proposed because the person's doctor considers that it is a treatment that can be effective for their particular mental condition and may be beneficial for them (the effect of the decision).

[87] Section 233 (2) (a) has not been previously considered in a published judgment in Queensland.

***Adamson v Enever & Anor* [2021] QSC 221**

[88] The *Guardianship and Administration Act 2000* (Qld) defines capacity in almost identical terms as section 233 of the Act:

> "**Capacity**, for a person for a matter, means the person is capable of –
>
> (a) understanding the nature and effect of decisions about the matter; and
>
> (b) freely and voluntarily making decisions about the matter; and
>
> (c) communicating the decisions in some way"

[89] In *Adamson v Enever & Anor* [2021] QSC 221 (**Adamson**), Applegarth J explained the meaning of the limb "understand the nature and effect of decisions" in relation to the *Guardianship and Administration Act 2000* (Qld):

> "[43] The Capacity Guidelines explain that the adult needs to be able to understand the information that is relevant to the decision, including the options and their consequences. It is sufficient for the adult to have a 'basic understanding of the key features' of that information, but for this criterion to be met, more complex decisions require more understanding.

> [44] The adult must also be able to retain the relevant information. This may only be for a short period, provided the period is long enough for the adult to make a decision. Also, the adult must have the ability to broadly identify the advantages and disadvantages of the available options and to understand the consequences of those options, then weigh those consequences and reach a decisions."

[90] Applegarth J drew heavily on the Queensland Capacity Assessment Guidelines prepared under section 250 of the *Guardianship and Administration Act 2000* (Qld) to assist people required to make assessments about the capacity of adults to make decisions about matters under Queensland's guardianship legislation. These guidelines do not apply to decisions about capacity under the Act. However, in my view *Adamson* is instructive when considering whether a person has the ability to understand the nature and effect of a decision relating to ECT as required by section 233 of the Act.

[91] A number of interstate decision have also considered the issue of consent in relation to their respective statutory schemes.

***PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141**

[92] In the leading Victorian case of *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141 (**PBU and NJE**), Bell J considered the relevance of lack of insight in deciding whether a person has capacity to consent under the *Mental Health Act 2014* (Vic) (**the Victorian Act**) and the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**the Victorian Charter**).

[93] In *PBU and NJE* two patients in separate appeals challenged VCAT orders that they be subjected to ECT. Bell J conducted a comprehensive review of the law relating to involuntary treatment including the specific issues of informed consent, capacity to give consent, the no less restrictive treatment principle, the absence of a best interests test, and the application of the Victorian Charter.

[94] Ultimately, Bell J concluded that the tribunal had misinterpreted and misapplied the statutory test, and upheld the appeals.

[95] The critical issue in *PBU and NJE* was the construction of the statutory test for "capacity to give informed consent" in section 68(1) of the Victorian Act which is a differently worded test to section 233 of the Queensland Act.

[96] Section 68 (1) of the Victorian Act is as follows:

> **"68 Capacity to give informed consent under this Act**
>
> (1) A person has the capacity to give informed consent under this Act if the person-
>
> (a) understands the information he or she is given that is relevant to the decision; and
>
> (b) is able to remember the information that is relevant to the decision; and
>
> (c) is able to use or weigh information that is relevant to the decision; and
>
> (d) is able to communicate the decision he or she makes by speech, gestures or any other means."

[97] Unlike the Queensland Act, this provision is not specific to ECT. However, it is broadly to the same effect. Further the Queensland HRA is modelled on the Victorian Charter and operates in a similar way.

[98] As to the level of understanding required in the test for capacity to consent in Victoria, it is relevant to note that in *PBU and NJE,* Bell J said in paragraph [160]:

> "[160] ... under the Mental Health Act, the test in s 68(1)(a) is whether the person 'understands the information he or she is given that is relevant to the decision'. The ordinary and natural meaning of the word 'understand' is 'perceive the meaning of, 'grasp the idea of or 'comprehend'. In that provision, I think the level of understanding intended is only a general kind of understanding that relates to the nature, purpose and effect of the treatment ..."

[99] In paragraph [280], Bell J said:

> "[280] It is enough that the person, like most people, is able to make and communicate a decision in broad terms as to the general nature, purpose and effect of the treatment."

[100] I note that this approach appears to be consistent with the way in which *Adamson* considered the statutory test for capacity to make decisions in the Queensland *Guardianship and Administration Act 2000* (Qld).

[101] In *PBU and NJE*, Bell J made a number of observations specifically about PBU's circumstances:[28]

> "[9] … Extensive medical evidence was given, including by PBU's treating psychiatrist and the clinical director of the Mental Health Service for the Northern Area. This evidence, which was carefully reviewed by VCAT, was that ECT was the only currently available appropriate treatment for PBU, that his mental state was slowly deteriorating, that he had refused to take Clozapine, and that only ECT would allow him to become well enough to engage in his treatment and improve sufficiently to leave hospital.
>
> …
>
> [13] VCAT ... accepted the contention of the clinical director that PBU did not have capacity because he did not accept the diagnosis of schizophrenia in relation to him:
>
> > I find that, as at the hearing date, he did not have capacity to give informed consent to whether ECT should be performed in circumstances where he did not accept the diagnosis for which the treatment was intended to be given. PBU has consistently disputed the diagnosis and the suggestion that ECT might be beneficial for him.
>
> VCAT expressed its conclusion at this level of generality. There is no discussion in the reasons for decision of how PBU's refusal to accept the diagnosis of schizophrenia related to his ability to remember and weigh and use information and communicate his decision.
>
> …
>
> [279] In the case of PBU, the central error of law was that VCAT determined that he did not have the capacity to give informed consent because he did not accept or believe, or have insight into, the diagnosis of his mental illness. For various personal, social and medical reasons, it is not uncommon for persons having mental illness and persons not having mental illness to deny or diminish their illness and the need for treatment. In both cases, lack of acceptance, belief or insight may be relevant when determining whether a person has the capacity to give informed consent, but it is only one consideration. It would be discriminatory to treat this consideration as determinative in relation to people having mental illness when it is not determinative in relation to people not having mental illness. In fact, PBU did accept that he had a mental illness for which he needed non-ECT treatment, but VCAT gave this little weight."

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28 *PBU & NJE v Mental Health Tribunal and Others* (2018) 56 VR 141, at [9], [13], and [29].

[102] As to the level of understanding required in the test for capacity to consent in Victoria, it is relevant to note that in *PBU and NJE,* Bell J said:[29]

> "[23] VCAT found that NJE met the criteria in paras 68(1)(a), (b) and (d):
>
> > I was satisfied that NJE had an understanding about ECT treatment as described in section 68 of the MHA in that she could understand the information, could remember it and could communicate her wishes and her anxieties.
>
> It is reasonable to infer that VCAT accepted that, in doing so, NJE understood that ECT was a procedure that would result in her having seizures and that she was concerned that it may cause her to have memory problems, as her legal representative submitted. It is reasonable to infer that, in doing so, VCAT also accepted the submission made for NJE that her preferred alternative to ECT was remaining in hospital for an extended period and the trialling of alternative medications, possibly Clozapine.
>
> [24] However, VCAT found under s 68(1)(c) that NJE could not use and weigh information relevant to the decision:
>
> …
>
> [25] VCAT ... accepted the evidence of Dr A that additional attempts to discuss, or provide more written information about, ECT only aggravated NJE. VCAT found that '[i]t was not that NJE did not understand but rather that she could not be persuaded that the information was relevant to her'.
>
> …
>
> [27] NJE's strongly and consistently expressed view and preference, of which VCAT made note, was to remain in hospital and continue to receive depot and oral medication. VCAT said that it gave weight to the medical evidence that 'ECT was the only treatment that has a chance to address both positive and negative symptoms' of NJE's schizophrenia.
>
> …
>
> [280] In the case of NJE, the central error of law was that VCAT determined that she did not have the capacity to give informed consent because she had not actually given careful consideration to the advantages and disadvantages of ECT. To have the capacity to give informed consent, it is not required of persons having mental illness, nor of persons not having mental illness, that they give, or are able to give, careful consideration to the advantages and disadvantages of

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29 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141, at [23] – [27], and [280].

> the treatment. It is not required that they make, or are able to make, a rational and balanced decision in relation to the decision. It is enough that the person, like most people, is able to make and communicate a decision in broad terms as to the general nature, purpose and effect of the treatment. Personal autonomy and the dignity of the individual are at stake. A person does not lack the capacity to give informed consent simply by making a decision that others consider to be unwise according to their individual values and situation. To impose upon persons having mental illness a higher threshold of capacity, and to afford them less respect for personal autonomy and individual dignity, than people not having that illness, would be discriminatory."

[103] In relation to the relevance of a person having a lack of insight into their mental illness, Bell J considered this issue and stated:[30]

> "[194] Insight into one's diagnosis and need for treatment varies significantly between different persons and between the same persons in different situations. Insight is potentially affected in nature and degree by various non-capacity influences, including educational background, language proficiency, familiarity with medical issues and family and social relationships (negative and positive) and (often critically) the availability of appropriate support. For these reasons, it is but one of the factual considerations that may be relevant when assessing capacity to give informed consent. As disability law scholars have written:
>
> > A lack of insight may impact a person's ability to understand [or use or weigh] relevant information, but the presence or absence of insight is not a proxy for the presence or absence of decision-making capacity. Insight is an extremely complicated phenomenon that is rarely either simply present or absent. Various aspects of insight - such as insight into diagnosis, insight into the presence or veracity of phenomenology and insight into the need for treatment - may all vary independently. This, in combination with the requirement that a person only needs to understand information that is relevant to the decision being made, means that while a lack of insight may suggest a lack of decision making capacity, this deficit alone will rarely be determinative."
>
> (citations omitted)

[104] His Honour concluded:

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30 At pages 198-203, [183] - [198].

> "[198] In conclusion, it may be accepted that the presence of delusional thinking and irrational fears is 'capable of depriving a person of capacity. The question is whether it does'. So may it be accepted that lack of belief or insight in respect of a mental illness or need for treatment may be capable of suppo1iing a finding of incapacity. The question is whether it does. This means giving due consideration to a relevant fact, not (in effect) applying a determinative normative criterion."
>
> (citations omitted)

[105] Bell J said that the test for capacity to consent in the Victorian Act reflects the "functional approach"[31] which asks "whether, at the time the decision had to be made, the person could understand its nature and effects", rather than the "status approach"[32] or the "outcome approach".[33]

[106] Bell J made it clear that in determining whether a person has the capacity to give informed consent to have ECT there is no room for a paternalistic or beneficial approach:[34]

> "[167] … One can understand the natural human tendency of health professionals and judicial officers, among others, to make decisions in the best interests of vulnerable persons, especially where treatment for grievous ill-health, or even the person's life, is at stake. It has been described as the 'protection imperative'.
>
> [168] However well intentioned, such a paternal or beneficial approach is not part of the common law test of capacity and was rejected when the functional approach was adopted ... as now reflected in s 68(1) of our Mental Health Act."
>
> (citations omitted)

[107] Bell J concluded[35] in relation to the two appeals that VCAT misinterpreted and misapplied the statutory test in the Victorian Act "in ways that undermined PBU and NJE's human right to self-determination, to be free of non-consensual medical treatment and to personal inviolability which are protected by the *Charter of Human*

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31 As explained by Baroness Hale in the House of Lords in *R v Cooper* [2009] 1 WLR 1786.

32 The 'status approach': excluded all people with a particular characteristic from a particular decision, irrespective of their actual capacity to make it at the time. *R v Cooper* [2009] I WLR 1786 per Baroness Hale at 1789.

33 The 'outcome approach': focused on the final content of the decision: a decision which is inconsistent with conventional values or with which the assessor disagreed might be classified as incompetent. *R v Cooper* [2009] 1 WLR 1786 per Baroness Hale at 1789.

34 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141, at [167] – 168].

35 At 225 [276].

Rights and Responsibilities Act".[36] His Honour explained the basis of that conclusion:[37]

> "[279] In the case of PBU, the central error of law was that VCAT determined that he did not have the capacity to give informed consent because he did not accept or believe, or have insight into, the diagnosis of his mental illness …
>
> [280] In the case of NJE, the central error of law was that VCAT determined that she did not have the capacity to give informed consent because she had not actually given careful consideration to the advantages and disadvantages of ECT. To have the capacity to give informed consent, it is not required of persons having mental illness, nor of persons not having mental illness, that they give, or are able to give, careful consideration to the advantages and disadvantages of the treatment. It is not required that they make, or are able to make, a rational and balanced decision in relation to the decision. It is enough that the person, like most people, is able to make and communicate a decision in broad terms as to the general nature, purpose and effect of the treatment."

[108] The decision in *PBU and NJE* has been applied in VCAT decisions and been the subject of commentary.[38] Clearly each case depends on its own facts.[39]

***TSC v Department of Health and Wellbeing* [2021] SASCA 93**

[109] In *TSC v Department of Health and Wellbeing* [2021] SASCA 93[40] (**TSC**) the Court of Appeal of South Australia gave careful consideration to *PBU and NJE,* noting the differences in the applicable statutory tests.

[110] In South Australia, section 5A (2) of the *Mental Health Act 2009* (SA) provides:

> "**5A-Decision-making capacity**
>
> (1) ...
>
> (2) For the purposes of this Act, a person will be taken to have impaired decision-making capacity in respect of a particular decision if-

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36 *PBU and NJE v Mental Health Tribunal and Others* (2018) 56 VR 141, at 225 [276].

37 At 226 [279]-[280].

38 Ian Freckelton QC, "Electroconvulsive Therapy, law and human rights", 2019 *Psychiatry, Psychology and Law,* Vol 20(l), pp 1-20.
Bernadette McSherry, "Electroconvulsive Therapy without Consent; The Influence of Human Rights Law", 2019 *Journal of Law and Medicine*, Vol 26(4), pp 732-736.

39 *YLY v Mental Health Tribunal (Human Rights)* [2019] VCAT 1383 (the Tribunal set aside the decision to approve ECT); *XJY v Mental Health Tribunal (Human Rights)* [2021] VCAT 83 (The Tribunal confirmed the decision to approve ECT).

40 At [22] – [41].

(a) the person is not capable of-

(i) understanding any information that may be relevant to the decision (including information relating to the consequences of making a particular decision); or

(ii) retaining such information; or

(iii) using such information in the course of making the decision; or

(iv) communicating his or her decision in any manner."

[111] Once again, like the Victorian legislation, this provision is not specific to ECT.

[112] The Court of Appeal noted that a question of capacity will be fact and context specific:[41]

> "[40] A question of capacity for the purpose of s 16(1)(c) will be fact-and context specific. While the capacity test does not admit of extraneous considerations, such as the 'best interests' of the person, that does not mean that incapacity cannot be proved, on the evidence, by reference to various considerations depending on the circumstances. Different factors may contribute to the conclusion, one way or the other. We endorse the observation by the Tribunal in *GKK v Department of Health and Ageing*:
>
> > 'Insight or acceptance of the fact of a mental illness is clearly a significant factor in assessing whether a person has impaired decision making capacity as to the need for treatment for a mental illness. A failure by a person to accept that they are suffering from a mental illness may consequently lead to a conclusion that the person has impaired decision-making capacity as to the appropriate treatment for their mental illness.'
>
> [41] On the other hand, depending on all of the circumstances, it may not."

[113] The Court of Appeal concluded that it was open on the facts of that case to conclude that TSC lacked the capacity to consent to treatment for his mental illness. The case was not concerned with ECT.

[114] The Court of Appeal endorsed the principles stated by Bell J in *PBU and NJE,* although it noted that "the absence of legislation in South Australia containing the interpretive commands of the Victorian Charter".[42]

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41 *TSC v Department of Health and Wellbeing* [2021] SASCA 93, at [40] – [41].

42 *TSC v Department of Health and Wellbeing* [2021] SASCA 93, at [33].

[115] The tribunal's decision appears to have been largely based on the fact that TSC did not accept his diagnosis of schizophrenia or the need for treatment, but the Court of Appeal noted[43] that the tribunal had taken into account the totality of the evidence and concluded[44] that TSC's "psychotic condition has clouded his judgment".

Summary of principles in relation to informed consent and section 233 (2) (a) of the Act

[116] One of the main objects of the Act is to improve the health and wellbeing of persons who have a mental illness who do not have the capacity to consent to be treated. This must be achieved in a way that:

(a) safeguards the rights of persons; and

(b) is the least restrictive of the rights and liberties of a person who has a mental illness; and

(c) promotes the recovery of a person who has a mental illness, and the person's ability to live in the community, without the need for involuntary treatment and care.[45]

[117] Persons who have, or may have, a mental illness have the same human rights as persons who do not have a mental illness and this must be recognised and taken into account. A person's right to respect for his or her human worth and dignity as an individual must be also recognised and taken into account.[46]

[118] To the greatest extent practicable:

(a) a person is to be encouraged to take part in making decisions affecting the person's life, especially decisions about treatment and care; and

(b) in making a decision about a person, the person's views, wishes and preferences are to be taken into account.[47]

[119] The Act rejects the best interest paradigm in relation to decisions about requiring people to have ECT and requires consideration of the person's views, wishes and

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43 *TSC v Department of Health and Wellbeing* [2021] SASCA 93, at [48] and [59]-[63].
44 *TSC v Department of Health and Wellbeing* [2021] SASCA 93, at [62].
45 Section 233 (2) (a) of the *Mental Health Act 2016* (Qld).
46 Section 9 of the *Mental Health Act 2016* (Qld).
47 Section 5 of the *Mental Health Act 2016* (Qld).

preferences together with an 'appropriateness' element such as a 'clinical merit' test. This is a fundamental change which must be acknowledged by those considering whether the section 509 criteria apply to a person. For example, I note that Dr C's latest report on 27 March 2023, still considers whether the performance of ECT is in the person's best interest. This is wrong.

[120] In relation to determining whether a person can understand the nature and effect of a decision relating to ECT the following matters are relevant:

(a) Capacity to give consent to ECT must be established on the balance of probabilities. No party bears the onus of proof of any matter.[48]

(b) A person has capacity to give informed consent to ECT if they have the ability to:

(i) understand the nature and effect of a decision relating to the treatment; and

(ii) freely and voluntarily make the decision; and

(iii) communicate the decision.[49]

(c) The starting point is that a person is presumed to have capacity to make decisions about the person's treatment and care.[50]

(d) The test for capacity applied to regulated treatments, including ECT, is decision and time specific and is distinct from the test for capacity that applies to involuntary treatment provided under a treatment authority.

(e) Therefore, a person under a treatment authority may be assessed as having capacity to consent to ECT even though they may be assessed, at the same time, as not having capacity to consent to other non-regulated treatments, such as psychotropic medications.

(f) If a person under an involuntary order has the capacity to provide informed consent and declines to undergo ECT, then this decision must be respected.

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48 Section 685 of the *Mental Health Act 2016* (Qld).
49 Section 233 of the *Mental Health Act 2016* (Qld).
50 Section 5 (c) of the *Mental Health Act 2016* (Qld).

(g) In order to have the capacity to provide informed consent a person needs to be able to understand the information that is relevant to the decision, including the options and their consequences. This information must be provided to the person before a person gives informed consent to ECT.

(h) Accordingly, section 234 of the Act requires that before a person gives informed consent to ECT, they must be given a full explanation (in a form and language able to be understood by the person) about:

(i) the purpose, method, likely duration and expected benefit of the 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) the consequences of not receiving treatment.[51]

(i) This explanation informs the context of whether the person has the ability to understand the nature and effect of a decision relating to ECT.

(j) Accordingly, the doctors' explanations about these matters, the circumstances in which they were given, and the person's response should be recorded in the material so that they can be considered and assessed.

(k) Based on this information, the person in general terms must have the ability to identify the advantages and disadvantages of the available options and to understand the consequences of those options, then weigh those consequences and reach a decision.

(l) A person must be able to:

(i) understand that they are making a decision about whether or not to have ECT as a treatment option (the nature of the decision); and

(ii) have at least some basic understanding that ECT is being proposed because the person's doctor considers that it is a treatment that can be

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[51] Section 234 of the *Mental Health Act 2016* (Qld).

effective for their particular mental condition and may be beneficial for them (the effect of the decision).

(m) To have the capacity to give informed consent to ECT, it is not required of persons having mental illness, nor of persons not having mental illness, that they give, or are able to give, careful consideration to the advantages and disadvantages of the treatment.[52]

(n) It is not required that a person makes a rational and balanced decision in relation to their decision. It is enough that the person, like most people, be able to make and communicate a decision in broad terms as to the general nature and effect of the treatment.[53]

(o) The capacity test must be applied in a non-discriminatory manner so as to ensure that people with mental illness are not deprived of their equal rights to exercise legal capacity upon the basis of contestable value judgments relating to their illness, decisions of behaviour, rather than upon the basis of the neutral application of the statutory criteria as set out in section 233 of the Act.[54]

(p) In short, the test is not to be applied so as to produce social conformity at the expense of personal autonomy.[55]

(q) A person's right to make decisions includes the right to take risks and make bad decisions.

(r) Those assessing capacity under section 233 of the Act must not assume that because the person is not accepting ECT, in circumstances when they objectively should, then they do not have the ability to understand the nature and effect of a decision relating to ECT.

(s) Those assessing capacity under section 233 of the Act must "vigilantly ensure that the assessment is evidence based, patient-centred, criteria focused and non-judgemental, and not made to depend, implicitly or explicitly, upon identification of a so called objectively reasonable outcome".[56]

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52 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141, at [279] – [280].
53 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141, at [279] – [280].
54 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141, at [206 (4)].
55 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141, at [206 (7)].
56 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141, at [206 (6)].

(t) Section 233 of the Act 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.[57] However, such an assessment may be relevant in considering whether the person has the ability to understand the nature and effect of a decision relating to ECT treatment.

(u) Acceptance of, belief in and insight into the diagnosis of illness and need for treatment varies significantly depending upon the person and the situation.[58]

(v) A lack of insight may impact 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.[59]

(w) A lack of insight into a person's metal illness may be capable of supporting that a person does not have the ability to understand the nature and effect of a decision relating to ECT. The question is whether it does. This means giving due consideration to a relevant fact, not (in effect) applying a determinative normative criterion.[60]

(x) Depending upon the facts of the case, a person with mental illness may lack insight or otherwise not accept or believe that they have a mental illness or needs ECT treatment yet may have the capacity to give informed consent when assessed under section 233 of the Act. The opposite may also be so.

(y) Accordingly, those assessing capacity under section 233 of the Act should not assume that because a person lacks insight into their mental illness they therefore lack capacity to provide informed consent. Further explanation is required as to how this lack of insight affects the person's ability to understand the nature and effect of a decision relating to ECT.

(z) Accordingly, thus assessing capacity under section 233 of the Act must set out the reasons why any lack of insight affects the person's ability to understand the nature and effect of a decision relating to ECT.

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57 cf. section 14 (1) (a) of the *Mental Health Court Act 2016* (Qld) – The meaning of capacity to consent to be treated.

58 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141 at [207 (8)]

59 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141 at [194]

60 *PBU and NJE v Mental Health Tribunal* (2018) 56 VR 141.

(aa) The presence of thought disorder[61] or psychotic thinking clouding the person's judgment[62] or delusions about treatment, may lead to the conclusion that the person does not have the capacity to consent.

(bb) However, there is a not a one size fit all approach. A question of capacity for the purpose of section 233 of the Act will be fact and context specific.

The appellant's submissions

[121] The appellant's counsel submits that the appellant has been engaging with the process as required by the Act and weighing up information given to her about the treatment. The appellant's counsel highlights the following matters:

(a) The appellant accepts that she has a mental illness and she told Dr Scott she was first diagnosed with what she described as "textbook paranoid schizophrenia".

(b) The appellant does not want ECT because she is concerned that it will cause memory and cognition problems. The appellant has observed what ECT has done to other people in the Mental Health Unit and that they look vacant and catatonic.

(c) The appellant would prefer to have psychotherapy or psychoanalysis instead of taking medications which all have side effects.

(d) In terms of therapies that have been shown to be effective as "stand-alone" treatment for schizophrenia, the appellant referred to a book entitled *Psychotherapy of Schizophrenia: The Treatment of Choice* (which was written by Bertram Karon and Gary van den Bos and first published in 1977).

(e) The appellant's plan is to not have ECT and wait to eventually get discharged.

[122] The appellant's counsel states that that these matters indicate that the appellant has been weighing up information about ECT treatment and that her reasoning has some form of logic, or connection, to real life and is not delusional.

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61 For example, *XJY v Mental Health Tribunal (Human Rights)* [2021] VCAT 83.
62 For example, *TSC v Department of Health and Wellbeing* [2021] SASCA 93.

[123] To this end, reference was made to the Administration of Electroconvulsive Therapy Guideline which acknowledges that cognitive risks are a "major source of concern for persons undergoing treatment", and that cognitive effects, including effects on memory, are risks of ECT.

[124] Accordingly, the appellant's counsel submits that it cannot be said that the appellant does not understand the nature and effect of the decision, even in circumstances where she does have disordered thought. Whilst others may not think the appellant's decision is not rational – that is not the test.

[125] The appellant's counsel emphasises that a person is not found to be lacking the capacity to give informed consent simply by making an unwise decision. Further, lack of insight does not mean that the appellant cannot provide informed consent per se. Although, the appellant's counsel acknowledges that lack of insight is a relevant factor to take into account.

[126] Accordingly, the appellant's counsel submit that the appellant understands the nature and effect of a decision relating to ECT treatment.

Consideration

[127] In this case, the appellant did not at the time of the tribunal hearing have the ability to understand the nature and effect of a decision relating to the treatment of ECT.

[128] Dr A in his clinical report, accompanying the ECT application dated 3 February 2023, set out that that the appellant continued to display psychotic symptoms with poor insight into her mental illness despite admission since September 2022 and had been prescribed with two depot antipsychotics for a sustained period of time.

[129] Relevantly, Dr A noted that the treating team had not been able to engage in meaningful discussion regarding ECT, including its risk and benefit, on her better days.

[130] Dr G's second opinion performed on 10 February 2023 stated that he found the appellant lying on her bed, refusing to talk, showing paranoid themes and formal thought disorder with no insight.

[131] I note that the appellant informed Dr Scott that the treating team had not provided her with any information about ECT. However, Dr Scott states that the clinical notes show otherwise.

[132] The appellant's belief. as to the lack of information provided to her, is consistent with the reports of Dr A where he states that the treating team has not been able to engage in meaningful discussion with the appellant regarding ECT on her better days.

[133] In my view the tribunal could not conclude that appellant had the ability to understand the nature and effect of a decision relating to the treatment.

[134] The tribunal found that she was not able to give informed consent:

> "The presenting consultant was of the view that given that the patient had continuing psychotic symptoms, persecutory delusions and mood symptoms including being elevated at times and disorganised in the context of a long-standing psychotic and affective disorder. Additionally, that she did not property have the capacity to consider the benefit of the treatment or the consequences of not proceeding with it.
>
> Overall, having regard to the opinion of the presenting psychiatrist and the patient's presentation at the hearing the Tribunal were satisfied that the person did not have capacity to give consent."

[135] Dr Scott's independent assessment then found that the appellant had no intellectual insight into the complexity of her chronic relapsing mental illness and its effects on her mood, thoughts and behaviours.

[136] Dr Scott was of the view that as the appellant demonstrates no insight into her chronic mental illness or her need for treatment, the appellant did not have capacity to consent to treatment for her chronic mental illness.

[137] At the hearing, Dr Scott strongly reiterated that the appellant does not understand the effect of her decision to not have ECT, because she doesn't have insight into her illness at all:

> "[The appellant] doesn't recognise the symptoms of her mental illness. She doesn't understand that her particular symptoms relate to having a psychotic illness. She doesn't understand that she has a need for treatment for her specific mental illness. She also doesn't understand that she's had treatment trials of medication which have not been effective. And, therefore, the treatment – the optimal treatment for her mental illness is to have ECT treatment. So there is a number of – a

> number of aspects to her lack of insight, but she has a profound lack of insight because she doesn't recognise any of those features of what we call insight into illness.
>
> …
>
> [The appellant] doesn't have an understanding of her mental illness and doesn't understand that her particular mental illness is characterised by the symptoms that she exhibits. She doesn't understand that, having had a number of trials of oral antipsychotic medication which have not been effective, that the optimal treatment for her is ECT. She has no insight into the fact that without treatment and without recovery, she's not likely to be discharged from the Mental Health Unit."

[138] In his evidence at the hearing, Dr Scott posed this rhetorical question: "How can you refuse to have a treatment for an illness that you don't recognise you have?"

[139] Dr Scott's point was that if a patient does not have insight into their illness and does not recognise they have an illness, then they do not have capacity to either accept or refuse treatment for that illness.

[140] In my view, at times, Dr Scott's evidence had a flavour of the best interest approach; although he disavowed such an approach:

> "I mean, I suppose it's semantics, but do you recognise that there are rights recognised– sorry – there are rights that are set out in the Human Rights Act that, on one view, are engaged, but is it your opinion that her fundamental right – what you called her fundamental right to treatment overrides those?---Not – not overrides them. So there are – are certainly a number of rights that ought to be observed, and I've listed those, and I agree that patient autonomy now is seen to be a fundamental right. But that right is in equal status to a number of other rights, and the most significant right that we should be considering in this case is her right to have evidence-based treatment so that she can recover from her illness and enjoy all the other rights that she currently is denied, that is, the right to autonomy, the right to privacy, all the things that we – we often pay lip service to, but we don't – we don't actually acknowledge in a patient who's detained, suboptimally treated on a mental health unit after many months.
>
> Okay. Thank you. So is this a correct way of summarising it? Is it your opinion that her best interests from a medical and psychiatric point of view is the overriding factor in – when it comes to the question of whether has – she has the capacity to consent?---No. Well, I – I wouldn't use that term, best interest. I'm sure I'll be admonished if I use that legal term. But what I'm saying is that there are a number of rights, and patient autonomy is – is a fundamental right. It has equal status to other rights, and one of those rights is to have evidence-based

> treatment for an illness so that you can recover and enjoy all the other rights. So it's not a matter, necessarily, of best interests. It's about which rights ought be recognised in this particular case of a – a mentally unwell woman who is confined to a mental health unit."

[141] Those assessing capacity under section 233 of the Act must not assume that because the person is not accepting ECT in circumstances when they objectively should, then they do not have the ability to understand the nature and effect of a decision relating to ECT.

[142] It cannot be the case that because the appellant refuses the best treatment available then she is taken to not have the ability to understand the nature and effect of her decision relating to ECT; even if such a decision condemns her to being locked in a mental health unit with a prognosis of deteriorating mental health.

[143] However, in my view, the appellant does not have the ability to understand the nature and effect of a decision relating to the ECT treatment.

[144] The appellant suffers from chronic paranoid schizophrenia. I note that at the time of Dr Scott's assessment, the appellant demonstrated no clear disorder of thought form (the connectedness of her thoughts). Her thought content consisted of paranoid and grandiose themes and her comments about her parents particularly her father was likely to be delusional. Dr Scott noted that the appellant may have been self-censoring her account for the purposes of the court-ordered assessment.

[145] The appellant denied any violent or intentional self-injury ideation to Dr Scott. The appellant specifically denied any abnormal percepts or passivity phenomena and she did not appear pre-occupied or distracted during the assessment.

[146] However, all of the reports assessing the appellant's mental state note her lack of insight. Dr Scott states that the appellant's judgement was chronically impaired. She demonstrated no insight into her chronic mental illness or her need for treatment.

[147] Whilst the appellant acknowledges that she has paranoid schizophrenia, Dr Scott states that that the appellant cannot give an explanation about the actual features and implications of her illness:

> "I'm sure that the appellant has had many discussions with many treating psychiatrists over the short period of her life where she would acknowledge or say that, "I have paranoid schizophrenia." But that –

> that is a very easy and glib thing to say. When you inquire of the actual features of her illness and what the implications of her illness are, that's where [the appellant] can't give you that explanation.
>
> So one of the things that she believed was that her father was a paedophile, that her parents were not her real parents, she was Anglo-Irish, indigenous, that she was raised by a man who, at the age of four, was recruited as a sniper during World War II. Those are indications of her psychotic thought content. So even though she says, "I have paranoid schizophrenia." She also believes that the things that she describes as her thoughts are not psychotic thoughts. So clearly, that there's a disconnect. Although she says she has paranoid schizophrenia, she doesn't actually recognise that she has paranoid schizophrenia."

[148] In my view this lack of insight fundamentally affects her ability to understand the nature and effect of a decision relating to the treatment.

[149] Further her refusal to have ECT is in circumstances where the treating team, due to her illness, have not been able to have meaningful discussions with the appellant regarding ECT including its risk and benefit. This was the position as at the tribunal hearing.

[150] The appellant states that she has not been provided any information about ECT. However, Dr Scott states that the clinical notes show otherwise. In my view, the appellant's lack of knowledge of being provided an explanation about ECT is due to her mental illness.

[151] Dr Scott confirmed the appellant is an intelligent woman and at an academic level the appellant can understand the information provided to her. However, he reiterated that:

> "She can listen to the information but she's not receptive to that information because she doesn't believe that ECT will be good for her because she doesn't believe she has a mental illness."

[152] Accordingly, I accept that the appellant has no insight into the complexity of her chronic relapsing mental illness and its effects on her mood, thoughts and behaviours. This lack of insight into her chronic mental illness or her need for treatment affects her ability to understand the nature and effect of a decision to give consent to the treatment of ECT.

[153] The appellant does not have the ability (in general terms) to identify the advantages and disadvantages of the available options and to understand the consequences of those options, then weigh those consequences and reach a decision.

The appropriateness of ECT

[154] Once I am satisfied that the appellant is not able to provide informed consent to ECT, I then need to consider the matters set out in section 509 (4):

(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; and

(c) if the therapy has previously been performed on the adult—of the effectiveness of the therapy for the adult.

[155] Section 509 of the Act sets out the criteria that must be satisfied before the tribunal can give approval for the performance of ECT. Accordingly, the Mental Health Court on an appeal may approve the performance of ECT only if satisfied of the same matters, and may give approval on the same basis.

[156] In this case the appellant states that section 509 (4) (a) is not satisfied as ECT is not appropriate in the circumstances because there remains an alternative to ECT that should be explored, being another trial of clozapine.

[157] The appellant's counsel instructs that she would consider treatment by clozapine. She is aware that she has had a previous, unsuccessful trial of clozapine, as she reported to Dr Scott.

[158] Clozapine has previously been trialled on the appellant. However, she had an adverse reaction, namely severe leucopenia.

[159] In his progress notes dated 8 November 2022, Dr G noted that a clozapine rechallenge could be considered "as a last option".

[160] No emergency ECT has been performed on the appellant. On 6 March 2023, Dr C recorded that "the treating team doesn't consider the ECT to be an urgent intervention".

[161] Dr Scott gave evidence about commencing another trial of clozapine at the hearing:

> "And just finally, Dr Scott, she's previously been – had a trial on clozapine but she suffered adverse side effects. Would you consider it appropriate for another effort be – that another effort be made to treat her with clozapine?---Well, every treatment has risks and benefits and it's almost a matter of weighing up the risks and benefits. Certainly, the option of a retrial or a rechallenge with clozapine is one option. It is not without risks and there are side effects to clozapine. It requires a lot of patient cooperation because when you begin someone on clozapine, you have got to take weekly investigations, you have got to do blood tests. But also, you have to have a patient accept the medication, so take the medication. And the risk is that [the appellant] could very easily disrupt the trial of clozapine by just refusing to either take her medication or agree to have the investigation of the blood test, the ECG. So it can be very problematic when you're dealing with a patient who has poor insight in a trial of clozapine because it very quickly can be aborted and you're back to square one.
>
> And sorry, there was just one other question. When clozapine is administered, is it correct that it's closely monitored for side effects?---Yes. So it has a number of quite serious side effects. They're uncommon side effects. But because they're – they're quite serious side effects, particularly, in the early phase where a trial of clozapine patients are very closely monitored. But, as I say, the difficulty is that you require the patients' cooperation, firstly, to take the medication and then to cooperate with the investigations. And if the patient either stops taking the medication or refuses to cooperate with the investigations and the trial is aborted."

[162] Assisting Clinician Dr Iqbal asked Dr Scott at the hearing about other alternative treatment lines that could be pursued, rather than ECT:

> "Certainly there's – there are other – other antipsychotics that [the appellant] hasn't been trialled on yet. So theoretically, she – she could be tried on all the alternatives – a combination of the alternatives, yes."

[163] In relation to commencing clozapine treatment again, Dr Scott re-iterated that:

> "And just repeating, perhaps, one of the questions which have been asked, but retrial with clozapine, as you've mentioned, yes, there are risks. She was having neutropenia. She's on lithium now, and your views around that – that – like, is a retrial a consideration of that reasonable approach?---So the treating team obviously have considered that as an option. They are concerned that not only are there considerable serious side effects to clozapine, but it requires the patient's cooperation. And as I say, the fact that [the appellant] on two depot antipsychotic medications suggests that the – the treating team would not be confident that [the appellant] would persist with a trial of clozapine. And as we know, it's a major effort to, firstly, start a trial of clozapine, the – to work up the investigations that are required to be done and then the monitoring, and then that also relies on the patient actually taking the medication. At any stage in a retrial of clozapine, [the appellant] could just say, "Well, I'm not going to take it anymore," and, therefore, the trial would be aborted."

[164] Assisting Clinician Dr Sundin, does not favour a retrial of clozapine or alternative anti psychotics:

> "HER HONOUR: But if it's available and she does not want ECT, should it not be considered?
>
> DR SUNDIN: Well, normally - - -
>
> HER HONOUR: And there is going to be negative consequences - - -
>
> DR SUNDIN: Well, not if the negative consequences outweigh the potential positive benefits and the doctors have gone through the decision-making pathway and decided that the negative consequences do outweigh the potential benefits. I would say, for example, someone who's on two neuroleptics plus lithium is at high risk for neuroleptic [indistinct] syndrome. That's a real risk for someone in this situation. So then to add in a third anti-psychotic or some other form of psychotropic only further increases the risk to her physical health and wellbeing. And doctors are always driven by the golden rule first, do no harm. So I know it was [indistinct] about this idea of let's try another anti-psychotic. No, I'm sorry, that's – that's beyond this court's remit. That's up to the treating team."

[165] Assisting Clinician Dr Iqbal disagrees with this position:

> "DR IQBAL: … I fully appreciate, very respectfully, what Doctor Sundin has said about – that the guidelines have been followed. The reports don't actually substantiate that. There have been – she's been given [indistinct] and [indistinct] I don't know for what duration. And the guidelines also would suggest that if a treatment isn't effective then you discontinue that. You go to another one. The numerous second generation anti-psychotics which haven't been tried either. So there's a gap over there – I'm not saying that they haven't been tried. What I'm saying is that the evidence presented – in some ways, I was thinking that if we had perhaps taken evidence from Doctor [C], and perhaps even from the patient as well, some of those issues could have been clarified. But the evidence before us, in my mind, doesn't fully substantiate that.
>
> My hunch is that that would have been tried, but it's a hunch. It's not evidence, and I think that, going back to the reports of Doctor [A] and in fact, my question to Doctor Scott was, 600 milligrams of [indistinct] that's not the peak dose of it. [indistinct] milligrams of zuclopenthixol, even Doctor [G] in his second opinion mentions, increase it to 300 milligrams and then if there is no improvement – and 300 milligrams, I might be corrected but I trained in the UK where 600 milligrams up to a week has been prescribed. Not fortnightly, 600 a week. So duration and dosing seems to me lacking – at least in the evidence provided. Six months duration would like to see a lot more activity and consideration in that regard.

I think that there are a couple of things which I'm speculating now, completely. It's this notion that when people – so she's improved to the extent that she can go on to [indistinct] and having worked in [X], that's the less troubled ward. She spent a good chunk of time sitting over here without being agitated or whatever. So there's evidence of improvement, and you feel that you might be playing Jenga if you start pulling out something and everything comes tumbling down, and I get that. But it's not substantiated, is my point. Now, going to the second, sort of chunk. So I've put down - - -

HER HONOUR: What do you say – what do you say is not substantiated?

DR IQBAL: That enough has been done in terms of the treatment. So if they're put down with [indistinct] had been tried, 120 milligrams for three weeks, no effect. We went onto this, to this. Just a few. At least three or four, it would have been good. Or even an increase in the zuclopenthixol, despite the sort of NMS possibility. Absolutely agreed. But there was a second opinion, there was a recommendation. Do this and then go onto the next step and then it would be supported. Saying that, I'm also putting my clinical hat completely separate, which says, I completely understand why we would want to – totally agree with that. There are a couple of other things ---

…

So I've made the argument around what I think the – and I think that clozapine would be a way forward. I think having a retrial, and from a clinical point of view, you go through that – so you go through the company who usually have their own haematologist who can advise you. That provides a degree of safety, but consideration of it – and if it turns out not to be the case, then maybe it gets referred to the tribunal again. And then they said, "Well, all avenues have been exhausted." Well, that bit that it's the last resorted treatment, I'm just not satisfied. It may very well have been the case. I'm not convinced from the evidence that has been provided.

Just, probably what I wanted to say, was these are contentious areas where there are finely balanced arguments on both sides. At this point in time, I would have loved that if Dr [C] could say, "Look, we've tried [indistinct] at a higher dose, we've written to the clozapine people and they're saying definitely not, this is going to kill her."

…

The reason why I asked about the lithium was that sometimes with leukopenia on a second trial people with lithium can boost up the blood cell counts and that's, at least in England, was a common practice to do that. But whether there were alternatives that could be considered. And if they had said all of that, I probably would have been saying, "Look, if the evidence is very clear that everything has been considered, this is the last resort treatment and a final [indistinct] that they did refer this lady to the extended inpatient service."

> And there would be quite a few people of very similar symptomatology as perhaps any institution would who stay there for a lot longer and maybe this relapsing and remitting cause of illness takes its course to the point where they become partially improved where they can be discharged or they just get fed up with being here and think that maybe a new epoch in my life should begin. I don't know if any of my thoughts have been helpful, your Honour."

[166] Taking into account the advice given to me by Assisting Clinician Dr Iqbal, I am not satisfied that there are no other alternative treatments available except for ECT.

[167] Dr Iqbal's advice in relation to this matter has materially contributed to my decision.

[168] As Dr Iqbal states there is a lack of evidence about this point. ECT applications should provide comprehensive material as to what medications have been considered and used or not used and the reasons for doing so.

[169] On 29 March 2023, when this matter was adjourned, Assisting Clinician Dr McVie stated that:

> "The written documentation indicates that there's no urgent need for ECT. It's merely the fact that she has this severe treatment resistance psychotic illness that may benefit from ECT, but there's no guarantee that ECT will actually benefit in this case. Secondly, I'd probably like to have more information on when her previous trial of clozapine actually was and whether or not she's been reviewed by a haematologist in relation to the likelihood of recurrence of the leukopenia and neutropenia that she had at that time."

[170] Dr McVie also wanted to know what the appellant's levels of lithium have been over the last few months.

[171] Dr Sundin also noted that at the adjournment application that:

> "I agree with Dr McVie that the opinion of a haematologist would be worthwhile. I have had patients who've had bad side-effects with clozapine on the first instance, but on re-exposure, actually been able to tolerate it. So a haematologist being involved in her care would be very wise."

[172] Dr C stated that he could facilitate these matters. However, no such evidence was placed before the Court.

[173] Accordingly, I am not satisfied that ECT is appropriate in the circumstances.

[174] The Act recognises the least restrictive practices should always be adopted in respect of patients. The least restrictive way is if it adversely affects the person's rights and liberties only to the extent required to protect the person's safety and welfare or the safety of others.[63]

[175] Further investigation needs to be done to investigate to see if clozapine is appropriate or other anti-psychotic medications. It may be that once these investigations are undertaken, and there is evidence that these alternatives are not appropriate, then another application for ECT to be performed on the appellant may be made to the tribunal.

[176] In the circumstances I am not satisfied that section 509 (4) (a) has been satisfied. Accordingly, the application for ECT should be refused.

Orders

1. The appeal is allowed.

2. The tribunal's decision dated 15 February 2023 to approve 12 treatments of electroconvulsive therapy (ECT) over a period of 60 days, which was to commence on the 15 February 2023, is set aside and substituted with the decision that the application for ECT is refused.

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63 Section 3 (3) of the *Mental Health Act 2016* (Qld).