

## Guidelines for ECT hearings and Orders

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## Introduction

1. The *Mental Health and Wellbeing Act 2022* (the Act) requires the Mental Health Tribunal (the Tribunal) to determine whether electroconvulsive treatment (ECT) can be performed on:
  - adult patients (an adult patient is defined as an assessment patient, court assessment patient; temporary treatment patient, treatment patient, security patient or forensic patient) if their authorised psychiatrist considers they do not have capacity to give informed consent
  - voluntary adults if their psychiatrist considers they do not have capacity to give informed consent
  - any young person under the age of 18 (whether they are a patient or receiving treatment on a voluntary basis).
2. These guidelines use the term 'patient' or 'person' to refer to this group collectively and use specific terms such as 'voluntary adult' if referring to only one of them. In addition, the term 'applicant psychiatrist' is used to refer to both authorised psychiatrists or psychiatrists and the specific terms are used if the provision under consideration only refers to one of these applicant types.
3. After the *Mental Health Act 2014* commenced on 1 July 2014, a number of questions arose about the administrative and substantive provisions of the Act relating to ECT. In addition, in November 2018 the Victorian Supreme Court decided the cases of *PBU v Mental Health Tribunal* and *NJE v Mental Health Tribunal* [2018] VSC 564 (referred to in these guidelines as PBU & NJE) and clarified how the ECT provisions of the Act should be interpreted and applied. Many of those questions, as well as the PBU & NJE decision, are also relevant to the ECT provisions in the Act.
4. These guidelines are intended to assist Tribunal users in relation to key issues that arise in practice. However, they do not attempt to cover every aspect of ECT hearings. Instead, the guidelines outline the Tribunal's general approach to:
  - scheduling ECT hearings
  - considering urgent ECT applications
  - determining a person's capacity to give informed consent
  - determining whether there is no less restrictive way for a person to be treated
  - setting the duration of ECT orders
  - determining applications for ECT where the application was received immediately or very soon after the Tribunal refused to grant a previous application for ECT.



## Scheduling ECT hearings

5. The Act requires the Tribunal to list and complete the hearing of an application for the performance of a course of ECT within 5 business days after receiving the application or as soon as practicable after receiving the request if a request for an urgent hearing is made.
6. An applicant psychiatrist may request an urgent hearing of the application if they are satisfied that the course of ECT is necessary as a matter of urgency:
  - (a) to save the life of a person in respect of whom the application is made
  - (b) to prevent serious damage to the health of a person in respect of whom an application is made or
  - (c) to prevent a person in respect of whom the application is made from suffering or continuing to suffer significant pain or distress.<sup>1</sup>
7. When listing and hearing ECT applications, the Tribunal must strike a complex balance. Tribunal processes must be as accessible and responsive as possible. For example, the requirement to seek an ECT order should not unreasonably delay treatment. However, to define the Tribunal's role as simply to handle ECT applications rapidly is not correct. The hearing process must be rigorous rather than instantaneous. The Act clearly obliges the Tribunal to handle ECT applications in accordance with the principles of procedural fairness.<sup>2</sup> This includes allowing reasonable time for a patient and those who support them to be properly notified of a hearing, consider the report that the treating team prepared to support the application and to seek legal advice if they wish. What is reasonable depends on the circumstances of the individual case.

## How does the Tribunal's registry list ECT applications?

8. When an ECT application is received, registry staff ask the mental health service a series of questions about the circumstances involved so that they can consider what is 'as soon as practicable'. These questions are:
  - Does the patient want, and are they able, to attend the hearing?
  - Does the patient want their carer, nominated person or other support person to attend the hearing?
  - Does the patient want a lawyer to represent them at the hearing or to obtain information, non-legal advocacy or a referral from an independent mental health advocate before the hearing?
  - When will the report be prepared and explained to the patient?
  - What is the proposed hearing date?
  - What is the proposed date of first treatment?



- If the application is lodged as urgent what are the reasons, and in particular, is it necessary to:
  - (a) save the life of the patient or
  - (b) prevent serious damage to the health of the patient or
  - (c) prevent the patient from suffering or continuing to suffer significant pain or distress?
- 9. For all applications, the registry will seek to maximise the notice period to allow as much time as practicable for the patient, and any support person or legal representative (if they have one), to prepare for the hearing.
- 10. The registry will also consider the Tribunal's hearing schedule and availability of a Tribunal division, the availability of the treating team, and the availability of the patient, their support persons or legal representative, to attend the hearing.

## Urgent applications

- 11. It is the applicant psychiatrist, and not the Tribunal, who must be satisfied of the existence of one or more of the relevant grounds of urgency before requesting an urgent hearing of an ECT application. This means neither the registry nor the division hearing the application determines that a matter is urgent.

### *The role of the Tribunal registry*

- 12. The registry has strict processing requirements to assist it to decide when to list ECT applications including urgent applications. These processing requirements were revised following the PBU & NJE decision. The judgment emphasises patients' rights and the objectives and principles in the Act that promote participation in decision making.<sup>3</sup>
- 13. In this context the Tribunal's listing processes need to consider patient participation in hearings as well as the urgency of the application. Particular caution is taken in relation to listing hearings on the same day or the day after an application is received.

### *The role of the Tribunal division*

- 14. The fact an application has been lodged as urgent does not limit the Tribunal's inherent power to adjourn an ECT hearing, provided the matter is heard within five business days. For this reason, when hearing an urgent application, if the Tribunal is concerned that the patient has not had enough time to prepare, it is open to the Tribunal to grant a short adjournment.
- 15. In deciding whether to adjourn the hearing, the Tribunal will consider the urgency of the situation as explained by the treating team, and what further preparation the patient intends to undertake during the period of the adjournment.



## Listing an ECT application with a treatment order hearing

16. When an ECT application concerns a person who also requires a hearing about their status as a compulsory patient, the Tribunal will consider whether to list the hearings together.
17. Generally, if an ECT application is made in the first two weeks of a temporary treatment order, the Tribunal will not list the two hearings together. This is because of considerations of procedural fairness. The Tribunal's policies seek to maximise the opportunity for patients to participate in their hearing. In circumstances where a patient is acutely unwell, which can often be the case in the immediate period after a temporary treatment order has been made, they may not be able to participate in a hearing. Allowing further time may mean that a patient is able to participate more fully.
18. In other instances when deciding whether it is appropriate to combine the hearings, the Tribunal will consider:
  - the need to inform participants, in particular patients and their compulsory contacts, about each hearing
  - the impact on all participants if separate hearings are conducted on two different dates in quick succession
  - whether all participants are ready to proceed with both hearings, having regard to the fact that separate clinical reports are required for each hearing
  - whether there is enough time to conduct both hearings
  - whether it is appropriate to dispense with giving written notice for the hearing regarding a treatment order.

## ECT and preparation for ECT should not interfere with patient participation in hearings

19. The Act requires that, when assessing a person's capacity to give informed consent, reasonable steps be taken to conduct the assessment at a time and in an environment in which the person's capacity to give informed consent can be assessed most accurately and that the person being assessed is provided with appropriate supports to enable them to give informed consent.<sup>4</sup> In addition, the rules of procedural fairness require the Tribunal to ensure patients have the opportunity to prepare for the hearing and respond to what is said at the hearing to the extent that is possible in the circumstances. Finally, the PBU & NJE decision emphasises the importance of patients participating in decisions involving their own treatment.
20. For these reasons, it is important that the treating team ensure that the timing of ECT and any necessary medical steps leading up to ECT (such as fasting) minimises any impact on the patient's capacity to provide informed consent to ECT or interfere with their ability to attend and participate in the hearing as actively as possible.



21. If the patient has undergone ECT on the day of the hearing or been required to fast in anticipation of ECT being administered, or there have been other changes or interventions that may impact on a patient's capacity to provide informed consent and/or participate in the hearing, this should be brought to the Tribunal's attention to enable consideration of an adjournment to afford the patient procedural fairness.

## Ongoing relevance of the PBU & NJE decision

22. The PBU & NJE decision was decided when the *Mental Health Act 2014* was in force. The new framework introduced by the *Mental Health and Wellbeing Act 2022* is yet to receive judicial consideration and there are likely to be new legal submissions raised about its operation. However, while there are new mental health and wellbeing principles that the Tribunal must now give proper consideration to, and some changes to the ECT framework in the Act, the criteria the Tribunal must apply in ECT matters for the most part remain the same.<sup>5</sup>
23. For this reason, the Supreme Court's decision in PBU & NJE has ongoing relevance and it is appropriate that the Tribunal and Tribunal users continue to be guided by it. These guidelines will be revised if and when there is fresh judicial consideration of the ECT criteria. In this section for ease of reference, section numbers are from the *Mental Health and Wellbeing Act 2022* rather than the previous Act.

## Determining applications for an ECT order – Capacity to give informed consent

24. Capacity is a key consideration in any ECT application before the Tribunal. In the vast majority of matters the issue is whether the person for whom ECT is being proposed has the capacity to give informed consent. In some matters relating to a young person the issue is whether they have in fact provided informed consent (and to do so they must have capacity).<sup>6</sup>
25. This means before making an application to the Tribunal the applicant psychiatrist must consider and form a view about the person's capacity. The Tribunal then forms its own view taking into consideration the information from the applicant psychiatrist, and what it hears from and observes of the person and anyone supporting or representing them at the hearing.
26. Section 85 contains a rebuttable presumption that a person has capacity to give informed consent. Section 87 sets out the meaning of capacity to give informed consent, including four elements or domains, namely that a person has capacity to give informed consent if they are able to:
  - understand the information they are given for the purpose of deciding whether or not to consent
  - remember that information



- use or weigh that information in deciding whether or not to consent and
  - communicate the decision by speech, gestures or any other means.
27. Section 87(2) sets out *guiding principles* about capacity and these are summarised in the Appendix.

## Applying the Supreme Court's decision on capacity

28. In PBU & NJE, the Supreme Court clarified a number of aspects of the capacity test. Key principles from that decision are summarised below.

### *Capacity test is functional and the threshold is relatively low*

29. Section 87(1) (section 68(1) of the previous Act) applies a functional capacity test: the person must have *an ability* to understand information they are given relevant to the decision as well as *an ability* to remember, use or weigh relevant information and communicate a decision or whether they could with appropriate supports.<sup>7</sup> They do not need to have actually done so.<sup>8</sup>
30. In practice, this distinction may be most relevant to the 'use or weigh' domain of capacity: if a person has the ability to use or weigh relevant information but chooses not to do so, that does not necessarily mean they lack capacity. It is beyond the scope of these guidelines to explore this distinction in detail. It is important to keep it in mind, but it may not be directly relevant wherever a person is able to be engaged in a discussion about their preferences in relation to ECT.
31. A functional test of capacity focuses on *the process of making a decision* rather than *the content of the decision made* and in doing so promotes the principles of the former Act as well as the mental health and wellbeing principles in the current Act, including the dignity of risk: a person does not lack capacity to give informed consent simply by making a decision that others consider to be unwise according to their individual values and situation. The judgment states:

*It is important to determine capacity by reference to the statutory criteria, which are based on the domains of cognitive functioning, not by reference to decisions or behaviours, which give rise to contestable value judgments. Variation in human behaviour is normal and not necessarily a sign of lacking the capacity to give informed consent.*<sup>9</sup>

32. This means if the domains of capacity are intact, a person's decision should not be evaluated. In particular, there is no scope to second guess the way in which a person uses or weighs information.
33. When assessing the presence or absence of each of the domains of capacity, the threshold is relatively low. This reflects the principles of self-determination, to be free of non-consensual medical treatment, personal inviolability and the dignity of the person.



34. A person is not required to give (or be able to give) careful consideration to the advantages and disadvantages of ECT in order to have capacity. Rather, according to the decision:

*It requires the person to have an understanding of and an ability to remember and use or weigh relevant information, and communicate a decision, in broad terms as to the general nature, purpose and effect of the treatment. It does not require the person to have the ability to use or weigh relevant information in every detail but only as to the salient features in those terms.*<sup>10</sup>

### *Appropriate supports*

35. It is a new requirement in the Act that in assessing whether a person has capacity to give informed consent, the person carrying out the assessment must take all reasonable steps to ensure that the person being assessed is provided with appropriate supports to enable the person to give informed consent.<sup>11</sup> Appropriate supports are measures that are intended to assist a person to make decisions and participate in decision making, understand information and their rights and communicate their views, preferences, questions or decision.<sup>12</sup>
36. In reaching its independent determination about whether a person has capacity to provide informed consent the Tribunal will consider whether or not it appears that if a person were provided appropriate supports they may be able to understand, remember, and use or weigh information to decide whether or not to consent to ECT and to communicate their decision.

### *'Insight' and the presence of positive symptoms*

37. The presence of positive symptoms including delusions does not mean a person can be automatically regarded as lacking capacity. Similarly, having insight, or demonstrating agreement, acceptance or appreciation of a diagnosis or of having mental illness is not required for a person to have capacity. The presence of symptoms and/or the absence of insight are factually relevant in an application for an ECT order, but they are not the determinants of capacity.<sup>13</sup>
38. In other words, it is incorrect to decide a person does not have capacity to provide informed consent because they exhibit delusional thinking, or do not think they have a mental illness. However, if it is demonstrated that a person's delusional beliefs are so intense or pervasive, or their lack of appreciation of their current situation is such that they are unable to use or weigh information relevant to the decision about whether or not to have ECT, that can support a conclusion that they do *not* have capacity. According to the judgment the capacity assessment needs to go into the relationship (if any) between the delusion and the ability to use or weigh the relevant information.<sup>14</sup>





### Example

A person who says they wish to refuse ECT on the basis it will 'fry their mind' might have capacity if this seems to be slang or their shorthand description for memory loss rather than a delusional belief. However, if they believe ECT is used to transplant their consciousness into another person this may demonstrate that their symptoms are impairing their understanding of relevant information and their ability to use or weigh it.

## Fluctuating capacity

39. Sometimes a person's capacity to give informed consent can fluctuate. This can lead to uncertainty and complexity about whether the first criterion for an ECT order is satisfied.
40. The Supreme Court has stated that a person's capacity 'may fluctuate in response to variations in the person's health and circumstances' and that a person may be capable of making a decision at some times or in certain circumstances but not in others.<sup>15</sup>
41. The Tribunal must determine whether the patient has capacity to give informed consent *at the time of the hearing*. As noted in the Appendix, section 87(2)(b) provides that in assessing whether a person has capacity to give informed consent, the Tribunal should take into account that a person's capacity to give informed consent may change over time. However, this does not require the Tribunal to make predictions about whether a person may or may not have capacity in the future.
42. Instead, the principle in section 87(2)(b) is reflected in the explicit recognition in the Act that a person may subsequently develop capacity. In such cases any ECT treatment authorised by the Tribunal must stop and the person can choose whether to consent to ECT. The Tribunal may also follow the principle in section 87(2)(b) by taking into account a person's history when making an assessment of the person's capacity. A person's history (for example, of being able to understand information even when it may initially appear they do not) may be relevant to the Tribunal's determination.

## Fluctuating capacity and changing one's mind

43. A person changing their mind, even when they do so multiple times, must not automatically be regarded as lacking capacity – the two things are distinct. People with capacity do change their mind – and in some cases this can in fact demonstrate that they are using or weighing relevant information. The direction in PBU & NJE that capacity is not determined according to the content of a decision is also highly relevant. When a person changes their mind, treating their initial or subsequent position as the capacity-based decision risks preferring or judging one decision as right and the other as wrong.
44. As with the presence of positive symptoms or the absence of insight, the fact that a person may frequently change their mind is not by itself determinative of whether they have capacity. However, it can be a relevant factual consideration. The question is whether frequent changes of mind are indicative of a mental state where one or more of the domains of capacity is impaired.



### *Fluctuating capacity over the course of an ECT order*

45. Sometimes, following a Tribunal hearing at which the Tribunal makes an ECT order, the patient's capacity fluctuates. They may develop capacity and refuse to consent to ECT at that time, but later they may again lose the capacity to give informed consent to ECT. The Tribunal is sometimes asked whether the applicant psychiatrist can rely on the ECT order the Tribunal made before the patient regained (and then lost) the capacity to give informed consent.
46. The answer is no. The Act states that the course of ECT ends at the earliest of a list of events one of which is that the person regains the capacity to give informed consent to ECT.<sup>16</sup> This means the applicant psychiatrist must make a new application to the Tribunal and cannot rely on a previous ECT order to perform ECT.

### **Determining applications for an ECT order – No less restrictive way for the person to be treated**

47. The Supreme Court in PBU & NJE also considered the second criterion the applicant psychiatrist must consider before applying for ECT and that the Tribunal must consider in determining ECT applications, namely: that there is no less restrictive way for the person to be treated.
48. In determining whether there is no less restrictive way for a person to be treated, the applicant psychiatrist must, to the extent that it is reasonable in the circumstances, have regard to various factors set out in the Act and summarised more fully in the Appendix. The factors listed in the Act include both subjective and objective considerations and include the following.
  - The views and preferences of the patient in relation to ECT (including in any advance statement of preferences) and any beneficial alternative treatments that are reasonably available and the reasons for those views or preferences, including any recovery outcomes the person would like to achieve.
  - The views of various other persons depending on whether the person is an adult patient, a voluntary adult or a young person. Such persons include the nominated support person (or medical treatment decision maker or support person in the case of voluntary adults), any guardian and carers if the Tribunal is satisfied that a decision to perform a course of ECT will directly affect the carer and the care relationship.
  - The likely consequences for the patient if ECT is not performed and any second psychiatric opinion.
49. There is no explicit or implicit requirement for the Tribunal to consider these factors. Instead, it is open to the Tribunal to satisfy itself that there is no less restrictive way for a person to be treated by considering such factors as it sees fit.
50. However, the Tribunal must exercise its discretion in the context of the objectives and purposes of the Act, as well as the principles of administrative law. On this basis, the



factors applicant psychiatrists must consider provide useful guidance for the kinds of matters that the Tribunal may wish to consider in its determination. While its discretion is not limited to considering these factors, the Tribunal is likely to look to these factors as guidance in making a determination.

## The purpose of the no less restrictive test: a paradigm shift away from the best interests model

51. The purpose of the no less restrictive test is to ensure that treatment is provided in a manner that respects human rights. According to the PBU & NJE judgment, the test is a paradigm shift away from the 'best interests' model of decision making and respects to a much greater degree the person's right to self-determination, to be free of non-consensual medical treatment and to personal inviolability.<sup>17</sup> It is intended to promote participation and supported decision making and, where possible, to incorporate recovery as an important therapeutic purpose in a holistic consideration of the person's health.<sup>18</sup>

## No less restrictive test involves considering broad range of factors, not just medical factors

52. The no less restrictive test involves considering a broad range of factors. Deciding whether there is no less restrictive way for the person to be treated is not simply a medical matter or a question of whether ECT is clinically the best treatment. Rather, the statutory intention is that the person's views and preferences which reflect their values, life experience and relationships in a wider sense (not just medical but social and psychological)<sup>19</sup> are included in a holistic consideration of the issue. Importantly, the Tribunal must have regard to the views and preferences of the patient to the extent that is reasonable in the circumstances *even where they have been found to lack capacity to give informed consent*.<sup>20</sup>
53. However, a person's self-determination, health and medical treatment are interrelated.<sup>21</sup> In PBU & NJE, Justice Bell also emphasised that the provisions of the Act are predicated on the 'central purpose of ensuring that persons with mental illness have access to and receive needed medical treatment consistent with the person's right to health.'<sup>22</sup> This means where the criteria under the Act are met, an ECT order is a necessary means of ensuring that patients are given that treatment and that their right to health is respected.<sup>23</sup>
54. It follows that medical or clinical considerations must also be weighed in the balance when determining whether there is no less restrictive way for the person to be treated. Medical and related considerations may include (but are not limited to) the following:
  - the state of the person's health and the severity of their symptoms
  - whether alternative treatments have been tried and have failed to treat the person's mental illness
  - whether the person's illness is resistant to alternative treatments (such as antipsychotic medication)



- whether alternative forms of treatment will introduce undesirable delay in alleviating or reducing the person's symptoms or ill-effects of illness noting the person's views of such delay will be important. For instance, some patients may prefer to be in hospital for longer and trial different medications rather than receive ECT and possibly be discharged sooner
  - the severity of the physical, mental and social side effects of previous ECT on the person (an alternative treatment option that produces significantly fewer debilitating side effects could be seen as less intrusive, and accordingly, less restrictive)
  - the severity of side effects or other restrictive elements of alternative treatments (for example, blood tests associated with some medication types)
  - whether the person's illness is likely to deteriorate without immediate ECT.
55. The PBU & NJE decision clarified that the no less restrictive test is not limited to treatment that is immediately necessary to address a serious deterioration in health or serious harm to the person or another person (the compulsory treatment criterion in section 143(b) of the Act). That is, the requirement does not mean the patient can only be treated to a minimum threshold or receive the minimum necessary treatment. The test is intended to ensure the provision of treatment in a manner that respects the human rights of patients, not to reduce the standard of care that a doctor must provide.<sup>24</sup>
56. Finally, maintaining the current treatment may be the least restrictive way for the person to be treated.<sup>25</sup>

## Duration of ECT orders

57. If the Tribunal grants an application for an ECT order, the order the Tribunal makes must specify the maximum number of authorised ECT treatments (up to 12) and the duration of the ECT order (up to 6 months).
58. In the case of compulsory patients, the Tribunal may consider it preferable to set the duration of an ECT order so that it aligns as closely as possible with the duration of the underlying treatment order or temporary treatment order. There are two main reasons for this. First, having expiry dates on all compulsory orders is about emphasising to patients that their compulsory status is for a specific period of time and will not extend beyond that unless another hearing regarding their compulsory status is held. There is a risk that an ECT order extending beyond a treatment order or temporary treatment order expiry date may dilute or confuse this by inadvertently suggesting that the Tribunal considers the person is going to be a compulsory patient for longer. Secondly, ensuring ECT orders do not extend beyond the date of the underlying order usually makes it more likely that all matters arising in relation to a patient will be dealt with at once and thereby reduces the possibility of a person having to have multiple hearings within a short period of time.



59. Despite this, the Tribunal may at its discretion set a duration for an ECT order that is longer than the duration of the underlying order. Importantly, if the underlying order to which a patient is subject is revoked or expires, the Act specifically provides that the course of ECT ends.<sup>26</sup> This means that ECT cannot be administered in reliance on that ECT order. This is because when an underlying order is revoked or expires the person is no longer a 'patient' within the meaning of the Act. Conversely, if during the life of an ECT order, the underlying order is replaced with another order in an unbroken chain of orders the person does not stop being a patient and the ECT order will continue to have effect.

## **Application for ECT order shortly after the refusal of an ECT application**

60. Sometimes an applicant psychiatrist may make a new application for ECT within a short period of a Tribunal hearing at which a previous application for ECT was refused. This is permitted under the Act which implicitly recognises that circumstances can change quickly and significantly.
61. The second division will be aware of the decision of the earlier division; however, it is not bound by it. Rather, the Tribunal's task is to consider whether the ECT criteria are met (in which case it must make an ECT order) or not met (in which case it must make an order refusing ECT).
62. The decision and reasons of the earlier division may be relevant in the following circumstances.
- If the application was refused on the basis that a less restrictive means of treatment was available and the fresh application was made before this other means of treatment had been attempted, the reasons for this will likely be explored in the second hearing.
  - If an application was refused because the person had capacity. The treating team would need to have a clear explanation regarding which domain of capacity was now impaired, and the basis of this conclusion.
63. However, even in these situations the new Tribunal division must reach its own decision on the material before it.
64. For the avoidance of doubt, it is not a pre-condition to an application being lodged that the treating team establish a change in circumstances. However, it is highly likely this will be a subject of inquiry in the determination of the second application.



## APPENDIX - Summary of relevant provisions of the Act

### Criteria applying to different types of ECT applications

65. For adult patients, the Tribunal may only approve ECT if it is satisfied that:<sup>27</sup>
- the patient does not have capacity to give informed consent to ECT and
  - there is no less restrictive way for the patient to be treated.
66. For a young person aged under 18 (young person) who is a compulsory patient, the Tribunal may only approve ECT if it is satisfied that the young person:<sup>28</sup>
- has given their informed consent in writing to receiving the course of ECT or
  - does not have capacity to give informed consent to the course of ECT and
  - there is no less restrictive way for the young person to be treated.
67. For a young person who is receiving treatment on a voluntary basis, the Tribunal may only approve ECT if it is satisfied that the voluntary young person:<sup>29</sup>
- has given their informed consent in writing or
  - does not have capacity to give informed consent to receiving the course of ECT and
    - the young person's medical treatment decision maker has given informed consent in writing to the course of ECT and
    - there is no less restrictive way for the young person to be treated.
68. For voluntary adults,<sup>30</sup> the Tribunal may only approve ECT if it is satisfied that:<sup>31</sup>
- the voluntary adult does not have capacity to give informed consent and
  - there is no less restrictive way for the voluntary adult to be treated and either
    - the voluntary adult has an instructional directive giving informed consent to ECT or
    - the person does not have an instructional directive giving consent to ECT and the voluntary adult's medical treatment decision maker gives informed consent in writing to ECT.



## Summary of factors to consider when determining capacity to give informed consent (section 87)

69. The following must be considered in deciding whether a person has capacity to give informed consent:<sup>32</sup>
- (a) the person's capacity to give informed consent is specific to the particular decision that the person is making
  - (b) the person's capacity to give informed consent may change over time
  - (c) it should not be assumed that the person does not have the capacity to give informed consent only because of the person's age, appearance, disability, condition or behaviour
  - (d) it should not be assumed that the person does not have capacity to give informed consent only because the person makes a decision that could be considered unwise
  - (e) whether the person may be enabled to give informed consent by providing the person with appropriate supports.
70. When assessing a person's capacity to give informed consent, the person carrying out the assessment must take all reasonable steps to ensure that:<sup>33</sup>
- (a) the assessment is carried out at a time, and in an environment, that the capacity of the person being assessed can be determined most accurately and
  - (b) the person being assessed is provided with appropriate supports to enable the person to give informed consent.

## Factors that the applicant psychiatrist must consider and that the Tribunal may consider in deciding whether there is no less restrictive way to treat a person

71. In determining whether there is no less restrictive way for an adult patient to be treated, the Tribunal may<sup>34</sup> have regard to the considerations the authorised psychiatrist is required to have regard to as set out in section 99(2) of the Act:
- (a) the patient's views and preferences regarding ECT and any beneficial alternative treatment that is reasonably available, and the reasons for those views or preferences, including any recovery outcomes the patient would like to achieve
  - (b) any of the patient's relevant views and preferences specified in their advance statement of preferences (if any)
  - (c) any of the patient's relevant views and preferences expressed by the patient's nominated support person
  - (d) the views of the patient's guardian



- (e) if the authorised psychiatrist is satisfied that the decision will directly affect the carer and the care relationship, the views of the patient's carer,
- (f) whether the ECT is likely to remedy or lessen the symptoms of mental illness
- (g) the likely consequences for the patient if ECT is not administered
- (h) any second psychiatric opinion that has been given to the authorised psychiatrist.

71. The factors for young people are the same with the addition of:<sup>35</sup>

- If the young person is under the age of 16 years, the views of the young person's parent,
- In the case of voluntary young people, the views of the young person's support person (if any); any relevant values directive given by the young person and the views of the young person's medical treatment decision maker
- if the DFFH Secretary has parental responsibility for the young person under a relevant child protection order, the views of that Secretary

72. The factors for voluntary adults are:<sup>36</sup>

- (a) the person's views and preferences regarding ECT, and any beneficial alternative treatment that is reasonably available, and the reasons for those views and preferences, including any recovery outcomes the person would like to achieve
- (b) any relevant values directive given by the person
- (c) the views of the person's medical treatment decision maker
- (d) the views of the person's guardian (if any)
- (e) the views of the person's support person (if any)
- (f) if the psychiatrist is satisfied that the decision will directly affect the carer and the care relationship, the views of the person's carer
- (g) whether the ECT is likely to remedy or lessen the symptoms of mental illness;
- (h) the likely consequences for the person if ECT is not performed
- (i) any psychiatric opinion given by another psychiatrist that has been given to the psychiatrist making the application.

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<sup>1</sup> Section 97(2).

<sup>2</sup> Section 362(1)(b).

<sup>3</sup> *PBU v Mental Health Tribunal and NJE v Mental Health Tribunal* [2018] VSC 564, [67]. As Justice Bell put it: *'Together with the operative provisions of the Mental Health Act, the objectives and principles are intended to alter the balance of power between medical authority and persons having mental illness in the direction of respecting their inherent dignity and human rights.'*

<sup>4</sup> Section 87(3).





<sup>5</sup> One change is that section 87(1)(a) now only requires that the person be able to understand the information they are given for the purposes of deciding whether or not to consent rather than that they actually understand this information. This means the legal test for capacity is now purely a functional one.

<sup>6</sup> In addition, in some cases involving voluntary adults, the Tribunal must decide whether the voluntary adult's medical decision maker has given informed consent in writing to ECT.

<sup>7</sup> Section 87(2)(e) of the Act distinguishes the capacity test from that under the *Mental Health Act 2014*, in that the Tribunal is now to have regard to whether a person would have capacity to give informed consent, with access to appropriate supports.

<sup>8</sup> PBU & NJE, above n. 3, [206] (3).

<sup>9</sup> *Ibid*, [242].

<sup>10</sup> *Ibid*, [235].

<sup>11</sup> Section 87(3)(b).

<sup>12</sup> Section 6. See section 6 for examples of appropriate supports.

<sup>13</sup> *Ibid*, [194], [206](8).

<sup>14</sup> *Ibid*, [242].

<sup>15</sup> *Ibid* [149]. The judgment notes *'this is recognised in s68(2)(b), which provides that 'a person's capacity to give informed consent may change over time.'*

<sup>16</sup> See section 102(2)(c) for adult patients, section 107(2)(d) for adults who are not patients, section 112(2)(d)(i) for young patients and section 117(2)(d)(i) for young people who are not patients.

<sup>17</sup> *Ibid*, [252].

<sup>18</sup> *Ibid*.

<sup>19</sup> *Ibid*, [257].

<sup>20</sup> *Ibid*, [256].

<sup>21</sup> *Ibid*, [257]. As Justice Bell put it, *'... discriminatory denial of capacity and paternalistic medical treatment can undermine patients' dignity, autonomy and prospects of recovery in the long term; but, subject to safeguards, compulsory medical treatment may presently be necessary as a last resort to improve those prospects and contribute to the realisation of patient autonomy and self-actualisation.'* See also [99].

<sup>22</sup> *Ibid*, [206](10).

<sup>23</sup> *Ibid*.

<sup>24</sup> *Ibid*, [273].

<sup>25</sup> *Ibid*, [274].

<sup>26</sup> See section 102(2)(c) with respect to adult patients and section 112(2)(f) with respect to young patients.

<sup>27</sup> Section 100(a).

<sup>28</sup> Section 110(a).

<sup>29</sup> Section 115(a).

<sup>30</sup> The requirement to apply to the Tribunal for ECT treatment for voluntary adults who do not have capacity to consent was introduced by the *Medical Treatment Planning and Decisions Act 2016* and came into effect in March 2018. It is beyond the scope of these guidelines to describe the reforms, including what an instructional directive is and the role of the medical treatment decision maker. Mental health services are directed to other resources prepared by the Chief Psychiatrist and the Office of the Public Advocate. See, for example the following information from the Office of the Chief Psychiatrist: <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/medical-treatment-planning-decisions-act>.

<sup>31</sup> Section 105(a).

<sup>32</sup> Section 87(2).

<sup>33</sup> Section 87(3).

<sup>34</sup> See paragraph [49] and [50] above.

<sup>35</sup> See section 109(2) with respect to young patients and section 114(2) with respect to young people who are not patients.

<sup>36</sup> Section 104(2).