

**A review of the literature, the Acts of Parliament and relevant current practices on regulation of the use of ECT in New Zealand and in other like nations**

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## **EXECUTIVE SUMMARY**

### **1 REVIEW METHODOLOGY**

The aim of the review was to produce a review of the literature, the Acts of Parliament and relevant current practices on regulation of the use of ECT in New Zealand and other like nations.

## **PART I**

### **2 MEANS BY WHICH ECT MAY BE PROVIDED IN NEW ZEALAND**

Over the last two decades ECT has attracted the imposition of special regulatory controls in most jurisdictions reviewed in this paper. In New Zealand, special regulation of ECT applies only in respect of compulsory patients treated pursuant to the Mental Health (Compulsory Treatment and Assessment) Act 1992. However, ECT may potentially be provided in several circumstances in New Zealand. Chapters 3-7 deal with each of these in turn.

### **3 ELECTIVE / VOLUNTARY ECT - REQUIREMENTS OF A LEGALLY VALID CONSENT**

Consent may validate either the provision of ECT to a patient who receives ECT electively as with any health procedure, or who consents voluntarily under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

A consent must be voluntary, and if gained by unfair or undue pressure, or on the basis that committal procedures will be instigated if consent is not forthcoming, the validity of the consent may be undermined.

An essential requirement of consent is capacity, which is not a concrete concept but varies according to the gravity of the decision involved. Decisions involving greater potential risk demand greater levels of capacity than decisions of minor potential risk. This raises the question of what degree of capacity is required to consent to ECT, and whether it should be the same for refusal. The answer to this question will be influenced by the evidence and conclusions reached by the research team investigating the safety and efficacy of ECT.

Relevant considerations regarding obtaining consent to ECT include the fact that depressive illness can impair memory, as can some antidepressants and ECT. ECT involves a series of treatments during which the cost benefit ratio may change, the patient's ability to participate in informed decision-making may improve, while at the same time, memory of the original consent may

become impaired.

The minimum standard for informed consent in relation to ECT is adequate information in writing for patients and families as well as verbal consent in accordance with the Code of Consumers' Rights. The audit commissioned by the New Zealand Ministry of Health reported that hospitals surveyed did not universally include these requirements within their clinical governance.

There is a degree of variation in the information regarding ECT and associated risks and side effects provided to patients amongst the jurisdictions surveyed.

The RANZCP *Clinical Memorandum #12* provides guidance for psychiatrists practicing throughout the Australian States, Territories and New Zealand and deals with the issue of consent to ECT in very broad terms. It does not go into medico-legal issues that may arise in clinical practice in any depth, nor is it specific to the New Zealand medico-legal environment.

#### **4 ECT WITHOUT CONSENT - DOCTRINE OF NECESSITY**

It has been stated in the House of Lords that treating a compliant incapacitated person in need of psychiatric care on the basis of necessity under the common law may result in "effective and unqualified control in the hands of health care professionals". However some protections exist in New Zealand in regard to the provision of treatment on the basis of necessity to an incapacitated patient by virtue of the Code of Consumers' Rights. These must be compared with the procedural protections provided under the MH(CAT) Act in relation to ECT. Of these, the requirement for a second opinion and regular formal clinical review have no counterpart in the Code.

#### **5 TREATMENT WITHOUT CONSENT: PARENS PATRIAE POWER**

The Parens patriae jurisdiction is not suitable for authorising on-going treatment, but is invoked for one-off interventions.

#### **6 TREATMENT WITHOUT CONSENT- PROTECTION OF PERSONAL AND PROPERTY RIGHTS ACT 1988**

The PPPR Act provides some protection for the vulnerable mentally ill person. To establish jurisdiction under the Act incompetence must be established, and the proposed intervention must be the least restrictive intervention possible in the life of the person subject to the application having regard to the degree of that person's incapacity. There is no similar express requirement in the MH(CAT)Act.

Only the least restrictive intervention will be permitted under the Act, which

will sometimes prevent an order under the Act when alternatives to the treatment proposed exist. The PPPR Act may be limited when a patient objects to the intervention. Whilst orders may be subject to judicial scrutiny there is no statutory requirement for regular review as exists with the MH(CAT) Act. Nor is there a requirement for a second opinion, although the judge essentially provides a second opinion, albeit a non-medical one.

A positive aspect of the PPPR Act is that counsel is appointed to assist the person subject to the application. There is no equivalent requirement under the MH(CAT) Act, although patients do have a statutory right to legal advice. The PPPR Act may be used concurrently with the MH(CAT) Act, and has been invoked when death may occur as a consequence of ECT in emergency circumstances or when other restrictions which arise under the MH(CAT) Act are not warranted in the circumstances. In Scotland, the Adults with Incapacity (Scotland) Act 2000 does not permit the giving of consent or an intervention order in relation to ECT.

## **7 TREATMENT WITH OR WITHOUT CONSENT, THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992**

Whilst mechanisms exist under the Act to protect patient's rights when subject to compulsory treatment, such as the requirement of a second opinion in the case of non-consensual ECT, they may in fact be attenuated in the case of ECT.

Under the provision which authorises ECT on the basis of patient consent, there is no express reference either in the Act or in the *Guidelines to the MHCAT Act 1992* to the need to determine that a patient has the capacity to provide a valid consent. Consequently a patient's consent may validate treatment without a second opinion when in fact no decisional capacity exists. `

There is no express requirement under section 60 of the Act (as there is in relation to compulsory treatment orders of greater than one months duration) that the responsible clinician shall, where practicable, seek to obtain the consent of the patient prior to providing treatment even though it may be authorised by or under the Act without the patient's consent. However it has been argued that following due process is implicit in the section.

Section 60(b) provides that ECT may be provided in the absence of consent when it is in the patient's "interests". Case law suggests that the threshold for providing ECT non-consensually to a compulsory patient is when it would be "beneficial". Arguably this confers a very broad statutory power, with little in the way of guidance as to the circumstances in which it is appropriate to provide compulsory ECT without consent. This may mean that there is very little statutory restriction on the use of ECT.

In reality, the most enduring safeguards under the MH(CAT) Act are the

requirements of a second opinion and regular clinical review.

## **PART II: LEGISLATIVE FRAMEWORKS**

### **8 ENGLAND**

There has been significant attempts at reforming the Mental Health Act in England. Despite recommendations by the expert panel appointed to advise the government in relation to reform of the Act, the draft Bill retains the authority to provide ECT to a competent patient on the basis of Tribunal approval in the absence of consent as well as the ability to provide emergency ECT.

The Draft Mental Health Bill 2002 at first glance appears to broaden the circumstances in which ECT may be given by omitting to describe the circumstances which will authorise the provision of ECT. However, it should be read in conjunction with the NICE Guidance which restricts significantly the circumstances in which ECT is an appropriate therapy. The Bill is significant in that it confers upon compliant non-compulsory incapacitated patients similar protections in regard to ECT as exist under the Act for compulsory patients.

### **9 SCOTLAND**

The Mental Health (Care and Treatment) (Scotland) Act 2003 permits ECT to be given to a consenting patient when it has been certified that the patient is competent, consents, and having regard to the likelihood of ECT alleviating or preventing a deterioration in the patient's condition, it is in the patient's best interests that ECT be given.

In the case of incompetent patients, the process differs depending upon whether the patient resists or objects to ECT. If the incompetent patient does not object, ECT may be given when having regard to the likelihood of its alleviating or preventing a deterioration in the patient's condition, it is in the patient's best interests that ECT be given. In the case of an incompetent patient who objects, ECT may only be given if emergency circumstances exist.

ECT may not be given to a competent patient who refuses ECT. The new Act makes specific provision for advance directives.

### **10 AUSTRALIA - QUEENSLAND**

The Queensland legislature has enacted the most recent mental health legislation in Australia. Under the Mental Health Act 2000 (Qld) ECT may be given at an authorised hospital, and in the case of voluntary patients, either

when the specified informed consent provisions of the Act are met, or if a voluntary patient is incompetent, with Tribunal approval unless the person is known to object to ECT.

ECT may be given to an involuntary incompetent patient without consent when, after considering the application of a psychiatrist, the Tribunal is satisfied that the patient is incompetent and that ECT is the most appropriate treatment in the circumstances having regard to the person's clinical condition and treatment history. It may also be given in emergency circumstances when a psychiatrist and the medical superintendent certify in writing that performing ECT is necessary to save the patient's life or to prevent the patient suffering irreparable harm. A treatment application must be made to the Tribunal immediately after certification in emergency situations.

ECT may not be given to an involuntary patient who refuses ECT in any other circumstances.

Appeal rights to the Mental Health Court from a decision of the Tribunal are provided under the Act.

## **11 AUSTRALIA - WESTERN AUSTRALIA**

ECT may be given to a voluntary patient provided the necessary informed consent requirements specified in the Act are met. Informed consent is not required in emergency circumstances.

The Mental Health Act 1996 (WA) permits the provision of ECT to an involuntary patient on the basis of a second medical opinion that ECT has clinical merit and is appropriate in the circumstances. Regard must be paid to whether the patient is competent and has consented or refused, but is not determinative of the decision. ECT may be given to an involuntary patient without a second opinion in circumstances of emergency.

Proposals from a review group appointed to review the Mental Health Act have resulted in an Advisory Group on ECT being set up to provide advice and recommendations to the Chief Psychiatrist on the future developments of best practice and monitoring of ECT in Western Australia. The Mental Health Act review group have also proposed more stringent requirements on treating involuntary patients non-consensually in general, including review of treatment decisions by an independent body.

Specific recommendations were made in relation to ECT by the Mental Health Act review group. Notwithstanding that the review group had been presented with a considerable body of medical evidence that ECT could be highly beneficial to significant groups of people suffering mental illness, it was recommended that state-wide statistics to monitor the extent of the use of ECT should be collected. It was recommended that all second opinions obtained in

relation to ECT should be reported to the Chief Psychiatrist. It was the opinion of the review group that the provision in the Act permitting emergency ECT should be repealed.

A further recommendation made was that urgent Board or Tribunal review should be undertaken where ECT is proposed for minors, with prohibition for minors under the age of twelve. For minors over the age of twelve, it was recommended that the second opinion psychiatrist be a psychiatrist with specialist training in child and adolescent mental illness.

## **12 AUSTRALIA - VICTORIA**

In Victoria a capable patient has the right to refuse ECT unless the circumstances constitute an emergency.

In the case of an involuntary and incompetent patient, ECT may be provided when an authorised psychiatrist is satisfied of the following factors. Firstly that the proposed ECT has clinical merit and is appropriate, and having regard to any benefits, discomforts or risks the ECT should be performed. In addition the authorised psychiatrist must be satisfied that any beneficial alternative treatments have been considered and that unless the ECT is performed, the patient is likely to suffer a significant deterioration in his or her physical or mental condition. The decision to administer ECT in these circumstances is essentially a clinical one and not subject to any formal mechanism of external oversight. However, the Authorised Psychiatrist may only provide ECT to a patient who is incapable of giving consent, not a patient who is unwilling to give consent.

No other person who is lawfully entitled to consent to medical treatment on behalf of the patient may override a patient's refusal or consent to ECT.

Premises providing ECT in Victoria must be licensed pursuant to the Act. Key Licensing criteria set the minimum acceptable standard for premises at which ECT is to be performed, and address the suitability of the applicant to hold a licence, the suitability of the premises, the equipment and the suitability of the qualifications of persons performing ECT. There is an emphasis on safety, privacy, and designated staff with designated responsibilities. A licence must be renewed every five years.

## **13 AUSTRALIA - NEW SOUTH WALES**

The stringent informed consent provisions of the Mental Health Act 1990 (NSW) are significant as they are the only Australian state provisions which expressly state that possible loss of memory should be disclosed to a patient when informing a patient of discomforts and risks associated with ECT.

New South Wales is the only Australian state to require certification by two medical practitioners that ECT is a reasonable and proper treatment having considered the person's clinical condition, treatment history and alternative treatments and is necessary or desirable for the safety or welfare of the person in the case of a voluntary patient consenting to ECT.

Where a patient is involuntary Tribunal approval must be obtained prior to performing ECT as well as certification by two medical practitioners, regardless of whether the patient has consented or not.

However, a capable involuntary patient who objects to ECT may have that objection overruled under the Mental Health Act 1990 (NSW). (A legally appointed guardian cannot consent to ECT on behalf of an incompetent person). It is mandatory to keep an ECT register which may be inspected at any time.

#### **14 AUSTRALIA - NORTHERN TERRITORIES**

The Mental Health and Related Services Act 1998 contains comprehensive informed consent requirements. ECT may only be provided where these requirements are met.

In the case of an incompetent person the Tribunal may authorise ECT if it is satisfied that the person is incompetent and after receiving certification from two authorised practitioners that they are satisfied after considering the person's clinical condition, history of treatment and other appropriate alternative treatments, ECT is a reasonable and proper treatment to be administered and that without the treatment the person is likely to suffer serious mental or physical deterioration. Reasonable efforts must be made to consult a person's primary care provider, or in the absence of one a person who is closely involved in the care of the person.

ECT may be performed on an incompetent involuntary patient only when two authorised psychiatric practitioners are satisfied that it is immediately necessary to save the person's life; to prevent the person suffering serious mental or physical deterioration; or to relieve severe distress. In these circumstances the practitioners must make a report to the Tribunal as soon as practicable after it is performed. ECT may not be given to a competent patient who refuses ECT.

ECT premises must be licensed under the Act. A medical practitioner who performs ECT in contravention of the Act is guilty of professional misconduct. The holder of a licence must submit a monthly return of the details of ECT performed on the premises.

## **15 AUSTRALIA - AUSTRALIAN CAPITAL TERRITORY**

The Mental Health (Treatment and Care) Act 1994 authorises the provision of nine applications of ECT when consent is obtained in accordance with the Act.

Tribunal approval must be obtained in the case of all involuntary patients who either consent to ECT, or who are incapable of consenting to ECT. An application for an ECT order may be made by the Chief Psychiatrist or a doctor and must be supported by the evidence of a psychiatrist who is not the applicant. The order will only be given by the Tribunal in the case of a competent person if it is satisfied that consent has been given and not withdrawn. In the case of an incompetent person, the Tribunal must be satisfied of the patient's incompetency, that ECT is likely to result in substantial benefit to the person, and that all other reasonable forms of treatment available have been tried but have not proved successful or that it is the most appropriate form of treatment reasonably available.

Mandatory recording and reporting of ECT is required under the Act to the person in charge of the institution at which the therapy is administered.

## **16 AUSTRALIA - SOUTH AUSTRALIA**

ECT is classified as a Category B Prescribed Psychiatric Treatment under the Mental Health Act 1993. On this basis, ECT may be administered when it is authorised by a psychiatrist and a patient consents to it or, in the case of an incompetent patient, when a legally appointed person who is authorised to consent to medical treatment on their behalf does so. When there is no one who can provide lawful consent, the consent of the Board will suffice. ECT may be provided when it is needed urgently for the protection of the patient or other people, and in the circumstances it is not practicable to obtain consent.

## **17 CANADA - ONTARIO**

Most Canadian statutes do not have specific provisions relating to ECT. In Ontario a competent patient may refuse medical treatment, whether voluntary or involuntary. This extends to when they are incompetent, but have previously expressed a wish regarding ECT when competent.

In the case of incompetency, a substituted decision-maker must consent or refuse treatment in accordance with a previously expressed competent wish of the patient. This emphasis on self-determination and autonomy in Ontario has attracted criticism on the grounds that in some circumstances it may result in serious harm to the patient, including continued suffering and long periods of unnecessary detention. There are very limited appeal rights.

In the absence of a previously expressed wish, the substitute decision-maker

must act in accordance with the best interests of the patient.

## **18 CANADA - QUEBEC**

The Civil Code of Quebec provides that no person shall be made to undergo care, treatment or any other act except with consent. A substitute decision maker consents or refuses treatment on behalf of an incompetent patient, or in the absence of one the court may make a decision. Where an incompetent patient categorically refuses care to which a substitute decision maker has consented, authorisation by the Court is necessary. The Court will determine whether the patient is incompetent and whether the treatment is in fact necessary. This essentially provides an independent review mechanism.

Quebec has recently published an in depth review of ECT. The authors of the report made recommendations in regard to informed consent and the need for further research regarding safety and efficacy. They recommended strengthening existing institutional and professional regulation of ECT, implementation of quality control programmes, and the formation of clinical practice guidelines.

## **19 CANADA - ALBERTA**

The Mental Health Act (Alb) permits a substituted decision maker to make a treatment decision on behalf of an incompetent involuntary patient in accordance with what the substitute decision maker believes is in the best interests of the patient. Where an involuntary patient is believed to be incompetent and the patient objects to treatment, treatment cannot be given on the basis of the substitute decision-maker's consent unless a second medical opinion corroborates a finding of incompetency.

In the case of an involuntary but competent patient who objects to treatment, if a physician is of the opinion that the treatment is in the patient's best interests, the physician may apply to the review panel to order treatment be administered on the grounds that it is in the patient's best interests.

## **20 EUROPE**

A brief overview of European practice is presented.

## **21 UNITED STATES - CALIFORNIA**

The extensive provisions of the Californian Code prohibits the provision of ECT to a person who is capable of giving informed consent but refuses to do so, whether voluntary or involuntary. The risk of memory loss, and the fact that

there is a division of opinion as to the efficacy of the treatment, must be disclosed.

ECT may only be given to an involuntary patient if the treating physician enters adequate documentation of the reasons for ECT including that all reasonable treatment modalities have been carefully considered, and that the treatment is definitely indicated and is the least drastic alternative available for the patient. The patient's treatment record must then be reviewed by a committee of two physicians, who must agree with the treating physicians determinations. A relative of the patient's choosing or guardian, if the patient wishes, must be given an oral explanation by the treating physician. The patient must give informed consent, and the patient's attorney must agree as to the patient's capacity. If the physician or attorney believes the patient is incompetent to give written consent, then an application must be made to the superior court to determine capacity. If the court finds incapacity, then ECT may be performed upon gaining informed consent from the responsible relative or guardian. At any time during a course of ECT, a person who has been deemed incompetent has the right to claim regained competency.

A physician must also document in the case of a voluntary patient the reasons for ECT, that all reasonable treatment modalities have been considered carefully, and that ECT is indicated and is the least drastic alternative available. A psychiatrist or neurologist must verify that the patient has the capacity to give and has given written informed consent. If the patient does not have capacity, application to the Court for determination of capacity must be made.

California restricts the provision of ECT to minors. All facilities administering ECT must appoint a committee to review and verify the appropriateness of ECT. Mandatory reporting is required.

The Vermont legislature has recently approved a bill placing new responsibilities on the Mental Health Commissioner, who became responsible for establishing uniform consent processes, regulating ECT facilities, and monitoring its application.

## **PART III**

### **22 INSTITUTIONAL AND PROFESSIONAL REGULATION**

The establishment of adequate guidelines and standards are essential but not sufficient in themselves to ensure adequate administration of ECT. Ongoing training and supervision of trainee psychiatrists, appropriate equipment, consultant-led clinics, and completion of the audit cycle are contributing factors to ensuring quality ECT administration.

## CHAPTER ONE: THE LITERATURE REVIEW

### 1. REVIEW METHODOLOGY

#### *Aims*

1.1 Produce a review of the literature, the Acts of Parliament and relevant current practices on regulation of the use of ECT in NZ and other like nations.

#### *Criteria for inclusion*

1.2 Review of all statutes, case law, Health and Disability Commissioner opinions, journal articles, and relevant reports which pertained to the provision of ECT in New Zealand. Selective review of journal articles, recent texts, and current and proposed statute law in the UK, Scotland, Canada and Australia with regard to the provision of ECT. Californian legislation was also included, as well as a brief overview of European practice.

#### *Search strategy*

1.3 Searching of online legal databases including Legaltrac, Lexis, Linx and Proquest medical database using search terms “electroconvulsive,” “shock treatment”, “electroshock”, and “electrotherapy”. Online search of electronic journals; *Psychiatric Bulletin*, *British Journal of Psychiatry*, and *Advances in Psychiatric Treatment* using search terms “electroconvulsive” and “ECT”. Overseas legislation was accessed electronically either through legal databases Austlii or Canlii, or via the relevant government’s website. Secondary sources were referred to in regards to Ontario and Quebec legislation.

#### *Presentation of information*

1.4 Information is presented in three parts. The first part deals with an overview of issues relating to consent to ECT and the provision of ECT in the New Zealand context. The second part will deal with the legislative frameworks used in other countries to regulate ECT with an emphasis on other commonwealth nations. The third part provides an overview of issues relating to professional and institutional regulation of ECT and raising clinical standards.

## PART I

### CHAPTER 2: MEANS BY WHICH ECT MAY BE PROVIDED IN NEW ZEALAND

2.1 Over the last two decades ECT has attracted the imposition of special regulatory controls in most jurisdictions reviewed in this paper. The historical abuse and controversial nature of the treatment, coupled with the intrusiveness of the therapy and claimed cognitive side effects have contributed to this trend. Whilst special regulation of ECT in New Zealand applies only to the treatment of compulsory patients treated pursuant to the Mental Health (Compulsory Treatment and Assessment) Act 1992, there are several circumstances in which a person may potentially receive electroconvulsive therapy in New Zealand.

2.2 ECT may be provided electively to a patient as a matter of individual choice as with any health procedure. In the case of incapacity ECT could be provided under the common law on the basis of necessity, or by judicial authorisation under the *parens patriae* jurisdiction of the High Court, or pursuant to the Protection of Personal and Property Rights Act 1988. With a compulsory patient under the Mental Health (Compulsory Treatment and Assessment) Act 1992, ECT may be given either with the consent of the patient or without consent when certain safeguards are met.

2.3 ECT is not expressly covered by the emergency treatment provision of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Section 62 of the Act provides for urgent treatment non-consensually without a second opinion when need for treatment is “immediately necessary to save a patient’s life, or to prevent serious damage to the health of the patient or to prevent the patient from causing serious injury to himself, herself or others”. The effect of this is to override section 59(2) which relates to the provision of most other medical treatment whilst under a compulsory treatment order, but not ECT.

2.4 To administer ECT without consent to a compulsory patient under the Act a second opinion must, it seems, always be obtained, though it could, if necessary, be obtained quickly.

2.5 In contrast the Mental Health Act 1983 (UK), on which the New Zealand Mental Health Act 1990 was modelled, expressly provides that ECT may be provided without consent if there is an urgent need to do so in the person’s best interests and it is not practicable to arrange a second opinion.<sup>1</sup> This will remain the same under proposed new legislation.

2.6 Although there are at present no national data regarding the numbers of patients receiving ECT either consensually or non-consensually,<sup>2</sup> it is possible

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<sup>1</sup> Mental Health Act 1983 (UK), s62(1).

<sup>2</sup> The recent audit carried out by the Ministry of Health reported that about 414 people received

that many, if not the majority of recipients of ECT in New Zealand are consenting patients who are not subject to the MH(CAT) ACT. This is particularly so if NZ follows a similar pattern to England and Scotland.<sup>3</sup>

### CHAPTER 3: ELECTIVE / VOLUNTARY ECT - REQUIREMENTS OF A LEGALLY VALID CONSENT

#### *Generally*

3.1 Consent is the voluntary and continuing permission of a patient to receive a particular medical treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not a true "consent".<sup>4</sup> Therefore, in order to be valid, consent must be voluntarily given by a person who is appropriately informed and who has the requisite capacity either to consent to or to refuse treatment.<sup>5</sup>

#### *Capacity*

3.2 At common law there is a presumption of capacity, but this presumption may be rebutted.<sup>6</sup> Mental illness and competence are not mutually exclusive, and a person is not necessarily incompetent by virtue of suffering from mental illness, even when subject to commitment.<sup>7</sup> Capacity must be commensurate with the decision made, that is, the more serious the decision the greater the capacity required.

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ECT in NZ in the year 2001 - 2002. This equates to an incidence of about 92 per 100 000 people receiving ECT in New Zealand compared with 142 per 100 000 in Scotland in the years between 1997 and 2000 and 132 per 100 000 people in England in the year of 1999. See M Tovey, A Duncan, Electroconvulsive Therapy Audit Report (Draft) Oct 2003.

<sup>3</sup> In a survey carried out by the English Department of Health it was reported that during the quarter January 1999 to March 1999, 2800 patients received ECT in either English NHS trust hospitals or private hospitals. Of the 2800 patients who received ECT 413 (14.75% of the total patients) did not consent to the provision of ECT. Of the 2800 patients who received ECT, only 25% were formally detained under the Mental Health Act 1983. See [www.doh.gov.uk/public/ectbull99.htm](http://www.doh.gov.uk/public/ectbull99.htm) In the period between January 2002 and March 2002, 2300 patients received ECT, with 500 (~21%) receiving it non-consensually. See [www.doh.gov.uk/public/workhealthcare.htm-mentalhealth](http://www.doh.gov.uk/public/workhealthcare.htm-mentalhealth) In the audit carried out by the Scottish Health Department between February 1996 to August 1999 it was reported that approximately 1000 patients per year received ECT in Scotland. 81.8% of patients receiving ECT gave informed consent, with 20% of recipients being detained under the Mental Health (Scotland) Act 1984. See [www.sean.org.uk](http://www.sean.org.uk).

<sup>4</sup> R Harper, *Medical Treatment and the Law* (Jordan Publishing Limited, Bristol: 1999) 3.

<sup>5</sup> A Hockton, *The Law of Consent to Medical Treatment* (Sweet & Maxwell, London: 2002) 65. It has been argued that genuine informed consent for ECT is non-existent because psychiatrists deny or minimise its harmful effects and, as long as the threat - overt or covert - of involuntary treatment exists, there can be no truly voluntary informed consent. See J Breeding, "Electroshock and informed Consent" (2000) 40 *Journal of Humanistic Psychology* 65.

<sup>6</sup> *Re T* [1992] 3 WLR 782, 796E. Nb also the Code of Consumers' Rights, Right 7(2).

<sup>7</sup> *Re S* [1992] 1 NZLR 363, 374. See also D Court, "Mental Disorder and Human Rights: The Importance of a Presumption of Competence" (1996) 8 *Auckland University Law Review* 1. And see *Fleming v Reid* (1991) 82 DLR (4<sup>th</sup>) 298, 310 (Ont CA).

3.3 It has been suggested that a sliding scale approach to the ability to consent should be adopted to take into account that different decisions require different levels of understanding. Decisions involving most potential risk, eg death, demand greater levels of capacity than decisions of minor potential risk. If the consequences for welfare are grave, the need to be able to certify that the patient possesses the requisite capacities increases, but if little in the way of welfare is at stake, the lower the level of capacity should be required for decision-making.<sup>8</sup>

3.4 This raises the question of what degree of capacity is required to consent to ECT and is it the same for both refusal and consent? The answer to these questions will be influenced by the conclusions drawn from the review undertaken of the safety and efficacy of ECT.

#### *Voluntary*

3.5 Patients suffering from severe depression may be faced with “consent or be committed” proposals. It is necessary to ascertain how often psychiatrists will be prepared to commit a patient in view of a refusal to consent, and communicate this to the patient. However, a coerced consent is not a lawful consent.<sup>9</sup>

3.6 Some patients when aware that committal procedures may be initiated in the absence of consent may wish to avoid committal by providing consent. In this situation, is there a degree of permissible trade-off in avoiding being “sectioned”? That is, is it legitimate to give a choice between what is essentially coerced treatment and non-consensual treatment with the restrictions existing under the MHA? In these circumstances should there at least be a second opinion provided to the patient to the effect that if made a compulsory patient, the requisite second-opinion by a psychiatrist appointed by the Tribunal would be in favour of ECT so that the choice between committal or consent is based on reality? However, it remains that the consent in reality is coerced.

#### *Assessment of capacity*

3.7 There is no single valid test for capacity, however “the ability of a patient to understand the risks, benefits, and alternatives to treatment (including no treatment at all) is increasingly becoming the commonly applied standard of competence for consenting to ECT.”<sup>10</sup>

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<sup>8</sup> See P Lepping, “Consent in Psychiatry – an Ethical Review” (2003) 27 *Psychiatric Bulletin* 285. This seems to be implicit in the Code of Health and Disability Consumers’ Rights, right 7(3) “Where a consumer has diminished competence, that consumer retains the right to make informed choices and to give informed consent, to the extent appropriate to his or her level of competence.”

<sup>9</sup> Whether consent is voluntary is a question of fact. In a prison setting, where a doctor has the power to influence a prisoner’s situation and prospects, a court must be alive to the risk that what may appear, on the face of it, to be real consent is not in fact so. See *Freeman v Home Office* (No 2) [1984] QB 524; All ER 1036 cited in A Hockton, *The Law of Consent to Medical Treatment* (London, Sweet & Maxwell; 2002) 7.

<sup>10</sup> R Abrams, *“Electroconvulsive Therapy”* 4<sup>th</sup> ed (New York, Oxford University Press; 2002) 228.

3.8 The decision need not be rational to be legally acceptable.<sup>11</sup> This is exemplified by the example given of a patient who fully understood the nature of the ECT that was being offered to her, but accepted it because she hoped it would kill her.<sup>12</sup> However, it has also been cautioned that if consent is given on the basis of delusional thinking – for example, the person believes that death would be just reward for some perceived transgression, then serious consideration of a person's capacity would need to be made.<sup>13</sup>

3.9 The English courts apply the three-stage test outlined by Thorpe J in *Re C*.<sup>14</sup> There must be an ability to comprehend and retain the relevant information, believe it, and weigh it in the balance so as to arrive at a choice.

3.10 In *Re MB*<sup>15</sup> Butler-Sloss LJ held that a person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to accept or refuse treatment. That inability to make a decision will occur when: the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question, the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.

3.11 A recent study involving forty severely depressed patients needing ECT concluded that most had decisional capacity to give informed consent to ECT. The subject's decisional capacity was measured using the MacArthur Competence Assessment Tool for Treatment. Additionally it was found that the patient's decisional capacity could be improved through patient information.<sup>16</sup>

#### *Sufficient information*

3.12 For a consent to be valid, sufficient information must be communicated to enable an informed judgment. Failure to provide such information will not necessarily vitiate the consent when information has been provided in broad terms, but may constitute negligence in failing to inform.<sup>17</sup> A major issue in relation to ECT is what constitutes sufficient information.

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<sup>11</sup> See *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782, 800A.

<sup>12</sup> Roth LH, Meisel A, Lidz CW "Tests of Competency to Consent to Treatment" (1977) 134 *Am J Psychiatry* 279-84 cited in Abrams, op cit n10, 228.

<sup>13</sup> See *ECT Manual*, Department of Human Services, Victoria, Australia, Part D at p3.

<sup>14</sup> [1994] 1 All ER 891.

<sup>15</sup> [1997] 2 FLR 426.

<sup>16</sup> However there was a point at which further educational intervention no longer improved scores. See M Lapid et al, "Decisional Capacity of Severely Depressed Patients Requiring Electroconvulsive Therapy" (2003) 19 *Journal of ECT* 67.

<sup>17</sup> See *Chatterton v Gerson* [1981] QB 432, 443 "once the patient has been informed in broad terms of the nature of the procedure which is intended and gives her consent, that consent is real, and the cause of action on which to base a claim for failure to go into risks and complications is negligence, not trespass.

3.13 In *Bolam*,<sup>18</sup> a case decided in 1957, the plaintiff was advised by the consultant psychiatrist to undergo ECT for chronic depression. He signed a consent form but was not warned of the risks involved. In the course of treatment, during which no relaxant drugs were administered, the plaintiff suffered severe physical injuries consisting of the dislocation of both hip joints with fractures of the pelvis on each side. The issue was whether the Doctor was negligent in failing to inform the plaintiff regarding the risks associated with unmodified and unrestrained ECT. It was the evidence at the time that doctors held divergent views on the desirability of using relaxant drugs and on the question of whether a patient should be warned of the risks of ECT. Such injuries were reported as being rare.<sup>19</sup>

3.14 It was stated that negligence does not take place if a Dr has acted in accordance with the practice accepted as proper by a responsible body of medical people skilled in that particular art, even though there may be other members of the profession who take a contrary view. The Doctor had therefore not acted negligently by not informing the patient of the risks involved.

3.15 The Australian High Court in *Rogers v Whitaker* departed from this formulation, applying an objective standard, as distinct from one which focuses upon the views of cross-sections of the medical profession.<sup>20</sup> Essentially the test was what a reasonable person in the patient's position would perceive as a risk and would therefore wish to be informed of in advance.<sup>21</sup> Although ACC covers negligent failure to inform preventing civil actions against medical staff,<sup>22</sup> the *Rogers v Whitaker* approach has been followed in ACC disciplinary proceedings.<sup>23</sup> Hence it still informs what information is required to constitute a valid consent at common law in New Zealand.

3.16 Therapeutic privilege refers to the withholding of information that is perceived may be detrimental to or reduce the effectiveness of treatment. In the current medico-legal climate it has become increasingly difficult to justify the withholding of information on this basis.

3.17 In addition to the common law the Code of Consumer's Rights protects a

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<sup>18</sup> *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

<sup>19</sup> The risk of fracture was in the vicinity of one chance in 10 000.

<sup>20</sup> (1992) 175 CLR 479, 490 "the law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege".

<sup>21</sup> *Rogers v Whitaker* has been followed in Australian High Court in *Rosenberg v Percival* [2001] HCA 18.

<sup>22</sup> Injury Prevention, Rehabilitation, and Compensation Act 2001, s33.

<sup>23</sup> *Rogers v Whitaker* has been expressly adopted by Elias J in the High Court of New Zealand in *B v Medical Council* (unreported, High Court, Auckland HC 11/96).

patient's right to make a sufficiently informed consent.<sup>24</sup> Mental health consumers are not specifically included in the broad definition of health and disability services consumers in the parent Act,<sup>25</sup> but it is evident that it encompasses them. The Act expressly refers to mental health services,<sup>26</sup> and ECT would come within the broader definition of services as a "health care procedure".<sup>27</sup>

3.18 The code provides that consumers have rights to effective communication from providers and to be fully informed regarding illness and treatment.<sup>28</sup> Rights 6 and 7 lay down detailed requirements for obtaining informed consent, and are largely a restatement of the common law.

3.19 Right 6 provides that "every patient has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive", thereby endorsing the patient-centred approach taken in *Rogers v Whitaker*.<sup>29</sup> Consumers must receive an explanation of the options available, including an assessment of the expected risks, side effects and benefits, of each option.

3.20 Relevant considerations regarding consent to ECT include the fact that depressive illness can impair memory, as can tricyclic antidepressants and ECT.<sup>30</sup> Concentration and retention of information may also be impaired.

3.21 In addition, ECT involves a series of treatments during which the cost-benefit ratio continues to change and the patient's ability to participate in informed decision-making may continue to improve, while at the same time, memory of the original consent may become impaired, potentially contributing to patient perceptions that side effects were worse than expected.<sup>31</sup>

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<sup>24</sup> The Code of Rights defines 10 broad categories of rights and obliges providers to inform consumers of their rights and how those rights can be enforced. See PDG Skegg, "The New Zealand Code of Health and Disability Services Consumers' Rights" (1997) 5 *Journal of Law and Medicine* 124.

<sup>25</sup> Health and Disability Commissioner Act 1994, s2.

<sup>26</sup> For example, s3(b) of the Act defines "health care providers" as including a controlling authority of a hospital within the meaning of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

<sup>27</sup> "Services" is defined in clause 3 of the Code of Health and Disability Services Consumer's Rights as including a health care procedure. The definition of a health care procedure is found in section 2 of the Act, not the Code, and includes any health treatment administered to or carried out on or in respect of any person by any health care provider and includes any provision of health services to any person by any health care provider. "Health services" is further defined as services to promote health.

<sup>28</sup> Rights 5 and 6.

<sup>29</sup> See N Peart, "Patient and Family Rights in the Mental Health Context" (1996) 6 *Mental Health and the Law* 83, 85.

<sup>30</sup> J Greening et al "The Effect of Structured Consent on Recall of Information Pre-and Post Electroconvulsive Therapy: a Pilot Study" (1999) 23 *Psychiatric Bulletin* 471.

<sup>31</sup> A Donohue, "Electroconvulsive Therapy and Memory Loss: A Personal Journey" (2000) 16 *The Journal of ECT* 133 citing Consensus Conference. Electroconvulsive Therapy. (1985) 254 *JAMA* 103.

3.22 Right 6 may require more in this respect than is required normally required in the case of a patient who is not suffering from mental illness or impairment, or who has not undergone ECT.

3.23 Simple information leaflets can improve knowledge in patients receiving ECT.<sup>32</sup> *Clinical Memorandum #12*,<sup>33</sup> which is the guideline on the administration of electroconvulsive therapy published by the Royal Australian and New Zealand College of Psychiatrists, states in regard to preparation for ECT that careful explanation of the procedure including the side effects should be given and that “educational pamphlets and videos are useful for this purpose”.<sup>34</sup>

3.24 However documentation should not be a substitute for more detailed personal discussion tailored to the level of concentration, depression and prior knowledge of the person considering ECT and their significant others.<sup>35</sup>

3.25 Some sort of record, or having a family member or friend present may be valuable evidence at a later stage of the patients participation in the consent process. One of our consumers who has received ECT has recommended an ECT pack for this purpose.

3.26 The minimum standard of information that must be disclosed and the material risks in relation to ECT are contested, depending upon the stance of the individual. There is a significant gap between research and anecdotal evidence regarding the extent of possible memory loss after ECT.

3.27 Dr H Sackheim, an American psychiatrist who has been involved in clinical research on ECT over the last twenty five years has stated “in informing patients about ECT, it is important to relate that a few individuals report profound and long-lasting cognitive impairment that they attribute to this treatment modality”. This is despite the fact that this phenomenon has not been established with objective testing, and the reasons for this discrepancy are not clear.<sup>36</sup>

3.28 A compelling personal account which is accompanied by an extensive review of the scientific literature regarding ECT and cognitive side effects attributes ECT with lifting the author from “seemingly intractable and severe

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<sup>32</sup> J Greening et al “The Effect of Structured Consent on Recall of Information Pre-and Post-Electroconvulsive Therapy: a Pilot Study” (1999) 23 *Psychiatric Bulletin* 471 citing Jenaway A, “Educating Patients and Relatives about Electroconvulsive Therapy: the Use of an Information Leaflet” (1993) 17 *Psychiatric Bulletin* 10.

<sup>33</sup> *Clinical Memorandum # 12*, The Royal Australian and New Zealand College of Psychiatrists (1999).

<sup>34</sup> *Ibid*, 5.

<sup>35</sup> Expert medical opinion to the Health and Disability Commissioner, Opinion 00HDC07173.

<sup>36</sup> Sackheim H, “The Cognitive Effects of Electroconvulsive Therapy” in L Thahl, W Moss, E Gamzu (eds), *Cognitive Disorders: Pathophysiology and Treatment* (New York, Marcel Dekker; 1992) 217.

depression” but also with leaving her with permanent retrograde amnesia.<sup>37</sup>

3.29 The author, whilst not challenging the necessity of the treatment in her case, challenged what she perceived as the lack of adequate communication between physicians and their patients regarding possible side effects. It was suggested that preparing a patient for the predictable effects of ECT on memory and other domains of cognition was honest, necessary and helpful, leading to realistic expectations of the treatment. It was also useful in helping the patient and family prepare for the post-ECT period.<sup>38</sup>

3.30 The NICE guidance expressly addresses issues relating to memory loss, “ECT may cause short or long term memory impairment for past events (retrograde amnesia) and current events (anterograde amnesia). As this type of cognitive impairment is a feature of many mental health problems it may sometimes be difficult to differentiate the effects of ECT from those associated with the condition itself. In addition there are differences between individuals in the extent of memory loss secondary to ECT and their perception of the loss. However, this should not detract from the fact that a number of individuals find their memory loss extremely damaging and for them this negates any benefit from ECT”.<sup>39</sup>

3.31 There is a Public Information Statement that accompanies the RANZCP *Clinical Memorandum*.<sup>40</sup> This describes ECT as “no more dangerous than minor surgery under general anaesthesia, and may at times be less dangerous than treatment with antidepressant medications.” It is stated that “some patients report a partial loss of memory for events that occurred during the days, weeks, and months preceding ECT. While most of these memories typically return over a period of days to months following ECT, some patients have reported longer-lasting problems with recall of these memories. However, other individuals actually report improved memory ability following ECT, because of its ability to remove the amnesia that is sometimes associated with severe depression. The amount and duration of memory problems with ECT vary with the type of ECT that is used”.

3.32 The Health and Disability Commissioner has requested that the College (RANZCP) information sheet be sent to all DHB’s so that it would be freely available to mental health consumers considering ECT.<sup>41</sup> It remains to be determined if this is still adequate in view of some of the recent randomised

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<sup>37</sup> See A Donohue, “Electroconvulsive Therapy and Memory Loss: A Personal Journey” (2000) 16 *The Journal of ECT* 133.

<sup>38</sup> The author refers to recommendations made in CH Kellner, “The Cognitive Effects of ECT: Bridging the Gap Between Research and Clinical Practice” (1996) 12 *Convulsive Therapy* 132.

<sup>39</sup> *Guidance on the Use of Electroconvulsive Therapy*, National Institute for Clinical Excellence April 2003, 9.

<sup>40</sup> *New Public Information Statement – Electroconvulsive Therapy Explained* Royal College of Australian and New Zealand Psychiatrists (1999). This statement was available from [www.ranzcp.org/statements/other/ect.htm](http://www.ranzcp.org/statements/other/ect.htm) however this page is no longer accessible.

<sup>41</sup> See opinion 00HDC07173 [www.hdc.org.nz](http://www.hdc.org.nz).

controlled trials and the NICE guidance.<sup>42</sup>

3.33 Risks disclosed must include those applicable to particular patient – not just generic risks but risks particular to the individual patient such as the risk of retinal detachment to a patient pre-disposed to this condition.

3.34 Right 7 of the Code of Consumers' Rights provides that services (which includes ECT) may only be provided to a consumer if that consumer makes an informed choice and gives informed consent". There is a presumption of competence, unless there are reasonable grounds for believing that the consumer is not competent. Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

3.35 The Health and Disability Commissioner has been influenced to a great extent by the guidelines provided by the RANZCP in an opinion involving ECT.<sup>43</sup> In this case, the provider was found to have breached Right 4(1) of the Code by failing to have appropriate policies and procedures in place for the administration of ECT.

3.36 The Health and Disability Commissioner conceded that *Clinical Memorandum #12* was a guideline only and not a treatment protocol.<sup>44</sup> However, providers must ensure that their policies and procedures in relation to ECT are consistent with professional guidelines, meet the requirements of the Code and incorporate legislative requirements.

3.37 Hence, providers risk breach of the code not only if they fail to inform but also potentially if their internal clinical governance policies do not meet the standard required by the Code in relation to informed consent.

3.38 The question arises whether the Code is sufficiently adhered to and observed by practitioners providing ECT.<sup>45</sup> There have been no (investigated) complaints to the HDC in regard to informed consent and ECT, although this may change in the future.<sup>46</sup>

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<sup>42</sup> The UK Royal College of Psychiatrists withdrew its patient information on ECT in 2002 and has since been working on it to take into account the NICE guidelines and the systematic review and meta-analysis by the UK ECT Review Group.

<sup>43</sup> See opinion 00HDC07173.

<sup>44</sup> Although this opinion did not relate to informed consent, but to the provision of services of an appropriate standard.

<sup>45</sup> "the language of rights does not guarantee their realisation" See R Paterson, "What's New in Mental Health Law?" 6<sup>th</sup> New Zealand Annual Medico-Legal Conference, 1998, 1

<sup>46</sup> There has only been one specific complaint investigated by the HDC relating to ECT. This involved failing to deliver services to an appropriate standard to a person receiving outpatient ECT. Three other complaints have been made to the commissioner in relation to the administration of ECT to persons but they did not fall within the jurisdiction of the HDC and could not be investigated. However, the Health and Disability Amendment Act 2003, s9 has extended the jurisdiction of the office of the Health and Disability to pre-1996 when certain conditions are met.

3.39 It is explicitly stated in Clinical Memorandum #12 that consent issues warrant close attention when adolescents have ECT, and that psychometric testing should be carried out prior to carrying out ECT.<sup>47</sup> This may also involve Gillick competence, but the Guidelines do not go into details. Pregnant women are also set apart. The guidelines refer to ECT in the context of the relevant Mental Health Act in either New Zealand or the Australian States. It does not refer to the provision of ECT to patients receiving ECT electively outside the MHA, nor does it go in any depth into any medico-legal issues.

3.40 The audit carried out by the Ministry of Health determined that the minimum standard for procuring consent for ECT was involvement by the consultant psychiatrist or suitably qualified medical officer of specialist scale. That the informed consent process should follow the Code of Rights, and that patients will be given written ECT info to at least RANZCP standards. Extra information should be provided when a patient has ECT as an outpatient. However, this does not appear in the guidelines although arguably it may be implicit.

3.41 All sites when audited had at least basic written information for service users and families, and 16 (of 19 audited) had a statement to the effect that people receiving ECT and their families should be given written information in local ECT guidelines. Eighteen sites had written information that included at least the information contained in the RANZCP *ECT Statement*, that is information covering what ECT is, how it works, when it is used, how effective it is, risks, and consent issues.

3.42 Having regard to the recommendations of the HDC and the minimum standards set by the audit standards, all District Health Boards clinical governance should require that adequate information in written or audio-visual form should be provided to patients and their families in addition to obtaining verbal consent in accordance with the Code of Rights. It remains to be determined on the basis of the medical review what information must be disclosed in regards to safety and efficacy.

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<sup>47</sup> Op cit n 32, .8

Figure 1: Information provided to patients in information statements by different bodies in various jurisdictions.

Patient information statements	
New Zealand RANZCP*	<p><i>When is it used</i> - ECT is generally used in patients with severe depressive illness when other forms of therapy, such as medications or psychotherapy, have not been effective, cannot be tolerated or, in life-threatening cases, will not help the patient quickly enough. ECT also helps patients who suffer with most forms of mania, some forms of schizophrenia, and a few other mental and neurological disorders.</p> <p><i>How effective is it?</i> - Clinical evidence indicates that for uncomplicated cases of severe major depression, ECT will produce a substantial improvement in at least 80 percent of patients. ECT has also been shown to be effective in depressed patients who do not respond to other forms of treatment. Medication is usually the treatment of choice for mania, but here too certain patients do not respond. Many of these patients have been successfully treated with ECT.</p> <p><i>Risks</i> - ECT is no more dangerous than minor surgery under general anaesthesia, and may at times be less dangerous than treatment with antidepressant medications. A small number of other medical disorders increase the risk associated with ECT, and patients are carefully screened for these conditions before a psychiatrist will recommend them for ECT.</p> <p><i>Side-effects</i> - Immediate side effects from ECT are rare. Some people will experience headaches, muscle ache or soreness, nausea and confusion, usually during the first few hours following the procedure. Over the course of ECT, it may be more difficult for patients to remember newly learned information, though this difficulty disappears over the days and weeks following completion of the ECT course. Some patients also report a partial loss of memory for events that occurred during the days, weeks, and months preceding ECT. While most of these memories typically return over a period of days to months following ECT, some patients have reported longer-lasting problems with recall of these memories. However, other individuals actually report improved memory ability following ECT, because of its ability to remove the amnesia that is sometimes associated with severe depression. The amount and duration of memory problems with ECT vary with the type of ECT that is used and are less a concern with unilateral ECT than with bilateral.</p> <p><i>Brain-damage</i> - There is no evidence that ECT causes any structural cerebral damage.</p> <p><i>Pregnancy</i> - The decision whether or not to treat pregnant women with ECT needs to take into account the risks associated with alternative treatments, the risks to the mother and foetus of withholding ECT and any complications of the pregnancy which may increase the risks of ECT or the anaesthetic. ECT may be used with confidence during the second and third trimesters. Little information is available for its use in the first trimester, so until further data are available, caution is advisable during this stage. ECT does not produce abnormal uterine contractions and it appears to be safe even in complicated pregnancies. Foetal monitoring during ECT has</p>

**United Kingdom RCP\*\***

not revealed any untoward effects on the foetus.

*How will I feel immediately after ECT* - some people wake up with no side effects at all and simply feel relaxed. Others may feel somewhat confused or have a headache. The nurse will be there to help you through any problems.

*How well does ECT work?* Over 8 out of 10 depressed patients who receive ECT respond well to it. In fact, ECT is the most effective treatment for severe depression. People who have responded to ECT report it makes them feel "like themselves again" or "as if life was worth living again". Severely depressed patients will become more optimistic and less suicidal. Most patients recover their ability to work and lead a productive life after their depression has been treated with a course of ECT.

*Side effects* - Some patients may be confused just after they wake from the treatment and this generally clears up within an hour or so. Your memory of recent events may be upset and dates, names of friends, public events, addresses and telephone numbers may be temporarily forgotten. In most cases this memory loss goes away with a few days or weeks although sometimes patients continue to experience memory problems for several months. As far as we know, ECT does not have any long term effects on your memory or intelligence.

*Risks* - ECT is amongst the safest medical treatments given under general anaesthesia. The risk of death or serious injury with ECT is rare and occurs in about one in 50,000 treatments. For example this is much lower than reported for childbirth. Very rarely deaths do occur and these are usually because of heart problems.

*Other treatments* - Anti-depressant drugs may be available to treat your particular condition and it is possible that some of them may work as well as ECT. The advantage and disadvantages of other treatments should be discussed with you by your doctor.

**Western Australia\*\*\***

*Safety* - ECT has been used for many years and is considered by doctors to be very safe. There is no medical evidence that the brain is damaged.

*Side effects* - When you wake up you may feel a bit confused and some people get a headache. The confusion will wear off and you can be given medication for the headache. Some people complain about having a poor memory for a while after the treatment, but this does not usually last.

**NICE\*\*\*\***

ECT should be used to gain fast and short-term improvement of severe symptoms after all other treatment options have failed, or when the situation is thought to be life-threatening.

A risk-benefit assessment for the individual should be made and documented. It should include the risks associated with the anaesthetic, whether the person has other illnesses, the possible adverse effects of ECT (particularly problems with memory), and the risks of not having treatment.

Doctors should be particularly cautious when considering ECT treatment for women who are pregnant and for older or younger people, because they may be at a higher risk of complications with ECT.

**Scotland\*\*\*\*\***

*Risks* - are small. The most commonly quoted low mortality

rate for ECT does not adequately account for all the risks of treatment. Patients with a pre-existing medical condition are at increased risk of experiencing cardiac or respiratory problems following treatment. The risk of a swing into manic mood is the same as for treatment with antidepressant drugs. Not having ECT also has risks. Studies have shown that depressive illness increases mortality rate and the suicide rate is higher in depressed patients not treated with ECT.

*Adverse events* - main problem that can occur is a temporary loss of memory. Memory impairment following ECT is common. Memory impairment can be associated with severe depression and can be marked even when patients have not had ECT. Some studies have shown that ECT does not increase the memory impairment already caused by severe depression. Despite this there is no doubt that short term memory impairment around the course of ECT and the few weeks afterwards is very common (60-70% of patients). Past memories can also be affected. It is difficult to know how much of this is caused by ECT and how much by severe depression. Memory impairment due to ECT recovers gradually over the six months following treatment though some patients only very slowly recover past memories and some have permanent gaps in their memory for some past events.

*Brain damage* - The straightforward answer to whether ECT causes brain damage is "NO". Could there be a small number of people who do have permanent memory changes after ECT? Yes, there are certainly patients who have lost memories from their past which have not returned even over many years. Detecting these gaps in individual memories has proved very difficult in large research studies. Even in this very small number of patients the ability to learn new facts remains intact.

\*Taken from *New Public Information Statement - Electroconvulsive Therapy Explained* accompanying the RANZCP Clinical Memorandum # 12, *Electroconvulsive Therapy* (1999).

\*\*Taken from "The Royal College of Psychiatrists Patient Factsheet on ECT Royal College of Psychiatrists (1993). Note that this factsheet was withdrawn in 2002 after the NICE guidelines were published. The Royal College of Psychiatrists have been working on a new factsheet to take into account the NICE guidelines and the associated systematic review and meta-analysis by the UK ECT Review Group.<sup>48</sup>

\*\*\*Taken from *Electroconvulsive Therapy Information about Electroconvulsive Therapy and your rights under the Mental Health Act 1996* Office of the Chief Psychiatrist, Department of Health, Government of Western Australia, 2003.

\*\*\*\*Taken from *Guidance on the Use of Electroconvulsive Therapy, Appendix C: Information for Patients*, National Institute for Clinical Excellence, 2003. This is not an official patient information statement. NICE has recommended the formulation of nationally consistent patient information statements.

\*\*\*\*Taken from Ian Kellagher, *ECT in Scotland A Guide to Electroconvulsive Therapy The Latest Evidence* Scottish ECT Audit Network.

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<sup>48</sup> See "Psychiatrists hits back at 'inaccuracies' of British Medical Journal Paper on ECT" 2003, <http://www.psychminded.co.uk>

## CHAPTER 4: TREATMENT WITHOUT CONSENT - COMMON LAW DOCTRINE OF NECESSITY

### *Generally*

4.1 Treatment may be justified by the doctrine of necessity where the recipient lacks competency to consent to treatment but the provision of medical treatment is necessary to preserve the individual's life or health and is therefore in the patient's best interests.<sup>49</sup> In the case of an emergency, treatment in the best interests of a patient not only can but must be given to patients where consent cannot be obtained.<sup>50</sup>

4.2 Historically it was held that treatment that satisfies the test laid down by the House of Lords in the *Bolam* case would satisfy the requirement for treating in a patient's "best interests". The *Bolam* test was formulated as a test to determine whether a Doctor is guilty of negligence, and requires an intervention to be in accordance with the practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question.<sup>51</sup> However, subsequent judicial consideration of a person's best interests has been held to extend beyond the considerations set out in *Bolam*, encompassing a broad assessment of the patient's welfare, not being confined to medical issues, and including ethical, social, moral and welfare considerations.<sup>52</sup>

4.3 Where there has been a refusal of consent, the necessity doctrine will only provide a defence to treating a person against their wishes if the individual's refusal was invalid. (Section 11 of the New Zealand Bill of Rights Act 1990)

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<sup>49</sup> The common law defence of necessity exists by virtue of s20 Crimes Act 1961.

<sup>50</sup> *Re F* [1990] 2 AC 1 per Lord Brandon.

<sup>51</sup> This is in accordance with the principles stated in *Bolam v Friern Hospital Management Committee* [1957] 2 ALL ER 545.

<sup>52</sup> See *Re A (Male Sterilisation)* [2000] 1 FLR 549, (CA), *Re S (Sterilisation)* [2000] 2 FLR 389 (CA). However there has been conflicting dicta regarding the extent to which treatment satisfying the *Bolam* principle will satisfy the "best interests" test. "A possible distinction may be made between the court's role when exercising its inherent jurisdiction in relation to *proposed* treatment and its more familiar role of determining liability *retrospectively* in relation to treatment which has been given. The court has traditionally been reluctant *ex post facto* to condemn (particularly in a criminal context) treatment which satisfies the *Bolam* test. Secondly, the extent to which satisfaction of the *Bolam* test will also satisfy the requirement of best interests must depend upon the extent to which the decision in question is a straight forward clinical one..... However the emphasis on the distinction between the best interests and the *Bolam* tests theoretically at least exposes doctors to a greater risk of being held liable in relation to potentially contentious treatment where the court's prior assistance has not been sought. The fact that a doctor who has wrongly treated an incompetent patient, contrary to the court's subsequent assessment of his best interests, happened to act in accordance with a responsible body of medical opinion will not necessarily constitute a defence to an allegation of battery or assault." See A Hockton, "*The Law of Consent to Medical Treatment*" (Sweet & Maxwell, London: 2002) 99, 110.

retains the right for a competent adult to refuse medical treatment).<sup>53</sup> If the person did not have the capacity to make the refusal, the refusal will be invalid. Where a refusal of treatment has been given prior to the onset of a mental disorder, the refusal will often be valid.<sup>54</sup>

4.4 Rights 7(1) and 7(4) of the code of rights effectively endorses and codifies the common law doctrine of necessity.<sup>55</sup>

#### *Common Law*

4.5 In *R v Bournewood Mental Health Trust*<sup>56</sup> a compliant mentally incapacitated autistic man was admitted informally (detained pursuant to the act, but not committed) under the Mental Health Act 1983 (UK) and treated on the basis of necessity. The House of Lords held that compulsion was not necessary for many mentally ill persons where although the patient could not express a positive desire for treatment, they are not unwilling to receive it.<sup>57</sup>

4.6 This approach means that in the context of English hospitals, patients who are unable to give an informed consent but who are deemed to need ECT may be given it under the common law and may not be sectioned under the MHA 1983 (UK) solely to provide ECT.

4.7 The *Bournewood* decision has been criticised on the basis that it leaves compliant incapacitated patients without the safeguards enshrined in the Mental Health Act 1983 (UK) which may result in “effective and unqualified control in hands of health care professionals”. There are “significant safeguards against inappropriate care deliberately enacted by Parliament. They should not be easily evaded by permitting reliance on common law powers to detain mentally disordered persons in situations covered by the act”.<sup>58</sup>

4.8 One NZ commentator has observed that in psychiatric emergency situations, intervention under the common law in appropriate ways to prevent harm is warranted without need to invoke statutory powers. However there is no need to rely on a common law power when a reasonable opportunity has been available to apply a statutory power in the same field which provides additional protections for vulnerable people. When there is time the statutory power should be used. When the emergency has passed the MHA’s rules

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<sup>53</sup> *In Re S* [1992] 1 NZLR 363, 374 Barker J.

<sup>54</sup> *Fleming v Reid* (1991) 82 DLR (4<sup>th</sup>) 298, 309-10, *In Re C (Adult Refusal of Treatment)* [1994] 1WLR 290, 295 cited in J Clapham “Treatment of Mentally Disordered Adults Against Their Wishes” 1995 *Mental Health and the Law* 36. See also the Code of Consumer’s Rights, right 7, which provides that every consumer may use an advance directive in accordance with the common law.

<sup>55</sup> Right 7(1) preserves the common law as services may be provided only with the informed consent of the consumer unless any other enactment or the common law provides otherwise.

<sup>56</sup> [1999] 1 AC 458.

<sup>57</sup> It was held that section 131 of the Mental Health Act 1983 when viewed from its historical perspective provided that committal was not necessary in the case of compliant patients.

<sup>58</sup> *R v Bournewood Mental Health Trust* [1999] 1 AC 458, 497 per Lord Steyn.

should be observed if ongoing hospital treatment for mental disorder is contemplated for a resisting patient.<sup>59</sup>

4.09 Rights under the MHA 1983 (UK) provide procedural protections which include formal certification stating why a patient meets criteria regarding compulsory care, the need for a second opinion prior to use of ECT when the patient does not consent, regular clinical review, and periodic access to a review tribunal. If civil commitment extended to compliant incapacitated patients entitlements for families such as the opportunity to refer a matter to review tribunal arise.

4.10 In the New Zealand context several questions arise in respect to treating patients on the basis of necessity. Firstly, should necessity be permitted, taking into account the human rights abuses of the 1970s and 1980s involving ECT? Secondly, whether the Code of Consumers' Rights is an effective regulatory control protecting against abuse of vulnerable patients when treated under the common law on the grounds of necessity, or should the Act be invoked. The third is whether the Act provides adequate protection when it comes to the provision of ECT? (Considered in Chapter 6).

4.11 The Health and Disability Commission provides an important role in both prevention and deterrence of provider misconduct by providing a minimum code of provider conduct, by investigating breaches of the code, by exerting monitoring pressures after a finding of breach, and by promoting change through education.<sup>60</sup>

4.12 The Code contains some broad and fundamental rights, eg rights to respect, to be free from discrimination and the right to have services provided in a manner that respects the consumer's dignity and independence. There are more detailed provisions, which may be of particular relevance to mental health consumers.

4.13 Right 7(4) of the Code provides a particular framework to be followed where a consumer is not competent. Services may be provided without consent where it is in the best interests of the consumer, and reasonable steps have been taken to ascertain the views of the consumer, and having regard to those views the provider believes on reasonable grounds that the provision of ECT is consistent with the informed choice of the consumer if he or she was competent. In this way the Code seeks to preserve patient autonomy.

4.14 If the views of the consumer cannot be ascertained the provider is required to take into account the views of other suitable persons who are interested in the welfare of the consumer. Hence Right 7(4) affords families an opportunity be involved in the decision-making process if the patient lacks the necessary competence. The families views are limited to when the patients

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<sup>59</sup> J Dawson, "Necessitous Detention and the Informal Patient" (1999) 115 *Law Quarterly Review* 40.

wishes are unascertainable, and are not decisive, there is merely an obligation to consult.

4.15 The Code provides the right to complain either to a patient advocate or to the Commissioner.<sup>61</sup> Third parties are able to complain, which is an important protection for vulnerable consumers.<sup>62</sup> Additionally the code may confer on families rights to co-operation as a provider<sup>63</sup> as families are often the carers of mental health consumers and may come within the definition of providers.<sup>64</sup> Right to information about how to obtain a second opinion exist under the Code but only in relation to the consumer.

4.16 Expansive rights to appropriate service standards are provided for in right 4 of the Code. Providers are required to meet the common law “reasonable care and skill standard” and “legal, professional, ethical, and other relevant standards”. Commissioner opinions record breaches of treatment standards through failing the requirements of: the Mental Health (Compulsory Treatment and Assessment) Act 1992,<sup>65</sup> Professional codes of ethics, Professional codes of conduct, Provider operations protocols and Ministry of health guidelines<sup>66</sup>

4.17 However, under the Code of Rights there is no requirement for a second opinion in the absence of consent, no requirement for clinical review, or appeal to the review tribunal by family members. Whilst families have an acknowledged role where a patient is incompetent, and have a right to complain to an advocate, and the Health and Disability Commission regarding care, this will often be a reactive process after a possible breach has occurred.

4.18 The professional guidelines of the Royal College of Psychiatrists (UK), the *ECT Handbook*,<sup>67</sup> recommends that an incompetent resisting patient should be treated as if competent and refusing. If a patient is not refusing but is not

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<sup>60</sup> See in general M Kazmierow “The New Zealand Health and Disability Commissioner: A Comparative Assessment of the Commissioner’s Contribution to Protecting the Rights of Mental Health Consumers” (2002) 9 *Journal of Law and Medicine* 279.

<sup>61</sup> Health and Disability Commissioner Act 1994, s31.

<sup>62</sup> This will include a range of mental health workers, such as social workers, nurses, doctors.

<sup>63</sup> See right 4(5) every consumer has the right to co-operation among providers to ensure quality and continuity of services.

<sup>64</sup> Families may be providers of health and disability services, by virtue of the definition of “disability services” which includes “any person who provides goods, services and facilities ...to people with disabilities for their care or support or to promote their independence”. “Disability” has not been defined but could well include certain mental illnesses. In this way medics may be obliged to co-operate with families in providing and planning care. See N Peart, “Patient and Family Rights in the Mental Health Context” (1996) 6 *Mental Health and the Law* 83.

<sup>65</sup> 97HDC9553

<sup>66</sup> M Kazmierow, “The New Zealand Health and Disability Commissioner: A Comparative Assessment of the Commissioner’s Contribution to Protecting the Rights of Mental Health Consumers” (2002) 9 *Journal of Law and Medicine* 279, 281.

<sup>67</sup> The Second Report of the Royal College of Psychiatrists’ Special Committee on ECT, edited by CP Freeman, 1995, 98. This handbook is currently under review.

competent to consent, the proper course of treatment is to use the relevant MHA. However, if the procedure is to be performed on the basis that it is in the patient's best interests, (ie under the common law) then it is recommended that a second opinion be obtained from a consultant colleague who is not involved with the patient's treatment and that the situation be discussed with the patient's relatives. There is nothing in the RANZCP's memorandum in relation to this.

4.19 In England a new legislative framework is proposed which will include safeguards for patients treated without the use of compulsory powers and which will bring them within the remit of the new Commission for Mental Health. There will be a right to apply to an independent Tribunal to challenge any detention and for a review where there are concerns about the quality or nature of the patient's care and treatment.<sup>68</sup>

4.20 The Health and Disability Commissioner has described ECT as a "highly potent treatment".<sup>69</sup> Whilst the Code of Rights provides some safeguards in relation to the provision of ECT to incapacitated patients, they are mostly reactive mechanisms, and may involve some time delays. There is no equivalent right to a second opinion in the case of incapacity.

4.21 Where there is doubt regarding a patient's competency, or about a patient's best interests, proceeding under the common law to administer ECT and in accordance with the Code may not be a prudent course of action in New Zealand, at least without obtaining a second opinion first. Unlike the UK, there are alternatives to invoking the Mental Health (Compulsory Assessment and Treatment) Act 1992, such as the Protection of Personal and Property Rights Act 1988, and the *parens patriae* jurisdiction.

## **CHAPTER 5: TREATMENT WITHOUT CONSENT - PARENS PATRIAE POWER**

5.1 Section 17 of the Judicature Act 1908 recognises the High Court's inherent jurisdiction over the "persons and estates of idiots, mentally disordered

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<sup>68</sup> The new framework of safeguards will potentially apply to any patient with long-term mental incapacity who is assessed as needing long-term care and/or treatment for serious mental disorder from specialist mental health services in his or her best interests. The new legislation will require the formulation of an individual care plan by the patient's clinical supervisor which is subject to the external scrutiny of an independent member of the new expert panel set up to provide expert advice to the tribunal. This second opinion doctor must assess the patient and discuss the treatment plan. Carers and close relatives must be consulted prior to finalising the plan. Additionally, the legislation provides for representation of the patient by a nominated person, and the right to go to the new mental Health Tribunal to challenge the lawfulness of detention or for a review of the care plan. There will also be a right of access to independent specialist mental health advocacy services. See White Paper: *Reforming the Mental Health Act*, December 2000 (Cm 5016-I).

<sup>69</sup> Opinion 00HDC07173 at 38.

persons, and persons of unsound mind, and over the managers of such persons and estates respectively”.

5.2 The Judicature Act may be invoked for a wide range of persons who lack the capacity to consent to treatment. In exercising the *parens patriae* jurisdiction, the courts effectively consent on behalf of an incompetent person in what is perceived to be that person’s best interests. It is similar to the guardianship jurisdiction which the family court may exercise over children.

5.3 In *Re S<sup>70</sup> (a mental patient)* it was held that s 84 of the MHA which permits any person to make an application to the High Court to inquire into whether a patient is being appropriately or properly detained in hospital was additional to the protection given to such persons by s17 of the Judicature Act.

5.4 The Court’s inherent jurisdiction is not appropriate where ongoing treatment is required, but is more suited to authorising “one-off” procedures. The *parens patriae* jurisdiction has not been invoked to authorise ECT, and would arguably not be suited to ongoing ECT treatment.<sup>71</sup>

## **CHAPTER 6: TREATMENT WITHOUT CONSENT - PROTECTION OF PERSONAL AND PROPERTY RIGHTS ACT 1988**

### *Jurisdiction*

6.1 To establish jurisdiction over an individual pursuant to the PPPR Act, it must be shown that the individual “lacks, wholly or partly, the capacity to understand the nature, and to foresee the consequences of, decisions in respect of matters relating to [his or her] personal care and welfare”.<sup>72</sup>

6.2 It is significant that the language of the PPPR Act does not refer to abnormal mental states, but focuses on a functional definition of incompetence. This may be relevant where there are concerns about the connotations arising from being “sectioned”. Independent counsel are appointed to represent anyone subject to an application under the Act. Orders are subject to periodic review by the Family Court.<sup>73</sup>

6.3 There is a presumption of capacity - the onus of proof regarding lack of

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<sup>70</sup> [1993] FRNZ 15. S was a compulsory patient who had objected to the responsible clinician’s decision that he should be given ECT, S sought the Court’s intervention under s84 where the High Court is charged with the duty of supervising the care and treatment of mental patients.

<sup>71</sup> In *Re G* [1997] 2 NZLR 201, the *parens patriae* jurisdiction was invoked to consent to the termination of life-sustaining treatment of a brain-damaged accident victim. The jurisdiction has also been used by the court to consent to the sterilisation of a 15 year old intellectually disabled child. *Re X* [1991] 2 NZLR 365.

<sup>72</sup> PPPR Act 1988 s6(1)(a).

<sup>73</sup> J Dawson, “The Changing Legal Status of Mentally Disabled People” (1994) *Journal of Law and Medicine* 38, 45.

capacity rests on the applicant who must rebut the presumption.<sup>74</sup>

6.4 If the court has jurisdiction under section 6 then it can make an order under s10(1)(f) “that the person be provided with medical advice or treatment of a kind specified in the order”.<sup>75</sup> Orders have been made in regards to the provision of ECT to incompetent persons.

#### *Primary Objectives*

6.5 Proposed treatment must accord with the Court’s primary objectives under section 8. The Court must ensure that treatment is “the *least restrictive* intervention possible in the life of the person in respect of whom the application is made, having regard to the degree of that person’s incapacity”. Treatment may be rejected at this stage because there are less invasive alternatives.<sup>76</sup>

6.6 The second objective is enabling or encouraging the person “to exercise and develop such capacity as he or she has to the greatest extent possible.”<sup>77</sup> Hence orders must be tailored to the circumstances of the person.

6.7 The PPPR Act seeks to avoid unnecessary paternalism; “the fact that the person in respect of whom the application is made.... has made or is intending to make any decision that a person exercising ordinary prudence would not have made or would not make given the same circumstances is not in itself sufficient ground for the exercise of that jurisdiction by the Court”.<sup>78</sup>

6.8 This gives rise to the question of how willing will the court be to override a refusal by the person subject to the application?

#### *Case Law*

6.9 The case of *Re CMC*<sup>79</sup> (District Court, MacCormick J) did not involve ECT but is illustrative of how the court will apply the PPPR Act. In this case a woman had been admitted reluctantly to hospital for treatment of severe anorexia nervosa. She had accepted admission on the basis that if she did not her husband would initiate committal proceedings under the MHA.

6.10 An application was made for an order under the PPPR Act authorising naso gastric feeding. It was held that if C had not expressed a wish to live, to recover fully and to lead a future life with her family and in particular with her children, it may not have been appropriate to make an order. Because she had, MacCormick J held that the proposed treatment was the least restrictive supplementary treatment that was available and it was a form of treatment which hopefully might enable C to ultimately exercise and develop her own

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<sup>74</sup> PPPR Act 1988, s5.

<sup>75</sup> PPPR Act 1988, s10(1)(f).

<sup>76</sup> *Re S (Shock Treatment)* [1992] NZFLR 208, 214.

<sup>77</sup> PPPR Act s8(a) 8(b).

<sup>78</sup> PPPR Act 1988 s6(3).

<sup>79</sup> [1995] NZFLR 538.

capacity to overcome her illness.

6.11 It was stated that “although an order under the PPPR Act is probably not as far reaching in its effect as a compulsory treatment order under the MHA it is nevertheless in my view, just as difficult to obtain”

6.12 Under the PPPR Act the test to be applied is an inquiry into the degree of incapacity suffered by the subject, and having regard to the degree of incapacity, what is the least restrictive intervention possible that would enable the subject person to exercise capacity to the greatest extent possible.<sup>80</sup> In determining this, the first and paramount consideration shall be the promotion and protection of the welfare and best interests of the person subject to the application.<sup>81</sup>

6.13 In *Re W*<sup>82</sup> (District Court) involved a 74 year old man suffering from severe depression. He was subject to compulsory assessment and treatment under section 11 of the MHA (first period of assessment and treatment). Two medical reports were obtained to the effect that unless W received treatment he would die from malnutrition and dehydration within a few days. Anything short of electro-convulsive therapy would be ineffective, but the procedure carried a substantial risk to W.

6.14 It was held that in the circumstances it was not possible for the clinician to invoke s60(b), which would allow the provision of ECT without consent where a second opinion had been provided that ECT was in the interests of the patient.

6.15 The judge stated that the application for a court order under PPPR Act was “understandable” because of the obvious risk to the patient from the procedure and anaesthetic and to avoid what could be “unfortunate consequences” pursuant to the MHA. It was stated that “this case is a good illustration of the way in which the two Acts are capable of intertwining to provide clear guidelines in cases where there is demonstrable risk.” In this case, ECT was the least interventionist approach possible for the court, as it was the only treatment capable of producing a result.

6.16 It is most unlikely that this case sets a precedent for emergency treatment. The PPPR Act effectively provided safe harbour for the psychiatrist when the patient was extremely debilitated and the mortality risk was high. However, the mortality risk was high regardless of whether the procedure occurred or not. The patient died a few days after the judgment of the court, without

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<sup>80</sup> This was *Re S (Shock Treatment)* [1992] NZFLR 208. This case will not be included in this analysis as it involved aversive shock treatment, which has nothing in common with ECT. Whilst the aim of ECT is to induce a convulsion, with aversive shock treatment the aim is to administer a painful or noxious non-convulsive electric shock in clear consciousness to alter behaviour.

<sup>81</sup> See *Re H* [1993] NZFLR 225 and *KR v MR* [2004] 2 NZLR 848, 858.

<sup>82</sup> [PPPR] 12 FRNZ 573.

receiving the ECT. It could have been argued that the doctors were under an obligation to provide the ECT if they believed it was in the patient's best interests and they had a legal mandate to do so under the Act.<sup>83</sup>

6.17 *In the matter of IMT*<sup>84</sup> (District Court) the patient had a history of a schizo-affective disorder which had been successfully treated with ECT, achieving remission. Mrs T had subsequently developed alzheimer's disease and was unable to consent to continuation of the treatment. Alternative applications were made under the MHA and PPPR Act for an order providing for the continuation of ECT on a periodic basis.

6.18 It was held that an order under the PPPR Act would serve Mrs T's interests better than dealing with her under the MHA. The court was satisfied that the primary objectives in exercising the jurisdiction to make the least restrictive intervention possible in the life of the patient and to enable or encourage her to exercise and develop such capacity she had to the greatest extent possible made such an order appropriate.

6.19 It was ordered pursuant to s10(f) that T be provided with treatment of ECT on a periodic basis, the period varying from two to four weeks. The order was to be reviewed not later than 3 years later.<sup>85</sup>

6.20 It has been claimed that the PPPR Act was never intended to be de facto mental health legislation, and that the protections that are incorporated in the mental health legislation to protect a patient's rights are not available under the PPPR ACT such as the requirement for a second opinion, and regular clinical review. For this reason it has been cautioned that the PPPR Act's provisions should be invoked sparingly in sanctioning the treatment of people who, for whatever reason, are not competent to consent for themselves.<sup>86</sup> This needs to be balanced against an assessment of the adequacy of the rights available to a person in relation to compulsory ECT.

6.21 Welfare guardians appointed under the PPPR Act are prevented from consenting to ECT and psychosurgery<sup>87</sup> although welfare guardians can consent to standard medical procedures which could include psychotropic medication. However the limits on the powers of welfare guardians in section 18(1)(d) and (e) of the PPPR Act 1988 were written to match the consent requirements of the then Mental Health Bill 1987 regarding the provision of non-consensual compulsory electro-convulsive therapy or psychosurgery.<sup>88</sup>

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<sup>83</sup> As well as the general duty of care owed to a patient, section 66 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 provides the right of a compulsory patient to appropriate medical treatment.

<sup>84</sup> [1994] NZFLR 612.

<sup>85</sup> An order under the PPPR Act expires after 12 months if no specific time length is set, PPPR Act s17.

<sup>86</sup> S Bell, W Brookbanks, *Mental Health Law in New Zealand* (Brooker's, New Zealand: 1996) 120.

<sup>87</sup> PPPR Act, s18 .

<sup>88</sup> E Grant, "Consent to Medical Procedures and the Protection of Personal and Property Rights Act 1988" (1989) 7 *Otago Law Review* 161, 177. These provisions were unchanged when

6.22 It seems that the PPPR Act may have a role to play when medics are concerned with being responsible for ordering ECT when it may have fatal consequences, and wish to have the sanction of the court prior to providing the procedure. However, in the case of a refusal of treatment, the jurisdiction of the court may be more limited. Arguably in this case the MH(CAT) Act which specifically deals with ECT should be invoked. This would ensure extra safeguards available under the Act are triggered.

6.23 Although by applying to the court a second opinion regarding the appropriateness of the intervention is obtained, there is an absence of a second medical opinion under the PPPR Act. Other statutory rights under the MHA are not available to patients under an order pursuant to the PPPR Act. However, when the individual's other freedoms do not need to be restricted, the PPPR Act may be more appropriate.

6.24 The PPPR Act may have a role to play when patients do not meet the threshold for committal, but remain incompetent.

## **CHAPTER 7: MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1990**

### *Background to the Mental Health (Compulsory Assessment and Treatment) Act 1990*

7.1 The precursor to the Mental Health (Compulsory Assessment and Treatment) Act 1990 MH(CAT) Act was the Mental Health Act 1969. The 1969 Act's threshold for commitment was low. Anyone who was mentally ill, mentally infirm, or mentally subnormal and who required detention in a hospital for their own good or in the public interest could be committed for compulsory psychiatric care. People could be committed against their will or without an appreciation of what was occurring with relative ease. The duration of commitment was indeterminate. There were no statutory limitations on the forms of treatment which could be administered without consent.<sup>89</sup> Psychiatric patients had no right to legal information or representation. Options for redress for maltreatment were severely curtailed.<sup>90</sup> One commentator noted that in "no other country with similar legal traditions to our own has the law abdicated its protective function so completely, conferring this unique immunity on mental health professionals".<sup>91</sup> Patients were largely reliant upon professional self-regulation for protection of their rights.

7.2 The consequences of this were dire. In 1977 a commission of inquiry was held into the treatment of a 13 year old Niuean boy who was given ECT while

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the MH(CAT) Act was enacted.

<sup>89</sup> J Dawson, "The Changing Legal Status of Disabled People" (1994) *Journal of Law and Medicine* 38, 43.

<sup>90</sup> J Dawson, "Mental Health Law Reform" [1986] *New Zealand Law Journal* 323, 324.

<sup>91</sup> *Ibid*, 324

being held in secure confinement at Lake Alice Hospital as an *informal* patient.<sup>92</sup> The treatment had not been discussed with either his family or the Social Welfare Department who were responsible for his guardianship.

7.3 In 1982 the Oakley Committee of Inquiry was established after the death of a Maori man, Mr Michael Watene.<sup>93</sup> Amongst other things the inquiry revealed that ECT had been administered to Mr Watene, who violently objected, without anaesthetic or muscle relaxant and without any attempt to explain the procedure to him in circumstances when it was questionable whether ECT was even indicated.<sup>94</sup> It was stated in the report that ECT procedures were “alarmingly deficient,” and that “the procedures adopted after ECT did not meet accepted professional standards”.<sup>95</sup> The inquiry revealed inadequate care and dangerous practices, with no adequate system of safeguards for patients to make complaints of ill-treatment.

7.4 Mental law reform process commenced in 1983 in the wake of the Oakley Inquiry. The Legal Information Service and the Mental Health Foundation of New Zealand, (both independent organizations) combined to establish a Task Force to promote reform of the legislation and published their report, *Towards Mental Health Law Reform* in December of 1983.<sup>96</sup> Major changes occurred in the following decade, including a movement toward community care and debate about community safety expectations, patient rights and access to treatment and allocation of resources. It was nine years before the current MH(CAT) Act was enacted.

7.5 The authors of the report advocated the recognition of the right of all competent patients to give consent to or refuse treatment (including ECT) with the exception of emergency circumstances, and the right of patients found incompetent to a second opinion.

7.6 However, new legislation did not adopt all of the recommendations of the Taskforce. Under the 1992 Act ECT may be administered over a competent refusal if an independent psychiatrist believes the provision of ECT is in the “interests” of the patient.

#### *Criteria for civil commitment*

7.7 “Mental disorder” is defined in section 2 of the MHA and sets the threshold for civil commitment under the Act. There are two limbs to the test

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<sup>92</sup> *Report of the Commission of Inquiry into the case of Niuean Boy*, Government Printer, Wellington, 1977. This was not an isolated case. See *Summary of a Report Compiled Upon an Investigation into a Complaint against the Department of Health and the Department of Social Welfare*, Office of the Ombudsman, 1977.

<sup>93</sup> *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters*, Government Printer, Wellington, 1983.

<sup>94</sup> Mr Watene was suffering from acute paranoid reaction.

<sup>95</sup> Op cit n 91, paras 5.1, 5.2.

<sup>96</sup> Report of the Legal Information Service – Mental Health Foundation Task Force on Revision of Mental Health Legislation *Towards Mental Health Law Reform*, Mental Health Foundation, Auckland, (1983) 234.

for committal. Firstly, the patient must be suffering from “mental disorder”, defined as “an abnormal state of mind, whether of a continuous or an intermittent nature, which is characterised by delusions or by disorders of mood, volition, cognition or perception”.

7.8 Secondly, the person’s abnormal state of mind must be of such a degree that it “poses a serious danger to the health or safety of the person or of others; or seriously diminishes the capacity of the person to take care of himself or herself”. So the consequences of mental abnormality covered by the Act extend beyond “dangerousness” to severely diminished capacity for self-care and serious danger to one’s own health.

7.9 In contrast to this second limb, the law in some other countries such as the USA and some states in Canada (including Ontario and Quebec) have adopted a pure danger standard for involuntary commitment. The result is that treatment will be imposed in only the most extreme cases, when individuals are considered to be a danger to themselves or others.<sup>97</sup>

7.10 In New Zealand, Part V of the MH(CAT) Act specifically authorises compulsory treatment for “mental disorder”. Three categories of psychiatric treatment are created – treatment, which is principally pharmacotherapy, ECT and psychosurgery.

#### *Treatment other than ECT or psychosurgery*

7.11 Treatment, such as medication, may be authorised by the responsible clinician during the period of assessment and the first month of a compulsory treatment order.<sup>98</sup> Thereafter, either the informed consent of the patient must be obtained, or in the absence of consent the approval of a psychiatrist appointed by the Review Tribunal must be given on the basis of the patient’s interests. In effect, this provides a right to a second opinion after two months of the Compulsory Treatment Order. The requirement for patient consent or second opinion approval may be overridden in an emergency.<sup>99</sup>

7.12 It is significant that the statute requires that wherever practicable the responsible clinician shall seek to obtain the consent of the patient to any treatment even though that treatment may be authorised by or under the Act without the patient’s consent.<sup>100</sup>

#### *ECT*

7.13 ECT may be administered either with the informed consent of the patient, or without the patient’s consent when a second opinion is provided by a psychiatrist appointed by the Review Tribunal concurring that it is in the patients interests to have ECT.

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<sup>97</sup> K Brown, E Murphy, “Falling Through the Cracks: The Quebec Mental Health System” (2000) 45 *McGill Law Journal*, 1037.

<sup>98</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, ss58, 59(1).

<sup>99</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s62.

<sup>100</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s59(4).

### *Psychosurgery*

7.14 In contrast, psychosurgery requires the consent of the patient, and certification by the Review Tribunal that they have considered the case, are satisfied that the consent was made voluntarily and that the patient is competent to make such a decision. Additionally it must be considered that the psychosurgery is in the interests of the patient by the responsible clinician and an appointed psychiatrist<sup>101</sup>. Effectively, the provision prohibits psychosurgery unless a person with capacity to understand gives informed consent, and two psychiatrists certify that it is in the patient's interests.

### *Section 60*

7.15 Section 60 provides the following;

- 60. Special provision relating to electroconvulsive treatment**-Notwithstanding anything in section 58 or section 59 of this Act, no patient shall be required to accept electroconvulsive treatment for mental disorder unless-
- (a) The patient, having had the treatment explained to him or her in accordance with section 67 of this Act, consents in writing to the treatment; or
  - (b) The treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for the purposes of this section by the Review Tribunal

### *Section 60(a)*

7.16 It is notable that there is no express reference either in the Act, or in the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*<sup>102</sup> to the need to determine whether a patient possesses sufficient capacity to consent to ECT.

7.17 In contrast, in regard to the provisions authorising compulsory treatment (which is not ECT) after the first month of a compulsory treatment order, the *Guidelines to the MH(CAT) Act 1992*<sup>103</sup> provide that particular care should be taken to scrutinise whether the patient is competent<sup>104</sup> to give informed consent to the proposed intervention. It is further stated that in accordance with the Code of Rights the usual presumption of competence does not apply if there are reasonable grounds for believing the [patient] is not competent.<sup>105</sup>

7.18 In cases of doubt the approval of a psychiatrist appointed by the Review

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<sup>101</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s61.

<sup>102</sup> *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, Mental Health Services, Ministry of Health, June 1997.

<sup>103</sup> *Ibid.*

<sup>104</sup> Competence and capacity are the same thing, and are used interchangeably in medical and legal writing.

<sup>105</sup> Code of Consumers' Rights, right 7(2).

Tribunal *must* be obtained. There is nothing in the guidelines to this effect in relation to s60(a) and it is possible that ECT could be given to an incompetent person without a second opinion. In these circumstances, consent may validate treatment when a patient has no decisional capacity and no understanding of the treatment to which he or she is consenting to.

7.19 This is also in contrast to the express requirement of the review tribunal that validation of capacity is undertaken in cases involving psychosurgery and implies that a far lower level of capacity is necessary in relation to ECT. It remains to be determined whether this is warranted on the evidence. However, it would seem difficult to justify a requirement for assessing competency to consent to other treatment but not in relation to consenting to ECT.

#### *Section 60(b)*

7.20 Section 60(b) authorises non-consensual ECT on the basis of a second opinion. There is no express requirement that wherever practicable the responsible clinician shall seek to obtain the consent of the patient even though non-consensual treatment may be authorised by or under the Act. This is in contrast to the provision authorising compulsory treatment, which expressly requires that the responsible clinician shall, wherever practicable, seek to obtain the consent of the patient in regards to treatment even though non-consensual treatment may be authorised by or under the Act.<sup>106</sup>

7.21 One commentator has stated that there is a clearly implied legislative intention that the circumstances necessary to legitimate ECT should be different from those required to legitimate medication.<sup>107</sup> A possible reason for the distinction advanced is that ECT was regarded as a more potent therapy only used in individuals who are severely mentally disordered and who are therefore less likely to have decisional capacity. On this analysis clinicians have the option of effectively presuming incompetence and proceeding directly to 60(b).

7.22 A more persuasive interpretation of the section that has been advanced is that s60(b) is a consequential provision that only comes into effect when the patient's consent is not forthcoming under s60(a). "... it is clear that the examination of the patient's competency is a safeguard of due process and an important filter in determining whether compulsory treatment without consent is actually necessary".<sup>108</sup> It is also essential in determining whether a second opinion under s60(b) is required.

7.23 The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the UN General Assembly<sup>109</sup> preclude a decision that a person lacks legal capacity without an

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<sup>106</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s59(4).

<sup>107</sup> D Court, "Mental Disorder and Human Rights: "The Importance of a Presumption of Competence" (1996) 8 *Auckland University Law Review* 1, 11.

<sup>108</sup> *Trapski's Family Law* Volume 3, Brookers' Wellington 1992, para A-22.

<sup>109</sup> GA Res 119, UN GAOR 46<sup>th</sup> Sess, Supp 49, Annex at 188-92 (1991). These principles are not

independent and impartial tribunal hearing pursuant to domestic law.<sup>110</sup>

7.24 Appeal rights to the mental health tribunal for patients assessed as incompetent may in part address this issue, whilst avoiding unnecessary delay or perceived intrusiveness in some circumstances when appeal is not requested or desired.<sup>111</sup>

#### *Rights to information*

7.25 The MI Principles declare that where treatment is authorised without the patient's informed consent, every effort must be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.<sup>112</sup>

7.26 There have been concerns expressed by one commentator that the lack of express reference in s60(b) to providing information in accordance with section 67 of the Act may appear to authorise the administration of non-consensual ECT without any explanation to the patient.<sup>113</sup>

7.27 Section 60(a) provides that ECT may be provided after the patient consents in writing having had the treatment explained to him or her in accordance with section 67 of the Act. Section 67 states that patients are entitled to receive "an explanation of the expected effects of any treatment... including the expected benefits and the likely side-effects".

7.28 It is stated in the *Guidelines to the Mental Health (CAT) Act*<sup>114</sup> that this right under s67 supplements the general right, enjoyed by all health consumers, to receive all the information about treatment options and risks that any reasonable consumer, in that consumer's circumstances, would expect to receive.<sup>115</sup> This states categorically that the Code of Rights is still applicable

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formally recognised in domestic legislation in New Zealand. However GA resolutions can be used as a guide to the interpretation of convention-based rights. The MI principles provide guidance to legislators as to the requirements of international human rights law, although the fundamental obligations of governments are established by the international human rights conventions. See D Court, "Mental Disorder and Human Rights: The Importance of a Presumption of Competence" (1996) 8 *Auckland University Law Review* 1 and E Rosenthal, C Sundram "International Human Rights in Mental Health Legislation (2002) *New York School Journal of International and Comparative Law* 469.

<sup>110</sup>MI Principles, Article 1(6).

<sup>111</sup> See I Freckleton, B Wilson, "Electroconvulsive Therapy: Law, History and Practice" (2001) 8 *Journal of Law and Medicine* 389, 423. One New Zealand commentator has argued that when compulsory treatment is to be given to a patient who is refusing treatment, a formal hearing pursuant to law should be held to determine capacity and whether compulsory treatment is warranted in the circumstances. See W Brookbanks, "Compelling Civil Commitment and Consent to Treatment: a Workable Tension?" (2002) 4 *Family Law Journal* 72.

<sup>112</sup> MI Principles, 11(9).

<sup>113</sup> See W Brookbanks, "Electro-convulsive Therapy and Consent to Treatment" (1993) *New Zealand Law Journal* 235.

<sup>114</sup> *Guidelines to the Mental Health (CAT) Act*, Ministry of Health, Wellington (2000). Available at <http://www.moh.govt.nz>

<sup>115</sup> Code of Consumers' Rights, right 6(1), 6(2).

when administering ECT under the MH(CAT) Act 1990, regardless of whether the need to provide information is expressly stated.

7.29 So, whilst s60(b) abrogates the right to give consent, arguably it does not abrogate the right to be informed, which remains regardless of whether section 67 is expressly referred to or not.

7.30 The MI Principles also require that no treatment should be given to a person without his or her consent unless urgently needed to prevent immediate or imminent harm or if an incompetent patient unreasonably withholds consent to treatment deemed to be in their best interests.<sup>116</sup>

7.31 There have been concerns expressed that section 60(b) is insufficiently instructive as to when ECT should be given without consent. Section 60(b) does not define when ECT should be given, except when it is in the patient's "interests". The *Guidelines to the Mental Health Act* simply uses the words "best interests" and points out that due consideration of sections 5 and 6 regarding ECT for Maori patients is essential. The statutory power is arguably very broad.

7.32 In *Re S (A Mental Patient)*<sup>117</sup> Temm J interpreted section 60(b) to mean that if the patient is considered by the responsible clinician to be one for whom ECT would be "beneficial", it can be administered subject to a second opinion concurring on its clinical advisability even if a patient does not consent.

7.33 In contrast, the current UK Mental Health Act 1983 provides that overriding a patient's refusal should only occur when "having regard to the likelihood of its alleviating or preventing a deterioration of his condition the treatment should be given". This requirement is notably absent in the proposed new English legislation, which simply states that ECT may be given to a patient without consent when it is expressly authorised by the mental health tribunal or when circumstances of emergency exist. However, in view of the NICE guidance, the threshold for administering ECT is not easily met. Compared with Scotland, and all the Australian states surveyed, the MH(CAT) Act confers the broadest statutory power to provide ECT non-consensually.

7.34 One New Zealand commentator has advocated that s60 ought to be read subject to an implied limitation that where it is decided that the patient's refusal of consent may legitimately be overridden that the treatment must be considered to be "necessary" in the interests of the patient. Such a limitation would mean that the procedure under s 60(b) could not be invoked simply because it would be clinically "useful" or "beneficial" where other more benign treatments would be equally as effective and less intrusive. A requirement that the treatment be "necessary" would be valuable in limiting the scope of the procedure, whilst facilitating its use in cases where an imminent deterioration

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<sup>116</sup> MI Principles, Articles 11(1)(6)(8).

<sup>117</sup> (1993) 11 FRNZ 15.

of the patient's condition is foreshadowed. Such an approach would also be consistent with the accepted principle that all legislation affecting personal liberty should be given a narrow reading.<sup>118</sup>

7.35 It has also been claimed that other considerations in determining whether and in what circumstances patient objections may be legitimately overridden arise in the case of refusal of treatment. These include maximising patient autonomy, enhancement of the therapeutic relationship and the therapeutic value of choice.<sup>119</sup> In Scotland, the data collected by the ECT Audit Network indicated that patient choice was associated with one of the best response rates to ECT.<sup>120</sup>

#### *Case Law*

7.36 In *M v AG*<sup>121</sup> the plaintiff had appealed against a decision to strike out civil proceedings that she had brought in relation to her treatment whilst a compulsory patient under the Mental Health Act 1969. She alleged amongst other things that the administration of ECT and insulin treatment to her had not been justified, appropriate, or consented to by her.

7.37 The 1969 Act provided immunity for any person who does any act "in pursuance or intended pursuance" of any provisions of the MHA. Proceedings could not be brought unless there was leave by the Supreme Court Judge, who had to be satisfied that there was substantial grounds to the claim.

7.38 In an obiter comment, the Judge observed that as the claimant was not a voluntary patient, the issue of consent to treatment did not arise in the usual way. In this regard her situation could be contrasted with Mr Bolam.<sup>122</sup> A patient lawfully detained in a mental institution pursuant to a Mental Health Act was not a voluntary patient, so the usual requirements relating to informed consent may not be applicable.

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<sup>118</sup> W Brookbanks "Electro-convulsive Therapy and Consent to Treatment" (1993) *New Zealand Law Journal* 235, 236.

<sup>119</sup> W Brookbanks, "Compelling Civil Commitment and Consent to Treatment: a Workable Tension?" (2002) *Butterworths Family Law Journal* 72. See also K Riittakerttu, P Laippala, K R Salokangas, "Impact of Coercion on Treatment Outcome" [1997] *International Journal of Law and Psychiatry* 311. In this Finnish study involving 100 psychotic patients, involuntary legal status did not predict poorer outcome than voluntary treatment. However, in relation to satisfaction with outcome, *perceived* coercive admission proved to be more important than being subjected to coercive measures and compulsory treatment. Coercive treatment in the wider view aroused negative feelings in the patient, negative expressions about outcome and failed to result in a trusting relationship between patients and professionals. Compare with T Wheeldon, C Robertson, J Eagles, I Reid, "The Views and Outcomes of Consenting and Non-Consenting Patients Receiving ECT" (1999) 29 *Psychological Medicine* 221. This small study found no difference between consenting and non-consenting patients and formal and informal patients in the perception of ECT's helpfulness and their willingness to repeat the treatment.

<sup>120</sup> Scottish ECT Audit Network, Statement on ECT Practice available at [www.sean.org.uk/appraisal.php](http://www.sean.org.uk/appraisal.php) accessed 24/02/04

<sup>121</sup> High Court Wellington, CP 70/00 October 7, 2002 Goddard J.

<sup>122</sup> Discussed at para 3.07.

7.39 In *Re S*<sup>123</sup> a patient under s28 of the current MH(CAT) Act 1992 objected to the responsible clinician's decision that he should be given ECT. S sought the intervention of the court under s84 of the MHA whereby any person may apply to a High Court Judge to inquire into whether a patient is being appropriately or properly detained in hospital. The issue for the court was whether the provisions of s60 had been complied with or whether the court should invoke the power vested in it pursuant to section 84.

7.40 It was held in the High Court that Parliament had empowered the administration of ECT to non-consenting patients subject to the safeguard that the responsible clinician's opinion that treatment is beneficial is seconded by a psychiatrist appointed by the Review Tribunal. When the provisions of s60(b) were satisfied, no further inquiry need be made by those whose responsibility it is to administer treatment to the patient in question.

7.41 The Court did not address the question of competence or the duty to inform.<sup>124</sup> What is clear in these circumstances is that the supervisory function of the court does not afford the patient any right of appeal or review. This raises the question of what safeguards exist in relation to ECT apart from a second opinion against a decision to administer ECT non-consensually.

#### *Patient Rights, safeguards*

7.42 The MH(CAT) Act contains a specific statement of patients' rights or entitlements. A grievance mechanism is established through which complaints that rights have been denied or breached may be made to the District Inspector,<sup>125</sup> or the Official Visitor and thereafter to the Review Tribunal if the patient remains unsatisfied.<sup>126</sup> If recommendations are made to remedy breaches those responsible "shall ....rectify the matter".<sup>127</sup>

7.43 Specific rights granted include entitlements to: information about the patient's treatment<sup>128</sup> and legal position,<sup>129</sup> respect for cultural identity, language and religious beliefs,<sup>130</sup> right to receive medical treatment appropriate to their condition,<sup>131</sup> and to seek both independent legal<sup>132</sup> and psychiatric advice.<sup>133</sup>

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<sup>123</sup> [a mental patient] [1993] FRNZ 15

<sup>124</sup> See W Brookbanks, " Electro-convulsive Therapy and Consent to Treatment" [1993] *New Zealand Law Journal* 325 for a discussion of this case.

<sup>125</sup> The District Inspectors role resembles one of patient advocacy. They may appear before the Court at the hearing of a CTO application, as well as responding to complaints and inquiries. See J Dawson, "The Mental Health (Compulsory Assessment and Treatment) Act 1992 - Significant Advance on Previous Law" (1992) 378 *Law Talk* 3,4.

<sup>126</sup> MH(CAT) Act, s75.

<sup>127</sup> MH(CAT) Act, s75(2).

<sup>128</sup> MH(CAT) Act, s67.

<sup>129</sup> MH(CAT) Act, s64.

<sup>130</sup> MH(CAT) Act, s65.

<sup>131</sup> MH(CAT) Act, 66.

<sup>132</sup> MH(CAT) Act, s70.

<sup>133</sup> MH(CAT) Act, s69.

7.44 There is explicit recognition of the importance of cultural identity and beliefs to the well-being of the patient by virtue of section 5 of the Act.<sup>134</sup> This requirement is reinforced by section 65 which specifies as a basic patient right the entitlement to be dealt with in a manner which is consistent with the spirit and intent of section 5. “It may well be that the mandatory provision in s5 and the entitlement in s65 together would take precedence over a responsible clinician’s recommendation that ECT be administered in some circumstances”.<sup>135</sup> Where reasonably practicable, a practitioner must consult with family or whanau when assessing or providing treatment to a patient or proposed patient, unless it is not in the patient’s best interests to do so.

7.45 Breaches of the MH(CAT) 1992 can come within the jurisdiction of the Health and Disability Commissioner. Legal standards for compulsory care patients in Part VI of MH(CAT) can be incorporated into the Code by virtue of right 4(2) which provides that consumers have the right to services of an appropriate standard. This jurisdiction was established in Opinion 97 HDC 9553 where s67 of the Mental Health (CAT) Act was enforced by the office of the Health and Disability Commissioner.

7.46 In this case a psychiatrist treating a bipolar-disordered consumer failed fully to discuss the side-effects of medication prescribed for alcohol abuse treatment. The commissioner recommended redesigned systems to ensure that the providers understood and complied with the right preserved by s67. The provider had to provide evidence of protocols and policies on the treatment of patients with dual diagnosis including substance use disorders.

7.47 The Act has established an ongoing process of review. At any point after the first assessment at five days, and prior to the formal hearing for a Compulsory Treatment Order, a patient or other person specified in the Act may apply to have their situation reviewed by a Judge.<sup>136</sup> A CTO is initially granted for six months, with the requirement that a treatment team complete a clinical review after three months, and then every six months after that. If the patient is no longer in need of treatment, he or she must be discharged. After every formal clinical review, there is available to the patient a right of appeal to the Review Tribunal.<sup>137</sup> However the review is concerned with the patient’s

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<sup>134</sup> Section 5 states that a Court, Tribunal or person who exercises powers under the Act must do so with proper respect for a patient’s cultural and ethnic identity, language and religious or ethical beliefs; and with proper recognition of the importance to the patient’s ties with his or her family, whanau, hapu, iwi and family group. Section 5 may dictate not only the make up of the tribunal but also the language of the proceedings, and the nature of the evidence. Section 103(1)(b) permits tribunals to co-opt persons of a particular ethnic identity and s103(2) further emphasises this, making it mandatory to co-opt a person from the same ethnic background as the patient if the patient requests it. See S Bell, W Brookbanks, *Mental Health Law in New Zealand* (Brooker’s, New Zealand: 1996).

<sup>135</sup> Ibid, 151.

<sup>136</sup> MH(CAT) Act, s16.

<sup>137</sup> MH(CAT) Act, s76, 79. There must be an examination of the patient, consultation with other health professionals involved in the case, and those views must be taken into account in

legal status, and not treatment options, such as a decision to administer ECT.

7.48 There is no right of review against a decision to administer ECT to a patient without that patient's consent. The safeguards under the Act are attenuated in the context of ECT, and may promise more than they deliver in some circumstances. The most enduring safeguard is the provision of a second opinion. However, the robustness of second opinions has been questioned in some case law.<sup>138</sup>

*Refusal of treatment by a competent patient: Case Law - England*

7.49 There has been some suggestion that the decision of the English Court of Appeal in *R (on the application of W) v Broadmoor Hospital*<sup>139</sup> may cause New Zealand to revisit the permissible scope of a competent patient's ability to refuse consent to psychiatric treatment and how that power is to be balanced against competing issues of risk and public safety.<sup>140</sup>

7.50 In *R v Broadmoor*, the claimant was a convicted mental patient compulsorily detained at a secure hospital. The responsible medical officer proposed administering anti-psychotic medication to him which was endorsed by a second opinion appointed doctor. The patient objected vigorously, and sought a second opinion from an independent psychiatrist who supported the patient's objection. Although the case involved judicial review of a preliminary point of law, the Court of Appeal made several important observations.

7.51 The Court of Appeal approved the proposition that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention, and any derogation from the fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances. The Court also accepted that the admission of a person to a psychiatric establishment on an involuntary

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arriving at a finding concerning the patients condition. At the conclusion, the Responsible Clinician must complete a certificate of clinical review, stating whether the patient is fit to be released from compulsory status. Copies must be sent to the director of area mental health services, together with relevant reports and reasons for the opinion of the patients condition.

Where it is considered that the patient is not fit to be released from compulsory status, copies are sent with a statement of legal consequences and rights of review to the review tribunal, the patient, patient's principal care giver, DI, official visitor. Any person who received a certificate of clinical review under s76 can apply to the convenor of the review tribunal for a review of the patient's condition. That review must take place no later than 14 days after the application is received.<sup>137</sup>

<sup>138</sup> See *R v Broadmoor* [2001] EWCA Civ 1545 where Simon LJ found on evidence that is by no means apparent from his judgment that the approach of the second opinion doctors to the treatment proposals of RMO's was generally too "deferential". In the Canadian case *AM v Benes et al* 173 DLR (4<sup>th</sup>) 758 Sutherland J was damning of the Consent and Capacity Board's decision to overrule a substitute decision maker's decision to refuse consent to ECT on the grounds that there was eager and uncritical deference to the views of the medical practitioner. Whilst this was quite appropriate as to strictly medical matters it was not in dealing with related matters such as prior capable wishes or the substitute decision maker's motivations.

<sup>139</sup> [2001] EWCA Civ 1545; 1WLR 419

<sup>140</sup> *Trapiski's Family Law* Volume 3, Brookers' Wellington 1992, para 57.04.

basis should not be construed as authorising treatment without the person's consent.

7.52 Simon Brown LJ went further than the other Appeal judges, stating in obiter (a non-binding observation) that the introduction into English law of the Human Rights Act 1998<sup>141</sup> could make it unlawful to impose psychiatric medication upon a competent patient even though she or he was detained under the MHA.

7.53 The findings of Simon Brown LJ were consistent with the view taken by the Richardson Committee Report, which stated that the notion of patient autonomy and an emphasis on capacity would permit intervention in the absence of consent only in the case of those who lacked capacity.

7.54 However, neither the opinion of Simon LJ nor that of the Richardson Committee have been adopted by the Government in the proposed reform of the MHA (UK). The Government has stated that the principal concern in determining whether a patient should be made subject to a compulsory treatment order was not the capacity of the patient, but the degree of risk that the patient posed, to themselves or others.<sup>142</sup>

7.55 In the context of ECT, the retention of the ability to provide ECT to a competent refusing involuntary patient may depend upon the degree of confidence that ECT is a safe and effective treatment in the circumstances and the degree of harm posed by not providing it. Appeal rights to the Mental Health Review Tribunal in the case of a patient refusing ECT, whether competent or incompetent, may be worthy of consideration.

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<sup>141</sup> This Act incorporated the European Convention on Human Rights into English law. The MHA must subsequently be read down in a manner consistent with a patient's rights under the convention. Simon Brown LJ's judgment was influenced by a report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment.

<sup>142</sup> See D Hewitt, "An End to Compulsory Psychiatric Treatment?" (2002) 152 *New Law Journal* 194.

## PART II

### Legislative Frameworks

#### CHAPTER 8: ENGLAND

8.1 Under the current legislative framework in England, ECT may be administered to a patient if a patient consents and the responsible treater or a doctor appointed for the purpose by the Secretary of state certifies in writing that the patient is capable of understanding the nature, purpose and likely effect of ECT and has consented to it.<sup>143</sup>

8.2 If the patient is certified by the doctor appointed by the Secretary of State (the non-treating doctor) as unable to understand the nature, purpose and likely effects of ECT, or has not consented to it, ECT may still be administered subject to two safeguards.

8.3 The first requirement is that the doctor appointed by the Secretary of State certifies in writing that the patient should be given ECT having regard to the likelihood of its alleviating or preventing a deterioration in the patient's condition. The second is that prior to making the certifications the practitioner is obliged to consult two other persons who have been professionally concerned with the patient's medical treatment, one of them being a nurse and the other neither a nurse nor a medical practitioner.<sup>144</sup>

8.4 It is significant that whilst the New Zealand MH(CAT) Act was modelled on the English Act, the UK Act goes further, requiring certification of capacity in the case of consent and not only prescribing the circumstances in which ECT may be given but requiring multidisciplinary consultation when patient consent is not able to be obtained.

8.5 In circumstances of emergency, ECT may be given without consent or a second opinion where it is immediately necessary to save the patient's life; or which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or which (not being irreversible or hazardous) is immediately necessary alleviate serious suffering by the patient; or which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently

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<sup>143</sup> Mental Health Act 1983 (UK), s58 (3).

<sup>144</sup> "Consultation" does not require a unanimous decision, but a genuine invitation to give advice and a genuine consideration of that advice. See *R v Secretary of State for Social Services; Ex parte Association of Metropolitan Authorities* [1986] 1 All ER 164 at 167 per Webster J.

or being a danger to himself or to others.<sup>145</sup>

8.6 It was reported in 1996 that ECT was administered in circumstances of “emergency” at a “surprisingly high” level.<sup>146</sup> This means neither consent, nor a second opinion, nor consultation are required. There is no equivalent emergency provision in the New Zealand MH(CAT) Act.

8.7 In 1999 the English Government commissioned an expert committee under the leadership of Professor Genevra Richardson to offer advice in relation to the reform of the MHA (UK).<sup>147</sup>

8.8 The review group proposed that the criteria for compulsory detention under the new MHA should be capacity-based. The report advocated “patient autonomy”, and the desire to encourage the treatment of mental ill health according to principles similar to those which govern the treatment of physical ill health”.<sup>148</sup> This would permit intervention in the absence of consent only in the case of those who lacked capacity: a patient’s capable refusal of treatment would have to be allowed to prevail.<sup>149</sup>

8.9 Although “the enforced treatment of the capable and objecting patient simply in the interests of his or her own health as defined by professionals is no longer acceptable” it was suggested that compulsion might be permissible where, although it presented no dangers to the public, a capable patient’s mental illness could lead to self-harm.<sup>150</sup>

8.10 The committee recommended that certain forms of treatment, including ECT, should attract specific safeguards. Three recommendations in regard to ECT were made: that ECT should never be given to a patient with capacity who does not consent, that ECT should not be given to an incapacitated patient without the express approval of a tribunal, and that ECT should not be available on the equivalent of section 62 relating to the provision of emergency ECT without consent or a second opinion.

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<sup>145</sup> Mental Health Act 1983, s62 (1).

<sup>146</sup> P Fennell, *Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People Since 1845* (Routledge, London, 1996) 199. In a survey carried out between December 1991 and August 1992 112 of the 116 patients receiving emergency treatment were ECT cases. See also P Bartlett and R Sandland, *Mental Health Law, Policy and Practice* (Blackstone Press, London, 2000). Both cited in I Freckleton, B Wilson, “Electroconvulsive Therapy: Law, History and practice” (2001) 8 *Journal of Law and Medicine* 389, 416.

<sup>147</sup> See *Report of the Expert Committee. Review of the Mental Health Act 1983*. Department of Health, London (1999). Available at [www.doh.gov.uk/mhar/report.htm](http://www.doh.gov.uk/mhar/report.htm). It was thought that after the European Convention on Human Rights was incorporated into English domestic law by virtue of the Human Rights Act 1998 in October 2000 a new Mental Health Act was necessary.

<sup>148</sup> *Ibid*, para 2.1.

<sup>149</sup> *Ibid*, para 2.5.

<sup>150</sup> See *ibid*, paras 2.8, 2.9. 5.95, 7.19-7.24.

8.11 The subsequent White Paper on Reforming the Mental Health Act<sup>151</sup> did not accept either the concept of “patient autonomy” or the idea that compulsion ought to be contingent upon an absence of capacity.<sup>152</sup> Nor did it adopt the safeguards suggested by the committee in regards to ECT.

8.12 The White Paper stated that the new legislation would make provision for ECT provided as part of a care and treatment plan to require either the consent of the patient or the agreement of a doctor from the expert panel appointed to advise the Tribunal before the treatment is undertaken.<sup>153</sup>

8.13 In relation to emergency ECT, it was stated that “the Government is satisfied that ECT is a vital treatment that can save lives, particularly in cases of very severe depression. As now, clinical teams will be able to provide ECT to a patient without consent if there is an urgent need to do so in his or her best interests and it is not practicable to arrange for a second opinion”.<sup>154</sup>

8.14 The Department of Health requested the National Institute for Clinical Excellence to develop guidance on the treatment of resistant depression and as part of this to clarify the role of ECT and other treatment choices.<sup>155</sup> It was proposed that the policy for safeguards in legislation would be reviewed in the light of the new guidance.

8.15 The Draft Mental Health Bill 2002<sup>156</sup> was presented to the English Parliament in June 2002. Under the Bill, a patient who is subject to compulsory assessment and treatment may still be provided with electroconvulsive treatment either with their consent, or without consent on the basis of a second opinion. This will occur when such treatment is noted on the patient’s care plan by the patient’s clinical supervisor and is expressly authorised by the Mental Health Tribunal.<sup>157</sup>

8.16 Before a clinical supervisor makes an application to the Mental Health Tribunal for an order authorising ECT the clinical supervisor must consult the patient’s nominated person or carer where practicable (unless to do so would be inappropriate having regard to the patient’s wishes and feelings). If a carer

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<sup>151</sup> White Paper: *Reforming the Mental Health Act* (2000) (Cm 5016-I) Available at [www.doh.gov.uk/mentalhealth/whitepaper2000.htm](http://www.doh.gov.uk/mentalhealth/whitepaper2000.htm).

<sup>152</sup> D Hewitt, “An End to Compulsory Psychiatric Treatment?” (2002) *New Law Journal* 194.

<sup>153</sup> Op cit n 149, para 5.2.

<sup>154</sup> Op cit n 149, para 5.21.

<sup>155</sup> The National Institute for Clinical Excellence is part of the NHS. It produces guidance for both the NHS and patients on the use of medicines, medical equipment, diagnostic tests and clinical and surgical procedures and under what circumstances they should be used.

<sup>156</sup> Draft Mental Health Bill, Department of Health (2002) (Cm 5538-I). Available at [www.doh.gov.uk/mentalhealth/draftbill2002](http://www.doh.gov.uk/mentalhealth/draftbill2002). There has been significant protest against the bill which has been described as “draconian”. The Mental Health Alliance, a coalition of more than fifty organisations including the Law Society and the Royal College of Psychiatrists organised a lobby to parliament to oppose the draft bill. See <http://society.guardian.co.uk/mentalhealth/story/0,8150,817527,00.html> There is uncertainty as to whether it will be enacted in its current form.

<sup>157</sup> See Draft Mental Health Bill 2002, clause 118.

is consulted, they must inform the supervisor of what they think are the patient's wishes and feelings about treatment.<sup>158</sup>

8.17 ECT may be given in emergency circumstances on the same grounds as existed under the 1983 Act.<sup>159</sup> However, it does not authorise the provision of more than two applications of ECT to a compulsory patient on the basis of urgency.

8.18 In contrast to ECT, psychosurgery may only be performed if a registered medical practitioner who is a member of the expert panel and two other members of that panel who are not registered practitioners have certified in writing that the patient is capable of consenting to the treatment, that the patient has consented to it in writing, and that it is in the patient's best interests that he be given the treatment. Before providing a certificate the members of the expert panel must each consult with a registered nurse, and one other person (not a registered nurse) who have recently been professionally concerned with the patient's treatment, as well as any nominated person of the patient if practicable.

8.19 In the case of a patient who is incapable of consenting to psychosurgery, a medical practitioner and two others who are not medical practitioners but who are all part of the expert panel must certify that the patient is not capable of consenting to the treatment and there is no reasonable prospect that he will become capable of doing so, he is unlikely to resist the treatment, and it is in the patient's best interests that he be given the treatment. Similar consultation with two others and any nominated person prior to providing such a certificate is required. However, authorisation to proceed may only be given by the High Court declaring such a procedure to be lawful .

#### *Compliant Incapacitated Patients*

8.20 Patients with long-term mental incapacity, who are compliant incapacitated patients such as the patient in *Bournewood* continue to be treated under the common law, but the Bill introduces certain safeguards in relation to their care.<sup>160</sup>

8.21 Hospitalised persons qualifying under the Act for safeguards have a nominated person appointed to them who may be a relative, friend or

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<sup>158</sup> Ibid, clause 120.

<sup>159</sup> Ibid, clause 119.

<sup>160</sup> The safeguards are only available to compliant incapacitated patients receiving treatment in NHS or independent hospitals. The provisions do not extend to people in residential care homes or in the community. To qualify, the patient must be 16 or over, be suffering from a mental disorder which is of such a nature or degree as to warrant the provision of medical treatment to the patient, and it must be necessary for the patient to be a resident patient at a hospital for the purpose of providing the treatment to him. The treatment must be likely to continue longer than 28 days. The final condition is that the proposed treatment is capable of being provided under the common law. (The *Bournewood* decision is discussed at para 4.5).

professional person.<sup>161</sup> Such a person must be consulted about the patient's treatment.<sup>162</sup>

8.22 During the assessment period before approval of the care plan by a medical adviser appointed by the Expert panel, patients can be given no more than two applications of ECT. Further applications may only be given if a care plan proposing such treatment has been approved by the medical adviser or by the Tribunal.<sup>163</sup> The care plan must be formally reviewed at least every 12 months. The nominated person has a statutory right to request a review,<sup>164</sup> and further rights to apply to the Tribunal for a discharge.<sup>165</sup>

8.23 In response to some of the submissions regarding the White Paper, the Department of Health commissioned two systematic reviews of electroconvulsive treatment in 2001. One assessed the efficacy and safety in the treatment of depression<sup>166</sup> mania, and schizophrenia and the other reviewed surveys of patients' experiences.<sup>167</sup>

8.24 The evidence for the National Institute of Clinical Excellence's appraisal of electroconvulsive therapy was primarily drawn from these two reviews, and a Cochrane review on electroconvulsive therapy in schizophrenia.<sup>168</sup>

8.25 The NICE guidance on the use of electroconvulsive therapy<sup>169</sup> which was released in April 2003 would significantly restrict the circumstances in which ECT may be used, with heightened emphasis being placed on the need for improved consent procedures. It was recommended that ECT only be used to achieve rapid and short term improvement of severe symptoms after an adequate trial of other treatments has proven ineffective or when the condition is considered to be potentially life threatening, in individuals with severe depressive disorders, catatonia, and a prolonged or severe manic episode.<sup>170</sup>

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<sup>161</sup> Draft Mental Health Bill (2002), clause 127.

<sup>162</sup> Ibid, clause 128.

<sup>163</sup> Ibid, clause 131.

<sup>164</sup> Ibid 133(4).

<sup>165</sup> Ibid 136.

<sup>166</sup> The UK ECT Review Group, "Electroconvulsive Therapy: Systematic Review and Meta-analysis of Efficacy and Safety in Depressive Disorders." (2003) 361 *Lancet* 799.

<sup>167</sup> D Rose et al, "Patients' Perspectives on Electroconvulsive Therapy: Systematic Review" (2003) 326 *BMJ* 1363.

<sup>168</sup> See S Carney, J Geddes, "Electroconvulsive Therapy: Recent Recommendations are Likely to Improve Standards and Uniformity of Use" (2003) 326 *BMJ* 1343. The Cochrane study was P Tharyan, CE Adams, "Electroconvulsive therapy for Schizophrenia. Cochrane Schizophrenia Group (2003) 1 Cochrane Database Systematic Review CD000076.

<sup>169</sup> National Institute for Clinical Excellence, *Guidance on the use of electro-convulsive therapy*, London: NICE 2003. See [www.nice.org.uk/pdf/59ectfullguidance.pdf](http://www.nice.org.uk/pdf/59ectfullguidance.pdf)

<sup>170</sup> The institute was influenced by the review of patients' experiences and the recommendations are clearly meant to restrict the use of the treatment. The Royal College of Psychiatrists appealed that the recommendations went beyond the evidence and will prevent patients who would benefit from the treatment from being able to receive it. The appeal was rejected because the recommendations were considered to be sound in the face of uncertainty about long term adverse effects and the findings of the review of patients' experience. See National Institute for Clinical Excellence, *Appraisal of Electroconvulsive*

ECT was not recommended as a maintenance therapy in depressive illness.

8.26 The guidance emphasises the need for fully informed patient consent, with a thorough understanding of the risks, making clear that no patient should be coerced into treatment. It recommended the creation of nationally agreed evidence-based information leaflets.

8.27 The Draft Mental Health Bill is conspicuously less precise than the 1983 Act in describing in what circumstances it would be permissible to provide ECT to a patient, either consenting or non-consenting. However, as the guidance was commissioned by the Government in the course of drafting the legislation the Bill should be read in conjunction with the NICE guidance.

8.28 The Royal College of Psychiatrists have announced a new voluntary quality assurance scheme for ECT clinics, the ECT accreditation service.<sup>171</sup> They have also withdrawn and are revising their patient information statement on ECT.

8.29 Although the White Paper stated that advance agreements may be an important factor in determining what care and treatment is in a patient's best interests, this has not been incorporated into the Draft Bill. However, subsection 2 of Clause 1 of the Bill specifies that the Code of Practice, which is to be published by the Minister, will set out general principles that should guide all decisions made when using the provisions of the Bill.<sup>172</sup>

8.30 These general principles will be designed to ensure that, so far as practicable and appropriate, patients are involved in decisions affecting them, that decisions are made fairly and openly, and when providing compulsory medical treatment to patients, the least intrusive method of treatment should be adopted and the restrictions imposed on patients should be kept to the minimum necessary to protect their health and safety or to protect others. Guidance on advance agreements is to be included in the Code of Practice on the new legislation.

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*Therapy. Decision of the Appeal Panel.* London, NICE 2003. Available at [www.nice.org.uk/pdf/ECT\\_Final\\_panel\\_response.pdf](http://www.nice.org.uk/pdf/ECT_Final_panel_response.pdf)

<sup>171</sup> See C White, "New Guidance on ECT looks set to Curb its Use" (2003) 326 *BMJ* 1003.

<sup>172</sup> Draft Mental Health Bill, clause 1.

## CHAPTER 9: SCOTLAND

9.1 Scotland has also recently undergone a process of legislative reform. This began with the Millan Report,<sup>173</sup> which culminated in a Draft Mental Health Bill in 2002.<sup>174</sup> The new Mental Health (Care and Treatment) (Scotland) Act 2003 received Royal Assent on 25 April 2003 and should come into effect in April 2005.

9.2 The current Mental Health (Scotland) Act 1984 includes provision for the giving of ECT without consent.<sup>175</sup> The new legislation introduces significant changes in regard to ECT. Under the new Act, where a patient is capable of consenting and does not refuse consent, ECT may be administered where a medical practitioner certifies in writing that the patient is both capable and consents in writing to the treatment, *and* having regard to the likelihood of its alleviating, or preventing a deterioration in, the patient's condition, it is in the patient's best interests that the treatment should be given.

9.3 In the case of a patient who is incapable of consenting, ECT may be administered if a designated medical practitioner who is not the patient's responsible medical officer certifies in writing that the patient is incapable of understanding the nature, purpose and likely effects of the treatment, and that having regard to the likelihood of its alleviating, or preventing a deterioration in, the patient's condition, it is in the patient's best interests that ECT should be given.<sup>176</sup>

9.4 If a patient who is incapable resists or objects to the treatment, certification is effective only if the designated medical practitioner certifies in writing that the patient is incompetent and resists or objects to the treatment, but it is necessary to give treatment in order to save the patient's life, or to prevent serious deterioration in the patient's condition, or to alleviate serious suffering on the part of the patient, or to prevent the patient from behaving violently or being a danger to themselves or others.<sup>177</sup>

9.5 If a patient is competent, and refuses ECT, it cannot be given to that person

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<sup>173</sup> See *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984* Scotland (2001).

<sup>174</sup> For an executive summary of the Bill, see [www.scotland.gov.uk/library3/health.rhmls-00.asp](http://www.scotland.gov.uk/library3/health.rhmls-00.asp)

<sup>175</sup> Under the Mental Health (Scotland) Act 1984, a competent patient who did not consent to ECT could still receive ECT when a Doctor independently appointed by the Commission certified that having regard to the likelihood of its alleviating or preventing a deterioration of the patient's condition, treatment should be given (s98(3)(b)). Before granting the certificate the Doctor had to consult such persons as appeared to be principally concerned with the patient's medical treatment (s98(4)). However this did not apply in situations of urgency.

<sup>176</sup> Mental Health (Care and Treatment) (Scotland) Act 2003 s237, 238.

<sup>177</sup> Mental Health (Care and Treatment) (Scotland) Act 2003, s 237, 239, 243(3).

even in a situation of emergency.

9.6 The legislation expressly provides for advance directives made when the patient is competent. A person giving medical treatment to a patient who has made and not withdrawn an advance statement “shall have regard to the wishes specified in the advance statement”. Where a clinician does not follow the advance directive, the circumstances authorising treatment and the reasons for not following the advance statement must be clearly documented in the patient’s notes.<sup>178</sup>

9.7 The Adults with Incapacity (Scotland) Act 2000<sup>179</sup> is similar to the New Zealand Protection of Personal and Property Rights Act 1988. The purpose of the Act is to provide for decisions to be made on behalf of adults who lack legal capacity to do so themselves because of mental disorder or inability to communicate. These decisions may relate to administering property or financial affairs, or about personal welfare, and includes medical treatment.

9.8 During the time that a person is certified (by a doctor) as incompetent, a medical person or any person acting on their directions may lawfully provide medical treatment that is reasonable in the circumstances to safeguard or promote that person’s physical or mental health.<sup>180</sup> However, certain treatments, including ECT and brain surgery fall outside this general authority to give medical treatment to adults with incapacity.<sup>181</sup> The functions of a Guardian appointed under the Act are similarly curtailed.<sup>182</sup> Similarly the power of the Sheriff to make an intervention order does not extend to the power to direct detention of an adult in hospital for mental disorder or to consent to ECT or brain surgery.<sup>183</sup> Unlike the New Zealand context in regards to ECT, the Scottish Acts have distinct and separate jurisdictions.

9.9 The Royal College of Psychiatrists Special Committee on ECT and the Scottish ECT Audit Network have agreed upon a statement of good practice of ECT. This statement contradicts the NICE guidance in several respects.<sup>184</sup>

9.10 The Statement asserts that ECT is indicated for the treatment of moderate, not only severe, depressive disorder. It should not be reserved for treatment resistant depression on the basis that the evidence base for ECT provided by randomised trials carried out involved patients with moderate depression, not severe depression, because of the difficulties in obtaining consent from severely depressed people.

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<sup>178</sup> Mental Health (Scotland) Act 2003, s276. See *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984 Scotland*, (2001) 197.

<sup>179</sup> See [www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2000/00004-e.htm](http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2000/00004-e.htm)

<sup>180</sup> Adults with Incapacity (Scotland) Act 2000, s47.

<sup>181</sup> Adults with Incapacity (Scotland) Act 2000, s48.

<sup>182</sup> Adults with Incapacity (Scotland) Act 2000, s64(2).

<sup>183</sup> *Ibid*, s 53(14).

<sup>184</sup> This statement is available at [www.sean.org.uk/appraisal.php](http://www.sean.org.uk/appraisal.php)

9.11 Contrary to the NICE guidance it is stated that ECT may be used as a first line treatment in rare circumstances, such as where the patient has severe psychotic disorder which is extremely unlikely to respond to other treatments such as psychotherapy or antidepressants, where the patient has depressive stupor or such severe retardation that they are at physical risk, and where patients would choose ECT after a previous positive response. It was stated that patient choice was important and was supported by the SEAN audit data where patient choice was associated with one of the best response rates to ECT.

9.12 Whilst it was accepted that there was not good evidence for maintenance ECT, a small proportion of patients can only stay well when it is used. This was based on clinical experience and case studies.

9.13 Finally it was stated that the NICE conclusion that the cost benefit ratio (improvement versus side effects) against using ECT in moderate depression did not mean ECT was ineffective in the case of moderate depression. Contemporary forms of treatment such as brief pulse, titrated dosing and unilateral electrode placement were important in minimising cognitive adverse effects. In the absence of a life threatening condition, an initial trial of unilateral ECT will, in the opinion of the authors significantly alter the cost-benefit ratio because of a substantial reduction in the risk of retrograde amnesia.

## **CHAPTER 10: AUSTRALIA - QUEENSLAND**

### Queensland<sup>185</sup>

10.1 The Mental Health Act 2000 (Qld) is the most recent Australian state mental health enactment.<sup>186</sup> Whilst the Act's precursor did not make specific reference to the administration of ECT, the new Act does.

10.2 ECT may be provided at an authorised mental health service if informed consent has been given by the person<sup>187</sup> or the tribunal has approved the use of the therapy.<sup>188</sup>

10.3 Section 133 of the Act specifies the requirements for informed consent. The person must have capacity to give informed consent, and it must be in writing and signed.<sup>189</sup> Consent must be given freely and voluntarily. Specifically it is stated that consent is free and voluntary (not exclusively) when it is not obtained by force, threat, intimidation, inducement or deception or by

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<sup>185</sup> Sourced from [www.health.qld.gov.au/mha2000/](http://www.health.qld.gov.au/mha2000/) Current at July 2003. Accessed 18/02/04.

<sup>186</sup> The Act commenced on 28 February 2002 and replaced the Mental Health Act 1974 (Qld).

<sup>187</sup> Mental Health Act 2000 (Qld), s 139(1)(a).

<sup>188</sup> Mental Health Act 2000 (Qld), s139(1)(b).

<sup>189</sup> Mental Health Act 2000 (Qld), s134, 135.

exercise of authority.<sup>190</sup> An explanation must include the purpose, method, likely duration and expected benefit of the treatment; the possible pain, discomforts, risks and side effects associated with the treatment; alternative methods of treatment available to the person and be in a form and language able to be understood by the person.<sup>191</sup>

10.4 However there is a major limitation in the context of ECT being given to a voluntary patient without the patient's informed consent on the grounds of Tribunal approval. A doctor is prohibited from performing ECT on a person who is a voluntary patient if the doctor knows the person objects to the therapy.<sup>192</sup> "Objects" means that the person indicates that they do not wish to have ECT or the person previously indicated, in similar circumstances that they did not then wish to have ECT and since then the person has not indicated otherwise.<sup>193</sup>

10.5 Emergency ECT may be performed on an involuntary patient at an authorised mental health services when the following requirements are met. A psychiatrist and the medical superintendent for the health service must certify in writing that performing ECT on the patient is necessary to save the patient's life; or prevent the patient suffering irreparable harm.<sup>194</sup> Additionally a treatment application to perform ECT must be made to the Tribunal by the psychiatrist giving the certificate immediately after doing so.

10.6 A psychiatrist may apply to the Tribunal for approval to administer ECT to a person lacking capacity if the psychiatrist is satisfied that ECT is the most clinically appropriate treatment alternative for the person having regard to the person's clinical condition and treatment history; and the person is incapable of giving informed consent to the treatment.<sup>195</sup>

10.7 The psychiatrist must inform the patient and the patient's allied person in the case of an involuntary patient, or the person themselves if they are a voluntary patient regarding the application. The Tribunal must decide a treatment application within a reasonable time after it is made.<sup>196</sup> If the application is for emergency ECT then the tribunal must decide the application within 5 days.

10.8 The Tribunal must give written notice of a hearing of a treatment application for approval to administer ECT to the person the subject of the application, and the person's allied person if the person is an involuntary

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<sup>190</sup> Mental Health Act 2000 (Qld), s136.

<sup>191</sup> Mental Health Act 2000 (Qld), s137.

<sup>192</sup> Mental Health Act 2000 (Qld), s139(2).

<sup>193</sup> The examples provided in the Act of how a person may indicate that they do not want ECT include indication by an enduring power of attorney or advance health directive or in another way, including orally or by a person's conduct.

<sup>194</sup> Mental Health Act 2000 (Qld), s140(1)(2). The certificate remains in force for 5 days after it is made.

<sup>195</sup> Mental Health Act 2000 (Qld), s229(1)(a)-(b).

<sup>196</sup> Mental Health Act 2000 (Qld), s 231(1),(2).

patient; the parent or guardian if the person is a minor; the attorney or guardian if the tribunal reasonably believes the person has a personal attorney or guardian, the administrator of the authorised mental health service in which the ECT is to be administered, and the applicant.<sup>197</sup>

10.9 The Tribunal is statutorily directed not to approve ECT unless it is satisfied that the person does not have the capacity to give informed consent to the administering of ECT and ECT is the most appropriate treatment in the circumstances having regard to the person's clinical condition and treatment history.<sup>198</sup>

10.10 When approval is given, the tribunal must specify the number of treatments that may be given in a stated period.<sup>199</sup> A copy of the decision must be given to the parties to the proceeding, the administrator of the mental health service, and the person's allied person in the case of an involuntary patient.<sup>200</sup>

10.11 Additionally, the tribunal must give the parties written notice informing them that they may ask for written reasons for the tribunal's decision within seven days after receiving the notice, and within 28 days may appeal to the Mental Health Court against the decision, and information about how to appeal.<sup>201</sup> If a tribunal receives a request for information, they must give the reasons for the decision within seven days after receiving the request unless a confidentiality order displaces this requirement.<sup>202</sup>

## CHAPTER 11: WESTERN AUSTRALIA

### *Current practice*<sup>203</sup>

11.1 The Mental Health Act 1996 (WA) prohibits the performance of ECT on an involuntary patient or a mentally impaired defendant who is in an authorised hospital unless the treating psychiatrist recommends it and the recommendation is approved by another psychiatrist.<sup>204</sup> However this does not apply in an emergency when ECT is necessary to save the person's life, or to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.<sup>205</sup>

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<sup>197</sup> Mental Health Act 2000 (Qld), s232 (2)(a)-(g).

<sup>198</sup> Mental Health Act 2000 (Qld), s233(2).

<sup>199</sup> Mental Health Act 2000 (Qld), s233(3).

<sup>200</sup> Mental Health Act 2000 (Qld), s234(a)(b).

<sup>201</sup> Mental Health Act 2000 (Qld), s234(2)(a)-(c). The Mental Health Court is constituted by a Supreme Court judge assisted by two experienced psychiatrists.

<sup>202</sup> Mental Health Act 2000 (Qld), s234 (3)(4).

<sup>203</sup> [www.chiefpsychiatrist.health.wa.gov.au/documents/The\\_Mental\\_Health\\_Act1996.pdf](http://www.chiefpsychiatrist.health.wa.gov.au/documents/The_Mental_Health_Act1996.pdf)

<sup>204</sup> Mental Health Act 1996 (WA), s104. Penalty for breach of this section is a \$10 000 fine and imprisonment for 2 years.

<sup>205</sup> Mental Health Act 1996 (WA) s104(2).

11.2 Before a psychiatrist approves a recommendation for ECT the psychiatrist must be satisfied that the ECT has clinical merit and is appropriate in the circumstances. The second psychiatrist must determine whether or not the person concerned has the capacity to give informed consent to the proposed therapy.

11.3 If the person possesses capacity that psychiatrist must ascertain whether or not that consent has been given, and must have regard to whether or not that consent has been given. However, the principal criterion for administration of ECT to involuntary and “mentally impaired” patients is clinical merit and appropriateness, a very broad notion, and one in respect of which the patient does not have any right of appeal.<sup>206</sup>

11.4 In the event that the psychiatrist does not approve the recommendation for ECT the recommending psychiatrist is to refer the matter in writing to the Mental Health Review Board.<sup>207</sup> The Board is not authorised to substitute its decision for that of the psychiatrist withholding approval. However if that psychiatrist continues to withhold approval the Board may recommend an alternative treatment to the treating psychiatrist, or transfer responsibility for treating the person from the treating psychiatrist to another psychiatrist, or in the case of an involuntary patient, order that the person is no longer an involuntary patient.

11.5 In the case of patients who are neither involuntary patients nor a mentally impaired defendant who is in an authorised hospital, ECT may be given provided informed consent as described in the Act is obtained.<sup>208</sup> However the requirement may also be waived in the context of an emergency.<sup>209</sup> The fact that a person refused to give, or was incapable of giving informed consent is not a defence to a charge of breaching this requirement.<sup>210</sup>

11.6 The Act expressly provides the elements necessary for a valid consent. The consent must be freely and voluntarily given. Failure to resist does not of itself constitute consent to treatment.<sup>211</sup> A patient must have the requisite capacity to make an informed consent and as such must be capable of understanding the things that are required to be communicated pursuant to the

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<sup>206</sup> See I Freckleton, B Wilson “Electroconvulsive Therapy: Law, History and Practice” (2001) 8 *Journal of Law and Medicine* 389, 421.

<sup>207</sup> Mental Health Act 1996 (WA) s106(1). This is not a frequent occurrence. In the period between when the Act came into force in 1998 and 2001 it only happened once. See I Freckleton, B Wilson “Electroconvulsive Therapy: Law, History and Practice” (2001) 8 *Journal of Law and Medicine* 389, 421.

<sup>208</sup> Mental Health Act 1996 (WA) 107(1).

<sup>209</sup> Mental Health Act 1996 (WA) 107(2). “Emergency psychiatric treatment” is defined in s113(1) as treatment necessary to give to a person to save the person’s life; or to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.

<sup>210</sup> Mental Health Act 1996 (WA) s107(3). Penalty for breach of s107 is a fine of \$10 000 and 2 years imprisonment.

<sup>211</sup> Mental Health Act 1996 (WA) s95(1),(2).

Act, the matters involved in the decision and the effect of giving consent.<sup>212</sup>

11.7 Prior to making an informed consent, the patient must be given a clear explanation of the proposed ECT, containing sufficient information to enable the patient to make a balanced judgment about the treatment.

11.8 Any medication or technique about which there is insufficient knowledge to justify its recommendation or to enable its effect to be reliably predicted must be identified and explained and the patient must be warned about any of the risks inherent in the treatment.<sup>213</sup>

11.9 This requirement to warn about risks is limited to information that a reasonable person in the patient's position would be likely to regard as significant unless it is, or reasonably should be, known that the patient would be likely to regard other information as significant.<sup>214</sup>

11.10 It is expressly provided that anything required to be communicated to a patient is not to be considered to have been effectively communicated unless it is in a language or form that is readily understood by the patient using a competent interpreter if necessary and it is so expressed as to facilitate his or her understanding of what is required to be communicated.<sup>215</sup> It is further specified that sufficient time to consider the matters involved in the decision and to obtain such advice and assistance as may be desired must be given before informed consent is considered to be given.<sup>216</sup>

11.11 Whilst these are precise and detailed requirements, it is notable that the pamphlet provided by the office of the Chief Psychiatrist does not provide detailed information regarding ECT. ECT is described as "very safe." Side effects of ECT are described as possibly some initial confusion and a headache. It is stated that "some people complain about having a poor memory for a while after treatment, but this does not usually last".<sup>217</sup>

#### *Proposed Recommendations for change*

11.12 In July 2002 the Minister for Health and the Attorney General of Western Australia commissioned a review of the Mental Health Act 1996. The purpose of the review was to consider the operations and effectiveness of the Mental Health Act 1996 and the Criminal Law (Mentally Impaired Defendants) Act 1996 and make recommendations as to alterations in the legislation. The Review concluded at the end of 2003.

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<sup>212</sup> Mental Health Act 1996 (WA) s96.

<sup>213</sup> Mental Health Act (WA) 1996, s97(1) (a)-(c).

<sup>214</sup> Mental Health Act (WA) 1996, s95(2).

<sup>215</sup> Mental Health Act (WA) 1996, s97(4).

<sup>216</sup> Mental Health Act (WA) 1996, s98.

<sup>217</sup> See *Electroconvulsive Therapy, Information about Electroconvulsive Therapy and your Rights under the Mental Health Act 1996*, Office of the Chief Psychiatrist, Department of Health, Government of Western Australia 2003. Available at [www.chiefpsychiatrist.health.wa.gov.au/documents.cfm\\*legislation](http://www.chiefpsychiatrist.health.wa.gov.au/documents.cfm*legislation)

11.13 One of the recommendations of the review group in regards to the treatment of patients was that the Chief Psychiatrist should establish a Best Practice Committee to make recommendations concerning the treatment and care of mental illness. This should also include the production of information and educational strategies concerning treatment practices, medication, research and other relevant matters. It was also recommended that a statement of best practice principles be published by the office of the Chief Psychiatrist, made in accordance with the National Standards for Mental Health Services, and the UN Principles .

11.14 In September 2003 the Chief Psychiatrist Advisory Group on ECT was set up.<sup>218</sup> The purpose of the group is to provide advice and recommendations to the Chief Psychiatrist on the future developments of best practice and monitoring of ECT in Western Australia. It is proposed that the advisory group will

- develop a set of standards in relation to the practice of ECT throughout the state
- develop best practice guidelines in relation to ECT
- consider and report on the contentious issues in relation to ECT
- consider the development of an accreditation process in relation to clinicians and services who practice ECT
- consider the development of a framework for the Chief Psychiatrist to monitor the practice of ECT throughout the state
- other activities as requested by the Chief Psychiatrist or Director General of Health

11.15 Significantly, whilst the Western Australia government has provided a broad legislative framework, the finer points of regulating ECT has been left to a group which includes professionals involved with the administration of ECT, consumers, carers and governmental representatives.

#### *Informed consent*

11.16 Another recommendation made by the Mental Health Act review group was that the Act should have a more comprehensive statement of the general requirements for informed consent. This was as a result of concerns regarding the adequacy of how informed consent is defined in the WA Act. It is proposed that the informed consent provision in part 5 of the Act be expanded using the Northern Territories Act as a template. This would add the requirements that there should be no inducement, that information should be communicated on a form designed for the purpose, and the right to request that another person be present. In regards to capacity to consent it was recommended that the patient must have the ability to communicate consent. Other recommendations were that the patient should receive advice about alternative treatments, (which would include no treatment) that treatment may be refused, that a second

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<sup>218</sup> See [www.chiefpsychiatrist.health.wa.gov.au/ECT.cfm](http://www.chiefpsychiatrist.health.wa.gov.au/ECT.cfm) This website contains various documents and reports, and includes links to ECT sites that publish information against ECT.

independent opinion may be sought, rights of review, and disclosure of any relevant financial advantage for providers or research relationships.<sup>219</sup>

#### *Informed consent by voluntary patients*

11.17 In regards to voluntary patients, concern was expressed that there was no statutory guidance on the issue of consent to treatment where a voluntary patient is incapable of giving informed consent or the psychiatrist is unable to form a view as to whether the person is capable of giving consent. The proposed recommendation includes inserting a new section in the Act which clarifies that for a voluntary patient to receive psychiatric treatment, they must either give informed consent, have a guardian who gives informed consent on their behalf, or be deemed in need of emergency psychiatric treatment.

#### *Informed consent by involuntary patients*

11.18 In the context of administration of treatment to involuntary patients, significant reform is proposed. Currently s109 of the WA Act states that “An involuntary patient, or a mentally impaired defendant who is in an authorised hospital, may be given psychiatric treatment without his or her consent”. It is recommended that this should be moved to division 2 of part 5 and be replaced with the words “If by reason of mental illness a person is unable to give or unreasonably withholds informed consent then an involuntary patient or a mentally impaired defendant who is in an authorised hospital may be given treatment without his or her consent.”

11.19 Where the psychiatrist believes that treatment is in the best interest of the person; the anticipated benefits of the treatment would outweigh any risks, alternative treatments that would be likely to produce equivalent benefits and with less risks are not reasonably available; and the treatment represents the least restrictive and least intrusive treatment option reasonably available; then the treating psychiatrist may apply to the Mental Health Review Board of a similar independent body for such treatment to be authorised. Having made an application to authorise treatment to the MHRB or similar independent body on the grounds above, the treating psychiatrist may administer treatment while such an application is pending review.<sup>220</sup>

#### *Recommendations regarding ECT*

11.20 It was further stated in the recommendations that given that ECT is a

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<sup>219</sup> See section 7, Northern Territories Act.

<sup>220</sup> The review group noted that the proposal that involuntary treatment be reviewed (retrospectively) by an independent body such as the MHRB would be consistent with the UN Principle 11. The recommendations are also consistent with the UN principle that except where treatment is urgently necessary to prevent immediate or imminent harm to the patient or other persons, no treatment should be given to a patient without his or her consent, except under the following conditions: the patient is an involuntary patient; an independent and well informed authority is satisfied that the patient lacks the capacity to give or withhold informed consent, or the patient unreasonably withholds consent; the independent authority is satisfied that the proposed plan of treatment is in the patient’s best interest; and there is no personal representative empowered by law to consent to treatment for the patient.

controversial treatment that is seen to require a degree of regulation, the requirement for the collection of state-wide statistics to monitor the extent of its use was reasonable notwithstanding that the review had been presented with a considerable body of medical evidence that ECT can be highly beneficial therapeutically to significant groups of people with mental illness and especially those with severe psychotic depressive illness.

11.21 The review received evidence that at least in adults, ECT performed in accordance with contemporary best practice guidelines is a safe procedure with few side effects other than a loss of short-term memory.

11.22 In regards to second opinions, the review acknowledged concern that there is a perception that some second opinions are insufficiently independent and that this lack of independence is inconsistent with the spirit of the Act. It was stated that questionable independence is most likely to occur when the second opinion is sought from a psychiatrist at the same facility as the treating psychiatrist.

11.23 It was recommended that reference to a second opinion from a psychiatrist should be amended to “independent psychiatrist” and that the Chief Psychiatrist should publish guidelines for what constitutes a second opinion from an independent psychiatrist.<sup>221</sup> It is also proposed to make a recommendation that when a second opinion is sought and its subsequent outcome must be notified to the Chief Psychiatrist.

11.24 A significant recommendation for reform is to repeal the provisions relating to giving ECT as an emergency treatment. It was advised that under current practice ECT is neither undertaken nor considered appropriate as an emergency procedure.

11.25 It is recommended that urgent Board or Tribunal review should be undertaken in those cases where ECT is proposed for minors. It is also proposed to recommend that in the case of minors under the age of 12 ECT should be prohibited as there is no clinical evidence justifying the provision of the treatment in these circumstances. Where ECT is considered for minors over the age of 12, the proposed amendment requires that the second opinion psychiatrist be a psychiatrist with specialist training in child and adolescent mental illness.

## CHAPTER 12 AUSTRALIA - VICTORIA<sup>222</sup>

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<sup>221</sup> It would be expected that such guidelines would cover the absence of close professional, pecuniary or social relationships; but also allow for conditions under which the full independence of a second opinion may need to be compromised due to the practicability of obtaining any form of second opinion.

<sup>222</sup> Sourced from [www.health.vic.gov.au/mentalhealth/legislation.htm](http://www.health.vic.gov.au/mentalhealth/legislation.htm) Effective from

12.1 Section 53B of the Victorian Mental Health Act 1986 expressly provides the requirements for obtaining informed consent for the care and treatment of people with a mental disorder, which includes ECT. Informed consent will only be considered to have been obtained from a person if written consent to treatment occurs after;

- (a) the person has been given a clear explanation containing sufficient information to enable him or her to make a balanced judgement; and
- (b) the person has been given an adequate description of benefits, discomforts and risks without exaggeration or concealment; and
- (c) the person has been advised of any beneficial alternative treatments; and
- (d) any relevant questions asked by the person have been answered and the answers *have been understood*<sup>223</sup> by the person; and
- (e) a full disclosure has been made of any financial relationship between the person seeking informed consent or the registered medical practitioner who proposes to perform the treatment, or both, and the service, hospital or clinic in which it is proposed to perform the treatment.<sup>224</sup>

12.2 A further requirement is that the recipient of the treatment be given the prescribed brochure advising the person of their legal rights and entitlements including rights to legal and medical advice (including a second opinion) and to be represented before giving consent, and the right to refuse or withdraw consent at any time.<sup>225</sup> This must be supplemented by an oral explanation of the information contained in the statement. If the person appears not to have understood, or to be incapable of understanding the information contained in the statement, arrangements must be made to convey the information to the person in the language, mode of communication or terms which they are most likely to understand.<sup>226</sup> The provision of ECT without informed consent as prescribed above constitutes both an offence against the Act<sup>227</sup> and professional misconduct.<sup>228</sup>

12.3 Where a person in respect of whom a guardian (within the meaning of the Guardianship and Administration Act 1986 or a responsible person within the meaning of section 37 of that Act) or an agent has been appointed (under the Medical Treatment Act 1988) has refused or is unable to give consent to treatment, or has given such consent, only that person's personal refusal or consent is relevant and not the refusal or consent of that person's guardian, the

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<sup>223</sup> Italics are my emphasis.

<sup>224</sup> Mental Health Act 1986 (Vic) s53B (1).

<sup>225</sup> Mental Health Act 1986 (Vic) s53B (2). This brochure is "Electroconvulsive Therapy-About your Rights" Victorian Government Department of Human Services, Victoria, 2002. Also available at <http://www.health.vic.gov.au/mentalhealth/patientrights/ect.html>. Accessed 06/01/04.

<sup>226</sup> Mental Health Act 1986 (Vic) s53B (3). See section 3 A, Mental Health Act 1986 (Vic).

<sup>227</sup> Mental Health Act 1986 (Vic) 73 (1).

<sup>228</sup> Mental Health Act 1986 (Vic) 73 (2), unless the registered medical practitioner is able to prove that there were valid reasons for not obtaining that consent.

person responsible the agent or the Tribunal.<sup>229</sup> This effectively means that the consent or refusal of the patient overrides the consent or refusal of another person legally appointed to make medical decisions on the behalf of the patient.

12.4 In the case of a forensic, an involuntary, or a security patient who is incapable of giving informed consent, ECT may be performed if the authorised psychiatrist has authorised the proposed ECT after being satisfied of the following factors. The ECT has clinical merit and is appropriate, having regard to any benefits, discomforts or risks the ECT should be performed, any beneficial alternative treatments have been considered and unless the ECT is performed the patient is likely to suffer a significant deterioration in their physical or mental condition.<sup>230</sup> It is also necessary that all reasonable efforts have been made to notify the patient's guardian or primary carer of the proposed ECT.<sup>231</sup>

12.5 It is important to note that the Authorised Psychiatrist may only consent for a patient who is *incapable* of giving consent, not a patient who is *unwilling* to give consent. A capable person has the right to refuse ECT. The only exception is where the "nature of the mental disorder that a person has is such that the performance of the ECT is urgently needed".<sup>232</sup>

12.6 The decision in relation to the administration of ECT to involuntary patients in Victoria is essentially a clinical decision and not subject to any formal mechanism of external oversight.<sup>233</sup>

12.7 There is particular emphasis in the Victorian legislation on the licensing of premises in which ECT may be performed. ECT may only be performed on a person at premises which are licensed under the Act.<sup>234</sup> Again it constitutes both an offence against the Act and professional misconduct to perform ECT in unlicensed premises unless the medical practitioner satisfies the relevant professional body that there were valid reasons for contravening the Act.

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<sup>229</sup> See section 3 of the Mental Health Act 1986 (Vic).

<sup>230</sup> Mental Health Act 1986 (Vic), s73(3)(a)(i-iv).

<sup>231</sup> Mental Health Act 1986 (Vic), s73(3)(b). It is stated in the Victorian Clinical Practice Guidelines that where the primary carer or guardian opposes the performance of ECT, the Authorised Psychiatrist must wherever possible obtain a second psychiatric opinion and do everything possible to inform and relieve the anxiety of those concerned. However, the final decision rests with the Authorised Psychiatrist.

<sup>232</sup> Mental Health Act 1986 (Vic), s73(4). The circumstances which constitute "urgency" are not specified in the Act.

<sup>233</sup> See I Freckleton, B Wilson, "Electroconvulsive Therapy: Law, History and Practice" (2001) 8 *Journal of Law and Medicine* 389, 421. Whilst there is no statutory requirement for a second opinion it should be noted however that in the Clinical Practice Guidelines in the *ECT Manual* published by the Department of Human Services, Victoria it is stated that when ECT is proposed to be performed on an involuntary, security or forensic patient, a second opinion should be obtained. This opinion should be recorded in writing in the case notes before the ECT is given. Available at <http://www.health.vic.gov.au/mentalhealth/publications/ect/partd.htm> >accessed 06/01/04.

<sup>234</sup> Mental Health Act 1986 (Vic), s74.

12.8 In considering an application the Secretary must consider the suitability of the applicant to hold a licence, the suitability of the premises and equipment to be used for ECT, and the qualifications of any person to be permitted to perform ECT on the premises.<sup>235</sup> A licence may be issued subject to conditions, limitations or restrictions as the Secretary considers appropriate.<sup>236</sup> A licence continues for the period of five years, after which it must be renewed.<sup>237</sup> Appeals relating to licensing decisions may be made to the Victorian Civil and Administrative Tribunal.<sup>238</sup>

12.9 The Mental Health Legal Centre is an independent legal service which specialises in mental health legal issues in Victoria, and is an advocacy group for consumers. In May 2000 it published *A Position Paper on the Law and Electroconvulsive Therapy in Victoria*.<sup>239</sup> The paper recommended that the law be reformed to include compulsory review by the Mental Health Review Board for approval of all ECT where informed consent is not possible; that ECT only be given without consent where the person is likely to suffer serious mental or physical deterioration; informed consent to be a three-step process with regular review of the person's capacity; repeal of the existing legislation on emergency ECT, the risks and benefits to be explained in writing; the presence of an appropriately trained independent person; and the reporting of ECT in both private and public hospitals.

12.10 It has been observed by two academics writing in the area who have also been Presidents of the Mental Health Review Board in Victoria that it may be preferable that appeal rights be available rather than compulsory review by a tribunal which can itself be intrusive and delaying. External scrutiny via appeal rights for patients who do not wish to have ECT has much to commend it by introducing a form of additional perspective; giving consumers a voice in relation to a treatment that can have frightening associations for many patients; and by providing for greater transparency generally of ECT administration".<sup>240</sup>

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<sup>235</sup> Mental Health Act 1986 (Vic), s 75(5)(a)-(d).

<sup>236</sup> Mental Health Act 1986 (Vic), s75(4).

<sup>237</sup> For detailed licensing criteria, see part E of the *ECT Manual*, Department of Human Services, Victoria, available at <http://www.health.vic.gov.au/mentalhealth/publications/ect/partd.htm>>accessed 9/1/04

<sup>238</sup> Mental Health Act 1986 (Vic). S79(1).

<sup>239</sup> Mental Health Legal Centre Inc, *A Position Paper on the Law and Electroconvulsive Therapy in Victoria*, (May 2000). Available at <http://home.vicnet.net.au/~mhlc/lawref.html>>accessed 06/01/04.

<sup>240</sup> I Freckleton, B Wilson, "Electroconvulsive Therapy: Law, History and Practice" (2001) 8 *Journal of Law and Medicine* 389, 423, 425.

## CHAPTER 13: AUSTRALIA - NEW SOUTH WALES<sup>241</sup>

13.1 New South Wales imposes stringent regulations in regard to ECT. It is also the place where in the 1970's patients at the Chelmsford private psychiatric hospital were exposed to "deep sleep therapy". Patients were placed in a drug-induced sleep for up to three weeks, during which time they were administered ECT, at times without the patient's knowledge or consent. It has been claimed that 48 people died from this treatment.<sup>242</sup> It prompted a 1990 Royal Commission inquiry into the treatment to find that electroshock used without proper consent is an act of violence and an assault.<sup>243</sup>

13.2 The Mental Health Act 1990 (NSW) expressly prohibits deep sleep therapy, or insulin therapy, or certain prescribed operations or treatments.<sup>244</sup> ECT may only be administered by a medical practitioner<sup>245</sup> and the locations at which it may be administered are limited to hospitals, or a place approved by the Director General.<sup>246</sup> During the administration of ECT the Act specifies that no less than two medical practitioners are to be present, one of whom may be the medical practitioner performing the ECT. One must be experienced in the administration of ECT, and the other in the administration of anaesthesia.<sup>247</sup>

### *Informed Consent*

The following must be provided to a person before consent is obtained;

- (a) a fair explanation must be made of the techniques or procedures to be followed, including an identification and explanation of any technique or procedure about which there is not sufficient data to recommend it as a recognised treatment or to reliably predict the outcome of its performance.
- (b) a full description must be given, without exaggeration or concealment, to the person of the possible attendant discomforts and risks (*including possible loss of memory*), if any and<sup>248</sup>
- (c) a full description must be given to the person of the benefits, if any, to be expected, and
- (d) a full disclosure must be made, without exaggeration or concealment, to the person of appropriate alternative treatments, if any, that would be advantageous for the person, and
- (e) an offer must be made to the person to answer any inquiries concerning the procedures or any part of them, and
- (f) notice must be given to the person that the person is free to refuse or to withdraw consent and to discontinue the procedures or any of them at

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<sup>241</sup> Sourced from [www.austlii.edu.au](http://www.austlii.edu.au), current as of 19 December 2003.

<sup>242</sup> J Eastgate, "The Case Against Electroshock Treatment" *USA Today* November 1998, 28.

<sup>243</sup> See the *Report of the Royal Commission into Deep Sleep Therapy / The Honourable Mr Acting Justice JP Slattery, Royal Commissioner* New South Wales Royal Commission into Seep Sleep Therapy (1990).

<sup>244</sup> Mental Health Act 1990 (NSW) s197.

<sup>245</sup> Mental Health Act 1990 (NSW) s180.

<sup>246</sup> Mental Health Act 1990 (NSW) s182.

<sup>247</sup> Mental Health Act 1990 (NSW) s181.

<sup>248</sup> Italics are my emphasis.

- any time, and
- (g) a full disclosure must be made to the person of any financial relationship between the person proposing the administration of the treatment or the medical practitioner who proposes to administer the treatment, or both, and the hospital or institution in which it is proposed to administer the treatment, and
  - (h) notice must be given to the person that the person had the right to obtain legal and medical advice and to be represented before giving consent, and
  - (i) any question relating to the techniques or procedures to be followed that is asked by the person must have been answered and the answers must *appear to have been understood* by the person.<sup>249</sup>

13.3 The regulations are to prescribe forms used for the purpose of setting out in writing the matters required above and an oral explanation must be given to the person concerned in a language with which the person is familiar.<sup>250</sup> A person is to be taken to have given informed consent to ECT if the person has given a free, voluntary and written consent after the above has been complied with.<sup>251</sup>

13.4 Significantly, the Act provides that a person is presumed incapable of giving informed consent who has received medication which at the time the consent is sought impairs the person's ability to give consent.<sup>252</sup>

*Circumstances in which treatment may be administered with consent – persons other than involuntary patients*

13.5 In the case of capable persons who are not involuntary patients, and who have given consent in writing, treatment may only be administered if two medical practitioners, at least one of whom is a psychiatrist, certify in writing, that; "after considering the person's clinical condition, history of treatment and any appropriate alternative treatments, they are of the opinion that the treatment is a reasonable and proper treatment to be administered to the person and is necessary or desirable for the safety or welfare of the person".<sup>253</sup>

13.6 A medical superintendent who is unsure whether a person is capable of giving informed consent may apply to the Tribunal to have the Tribunal determine whether the person is capable of giving informed consent and has given that consent.<sup>254</sup> However if there is no doubt regarding competency Tribunal approval is not otherwise required in the case of voluntary patients

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<sup>249</sup> Mental Health Act 1990 (NSW) s183(1). It has been observed in regard to this last requirement that curiously it is only the answers to questions that must be "appear to be understood", not the general information provided. If a patient is significantly depressed or intimidated questions may be sparse. This means that the understanding criterion is largely irrelevant. See I Freckleton, B Wilson *Electroconvulsive Therapy: Law, History and Practice* (2001) 8 *Journal of Law and Medicine* 389.

<sup>250</sup> Mental Health Act 1990 (NSW), s183(2).

<sup>251</sup> Mental Health Act 1990 (NSW), s181(3).

<sup>252</sup> Mental Health Act 1990 (NSW), s184.

<sup>253</sup> Mental Health Act 1990 (NSW), s185(1).

<sup>254</sup> Mental Health Act 1990 (NSW), s184(2).

consenting to ECT.

*Circumstances in which ECT may be administered to involuntary patients*

13.7 In respect of involuntary patients, if at least two medical practitioners at least one of whom is a psychiatrist, certify in writing that after considering the clinical condition and history of treatment of, and any appropriate alternative treatments for a patient (not being an informal patient) or any other person under detention in a hospital, they are of the opinion that ECT is a reasonable and proper treatment, and necessary or desirable for the safety or welfare of the patient or person, the medical superintendent may apply to the Tribunal to determine the following:<sup>255</sup>

whether or not the patient or person is capable of giving informed consent and has given that consent, and  
if the patient is incapable of giving informed consent or capable of giving informed consent but has refused, or has neither consented nor refused ECT whether its administration is reasonable and proper and is necessary or desirable for the safety or welfare of the person.<sup>256</sup>

13.8 The medical superintendent must do all things reasonably practicable to give notice to the nearest relative or a relative nominated by the person or patient, or their guardian or any personal friends (up to 2) if the patient consents to such notification, and must hold an inquiry as soon as practicable.<sup>257</sup>

13.9 The Tribunal must consider the medical certificates and the person or patient's views about the treatment.<sup>258</sup> Inquiry must be made into whether the patient has been administered medication and take account of its effect on the patient or person's ability to communicate.<sup>259</sup>

13.10 The Tribunal may determine whether a voluntary or involuntary patient is capable of giving consent and whether consent has been given. In the case of an involuntary patient the Tribunal may determine whether the person or patient is incapable of giving informed consent to ECT or is capable but has refused, or neither consented nor refused and after considering the medical opinions and any other information placed before it be satisfied that the ECT is a reasonable and proper treatment and is necessary or desirable for the safety or welfare of the person or patient.<sup>260</sup> The case of an involuntary patient who consents to ECT must still go before the Tribunal. However, the medical superintendent may refuse to allow ECT even though a determination in favour of it has been made by a Tribunal.<sup>261</sup>

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<sup>255</sup>Mental Health Act 1990 (NSW) s188(1).

<sup>256</sup> Mental Health Act 1990 (NSW) s188(2)

<sup>257</sup> Mental Health Act 1990 (NSW) s190(1),(2) s191(1).

<sup>258</sup> Mental Health Act 1990 (NSW) s193.

<sup>259</sup> Mental Health Act 1990 (NSW) s193(2).

<sup>260</sup> Mental Health Act 1990 (NSW) s194.

<sup>261</sup> Mental Health Act 1990 (NSW) s195.

13.11 The power to administer ECT without approval by the Tribunal in circumstances of emergency was abrogated in 1997.<sup>262</sup> This was as a result of improvements in available technology enabling the tribunal to be able to deal promptly with emergency applications.

13.12 It is mandatory to keep an ECT register which may be inspected at any time by a member of the Tribunal the Principal Official visitor an official visitor or an authorised officer.

13.13 In the case of informal incapable patients who have a guardian appointed under the Guardianship Act 1987, ECT may not be provided pursuant to the guardians consent. The Mental Health Act 1990 (NSW) must be invoked.

## CHAPTER 14: NORTHERN TERRITORIES<sup>263</sup>

14.1 ECT may not be performed in the Northern Territories unless informed consent as defined under the Act is obtained, or the Tribunal authorises it when the patient is unable to give informed consent to ECT, or when serious circumstances exist in the case of an involuntary patient.<sup>264</sup>

### *Informed Consent*

14.2 Section 7 of the Mental Health and Related Services Act 1998 (NT) prescribes the essential elements to be met before informed consent may be considered to be obtained. The Northern Territories Act has extensively framed informed consent requirements in comparison to other Australian states. This is most easily illustrated by the following figure:

Element of informed Consent	NT	WA	ACT
Given freely and voluntarily	7(2)(a)	95(1)(b)	

<sup>262</sup> Mental Health Legislation Amendment Act 1997 (NSW).

<sup>263</sup> Sourced from [www.austlii.edu.au/au/legis/nt/consol\\_act/mharsa294](http://www.austlii.edu.au/au/legis/nt/consol_act/mharsa294) Valid at June 2002.

<sup>264</sup> Mental Health and related Services Act 1998 (NT) s66(1)(2).

No inducement	7(2)(a)		
Capable of understanding effects of consent	7(2)(b)	96(c)	
Person communicates consent on approved form	7(2)(c)		
Explanation of type, purpose and likely duration of treatment	7(3)(a)	97(1)(a)	54(1)(a)
Description of benefits, discomforts and risks of treatment	7(3)(b)	97(1)(b),(c)	54(1)(b)
Description of appropriate alternative forms of treatment	7(3)(c)		54(1)(c)
Answers provided to relevant questions	7(3)(d)		
Advice that treatment may be refused or consent withdrawn	7(3)(e)		54(1)(f)(ii)
Advice that independent legal or medical advice may be obtained	7(3)(f)		54(1)(f)(i)
Advice of all rights or review and appeal under the Act	7(3)(g)		50(1)
Advice of any financial advantage gained by provider	7(3)(h)		54(1)(e)
Advice of any relevant research relationship	7(3)(i)		
Communication in a manner or form the person is used to	7(3)(j)	97(4)(b)	
Adequate time to consider	7(4)	98	
Assistance from an interpreter where needed	7(5)	97(4)(a)	
Right to request another person be present	7(6)		
Person in charge must ensure procedures are followed	7(7)		
Failure to offer resistance does not constitute consent		95(2)	
Information required limited to what a reasonable person would see as significant		97(2)	
Provision of an information sheet			54(1)(g)
Capable of understanding the elements of consent			
Can communicate the decision to consent			

**Figure 2: Comparison of express legislative requirements in regards to informed consent.**

14.3 In the case of patients unable to consent to ECT, the Tribunal may authorise the procedure if it is satisfied that the person is unable to give informed consent to the treatment, and it receives a report from two authorised psychiatric practitioners that they are satisfied after considering the person's clinical condition, history of treatment and other appropriate alternative treatments, ECT is a reasonable and proper treatment to be administered and that without the treatment the person is likely to suffer serious mental or physical deterioration.<sup>265</sup>

14.4 The Tribunal must also be satisfied that all reasonable efforts have been made to consult the person's primary care provider, or if there is not a primary care provider, a person who is closely involved in the treatment or care of the person unless there is a valid reason not to do so.<sup>266</sup>

14.5 ECT may be performed in the case of an involuntary patient without consent or Tribunal authorisation where two authorised psychiatrists are satisfied that it is immediately necessary to save the person's life; to prevent the person suffering serious mental or physical deterioration; or to relieve severe distress.<sup>267</sup>

14.6 Hence ECT may only be provided non-consensually to an involuntary patient in serious circumstances. Where ECT is performed in these

<sup>265</sup> Mental Health and related Services Act 1998 (NT) s66(2).

<sup>266</sup> Mental Health and related Services Act 1998 (NT) s66(2)(c)(ii)-(ii).

<sup>267</sup> Mental Health and related Services Act 1998 (NT) s66(3)(a)-(c).

circumstances, the authorised practitioners must make a report to the Tribunal of the therapy performed as soon as practicable after it is performed, explaining why Tribunal authorisation was not obtained; the number of treatments performed; the person's response to ECT; and details of any significant side effects of the treatment on the person.<sup>268</sup>

14.7 The Northern Territories Act also specifies that at least two medical practitioners are to be present when ECT is performed, one of whom is to be experienced and trained in accordance with approved procedures in performing ECT and one who is experienced in administering anaesthesia.<sup>269</sup> ECT may only be performed in an approved treatment facility or premises licensed under the Act.<sup>270</sup> Breach of the Act constitutes unprofessional conduct.

14.8 The holder of a licence must submit a return to the Secretary after the end of each month containing details of ECT performed during the month on the premises to which the licence relates.<sup>271</sup>

## CHAPTER 15: THE AUSTRALIAN CAPITAL TERRITORY<sup>272</sup>

15.1 The Mental Health (Treatment and Care) Act 1994 provides that the administration of convulsive therapy or the performance of psychiatric surgery may only occur after informed consent as prescribed in the Act is obtained.<sup>273</sup> Once the consent is obtained, it is only valid for nine subsequent applications of ECT.<sup>274</sup> ECT may only be administered by a doctor, or a person who is authorised to do so by a doctor.<sup>275</sup>

15.2 In the case of involuntary patients, ECT administration must be preceded by the approval of the tribunal. Similarly, tribunal approval only legitimates a

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<sup>268</sup> Mental Health and related Services Act 1998 (NT) s66(4)(5).

<sup>269</sup> Mental Health and related Services Act 1998 (NT) s66(6).

<sup>270</sup> Mental Health and related Services Act 1998 (NT) s66(7). The Secretary must take into account the recommendations of the Chief Health Officer regarding the suitability of the applicant to hold a licence, the suitability of the premises, whether the equipment to be used in performing ECT complies with the prescribed standards and conditions, the qualifications of persons who are to perform ECT on the premises; any conditions specified in the licence and how long the licence should remain in force which may be no greater than three years. A licence may be cancelled if there has been a breach of a condition of the licence, or an offence against s66 is committed, if the premises are no longer suitable, the equipment does not comply with the prescribed standards and conditions or an unqualified or insufficiently qualified person has been performing ECT on the premises.

<sup>271</sup> Mental Health and Related Services Act, s73.

<sup>272</sup> Sourced from [www.legislation.act.gov.au/](http://www.legislation.act.gov.au/) Effective from 28 March 2003. Accessed 15/02004.

<sup>273</sup> Mental Health (Treatment and Care) Act (ACT) 1994, s55.

<sup>274</sup> Mental Health (Treatment and Care) Act (ACT) 1994, s55(2).

<sup>275</sup> Mental Health (Treatment and Care) Act (ACT) 1994, s55(1).

course of nine ECT applications.<sup>276</sup>

15.3 An application to the tribunal for an ECT order may be made either by the chief psychiatrist or a doctor and must be supported by the evidence of a psychiatrist who is not the applicant. The criteria for tribunal approval are either that the person has given informed consent to ECT and that consent has not been withdrawn, or in the case of a person who is incapable of making the decision, the tribunal must be satisfied that the administration of ECT is likely to result in substantial benefit to the person and – all other reasonable forms of treatment that may be available have been tried but have not proved successful, or it is the most appropriate form of treatment reasonably available.

15.4 The ACT criteria effectively limit the administration of ECT as a first line treatment by virtue of the fact that other reasonable forms of treatment available are required to be considered prior to administering ECT.

15.5 Further, the role of the tribunal in the context of involuntary patients provides ongoing external oversight of ECT administration in patients under civil commitment.

15.6 ECT is further regulated by requiring mandatory recording of ECT and providing the record to the person in charge of the psychiatric institution where the therapy is to be administered.<sup>277</sup> The person in charge of the psychiatric institution must retain a record for at least five years after the records are provided to them.<sup>278</sup>

## **CHAPTER 16: SOUTH AUSTRALIA<sup>279</sup>**

16.1 The Mental Health Act 1993 (SA) includes ECT in the definition of a “category B treatment” under the Act.<sup>280</sup> (Psychosurgery is defined as a category A prescribed treatment). A category B treatment may not be administered to a person who is a patient in any hospital or clinic unless it has been authorised by a psychiatrist who has examined the patient. Additionally, consent in writing must be obtained from the patient where the patient is capable of giving effective consent, or where the patient is incapable of giving effective consent and is under the age of 16 consent is obtained from the patient’s guardian. In the case of a person who is incapable of giving consent and is over the age of 16, a medical agent of the patient may consent where they are reasonably available and willing to do so, or in any other case, the

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<sup>276</sup> Mental Health (Treatment and Care) Act (ACT) 1994, s55(3).

<sup>277</sup> Mental Health (Treatment and Care) Act (ACT) 1994, s57.

<sup>278</sup> Mental Health (Treatment and Care) Act (ACT) 1994, s58.

<sup>279</sup> Sourced from [www.library.adelaide.edu.au/guide/med/mentalhealth/histlist.html](http://www.library.adelaide.edu.au/guide/med/mentalhealth/histlist.html). Accessed 10/02/04.

<sup>280</sup> Mental Health Act 1993 (SA), s3.

consent of the Board must be obtained.<sup>281</sup>

16.2 However, consent to a particular episode of ECT is not required if the nature of the patient's mental illness is such that administration of that particular episode of treatment is urgently needed for the protection of the patient or other persons and in the circumstances it is not practicable to obtain that consent.<sup>282</sup> It has been noted that this provision is effectively broader than other jurisdictions where ECT may be provided without consent where it is necessary for saving the patient's life. The South Australian legislation permits the provision of ECT where there is concern about what the patient might do if ECT is not administered.<sup>283</sup>

16.3 The sixth Australian state, Tasmania, does not have specific ECT provisions. The general provisions relating to psychiatric treatment apply to the administration of ECT.

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<sup>281</sup> Mental Health Act 1993 (SA), s22(1)(b)(i)(ii).

<sup>282</sup> Mental Health Act 1993 (SA), s22(2).

<sup>283</sup> See I Freckleton, B Wilson "Electroconvulsive Therapy: Law, History and Practice" (2001) 8 *Journal of Law and Medicine* 389, 419.

**Figure 3: Comparison of Australian states legislative requirements in regard to administration of ECT. (\*legislative amendments proposed).**

CRITERIA FOR ADMINISTRATION OF ECT	MHA (Qld)	MHA (WA)	MHA VIC	MHA NSW	NT	ACT
<b>VOLUNTARY PATIENTS</b>						
With informed consent	139(a)	107(1)	73		66(1)	55(2)(a)
Specifies informed consent requirements	133-137	95-97	53(B)	183	7	55
Informed consent by competent person and certification by 2 medical practitioners that ECT reasonable and proper, and necessary or desirable for safety or welfare of person				185(1)		
Application to Tribunal if psychiatrist believes ECT <i>most</i> clinically appropriate treatment and person incapable of making informed consent. Tribunal approval if satisfied of above. Approval prohibited if known objection	229(1)(a) (b)  233 139(2)					
Tribunal approval if 2 psychiatrists certify incompetent, ECT reasonable and proper, without will suffer serious mental or physical deterioration					66(2)(b)	
Notification of application	229(3)(b)				66(2)(c)	
Notice of hearing	232(2)					
Specifies number ECT	233(3)		72(2)			55(2)
Specifies Drs experienced in ECT and anaesthesia must be present						
Appeal rights	234(2)(b)					
Emergency ECT		107(2)*		181		
<b>INVOLUNTARY PATIENTS</b>						
With informed consent	139(a)		73		66(1)(a)	
Authorised by treating psychiatrist if incompetent patient, clinical merit and appropriate, other beneficial treatments considered, likely to suffer significant deterioration if ECT not given.			73(3)			
Second opinion - clinical merit and appropriate, regard to consent		104				
Emergency ECT	140(1)	104(2)*	73(4)		66(3)	
<b>Independent tribunal</b>						
Tribunal approval if satisfied patient is incompetent and ECT is most clinically appropriate treatment alternative.	233(2)(a) 233(2)(b)					
Tribunal approval if informed consent given or if incapable and ECT likely to result in substantial benefit, and other reasonable treatments tried by not successful or ECT most appropriate						55(5)
Incompetent, 2 psychiatrists certify ECT reasonable and proper and without will suffer serious mental or physical deterioration					66(2)	
Certification by 2 psychiatrists, that ECT reasonable and proper, and necessary/desirable for safety or welfare of person and tribunal approval. Regard to consent given				188(1)  194		
Tribunal specifies number ECT's						55(3)
Notice of application	229(3)			190	66(b)(1)	

Notice of hearing	232(1)					
Notice of decision	234(1)			190(1)		
Tribunal appeal rights	234(2)(b)					
ECT possible if competent refusal	No	Yes	No	Yes	No	No
Hospital must be authorised	139(1)	104		182	66(7)	
Licensing requirements			75		67	
Reporting requirements		*	80	196	66(5)	57

CRITERIA FOR ECT ADMINISTRATION	MHA (UK)	UK BILL	MHA SCOT	MHA NZ
<b>VOLUNTARY PATIENTS</b>				
Compliant incapacitated patients when receiving care in NHS/independent hospitals when ECT is prescribed in careplan approved by medical adviser or Tribunal. Two ECT administrations can occur prior to approval of careplan in assessment stage.		131		
<b>INVOLUNTARY PATIENTS</b>				
With informed consent		118(2)		60(a)
Second opinion ECT in patient's interests				60(b)
Treating Doctor certifies patient capable of understanding nature, purpose, likely effect and has consented.	58(3)(a)*			
Second opinion Dr certifies as unable to understand the nature, purpose and likely effects of ECT or not consenting but having regard to the likelihood of its alleviating or preventing a deterioration in condition ECT should be given	58(3)(b)			
Second opinion Dr must consult with two others professionally involved	58(4)			
Emergency ECT	62	119 (2 x)		
Competent and consenting - Patient's Doctor certifies patient competent and having regard to likelihood of ECT alleviating or preventing deterioration in condition, ECT is in best interests			238(1)	
Incompetent and not objecting - second opinion Dr certifies patient is incapable of understanding nature, purpose, likely effects of ECT, and having regard to the likelihood of ECT alleviating or preventing a deterioration in the patient's condition it is in best interests			239(1))	
Incompetent and objecting - second Dr certifies that patient is incapable, and the patient objects but ECT necessary to save the patient's life, prevent serious deterioration, alleviate suffering or prevent the patient from behaving violently or being a danger to themselves or others			239(2)	
Consultation with carer, nominated person		120(2)		
Consultation with family, whanau				7A
Authorised by Mental Health Tribunal in absence of consent		118(2)(a)		
Consideration of advance directive		Under Code of Practice	276 (4)	
ECT possible if competent refusal	Yes	Yes	No	Yes

Figure 4: Comparison of regulatory frameworks - UK, Scotland, New Zealand

## CHAPTER 17: CANADA<sup>284</sup>

17.1 Most Mental Health Acts in Canada make no reference to special treatments including ECT and psychosurgery.<sup>285</sup> Consequently most provinces authorise ECT in the same manner as medications, although Saskatchewan regulates ECT by designating it a special treatment under the regulations. This requires two psychiatrists to independently examine the patient, give consideration to the views of the patient and the nearest relative, and provide notice to the patient, nearest relative and official representative before ECT be administered.<sup>286</sup>

### CANADA - ONTARIO

17.2 In a relatively recent case decided in Ontario it was stated on the basis of the evidence that the “day is past when administration of ECT should require the satisfaction of additional conditions....It would also appear that the side effects of contemporary techniques of administering ECT pose significantly fewer risks than do the alternative drug therapies applicable in those serious settings in which ECT is an indicated treatment”.<sup>287</sup>

17.3 In Ontario, as in most common law countries, a competent patient may consent to or refuse treatment, even an involuntary patient. It was stated in *Fleming v Reid*<sup>288</sup> that “traditional common law principles extend to mentally competent patients in psychiatric facilities. They, like competent adults generally, are entitled to control the course of their medical treatment. Their right of self-determination is not forfeited when they enter a psychiatric facility. They may, if they wish, reject their doctor’s psychiatric advice and refuse to take psychotropic drugs, just as patients suffering other forms of illness may

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<sup>284</sup> Canada possesses some adverse history in relation to ECT. During the 1950’s and 1960s Dr Ewen Cameron, a psychiatrist working in Montreal experimented on patients using a technique described as “depatterning”. In the hope of effecting a cure for schizophrenia, Cameron combined electroconvulsive therapy, insulin coma therapy, and “brainwashing” to reprogram psychiatric patients. The patients received LSD to induce prolonged periods of sleep, lasting weeks or months. During this phase recorded messages played repeatedly to infantilise patients and to facilitate resocialisation. Neither the patients nor their families provided informed consent to the treatment. The treatment by Dr Cameron and has since been vilified and his motivations questioned. See A James, “Psychiatric Power and Informed Consent in Post-World War II Canada” (2002) 22 *Health Law in Canada* 101.

<sup>285</sup> See J Gray, M Shone, P Liddle, *Canadian Mental Health Law and Policy* (Butterworths, Toronto Canada; 2000) 218.

<sup>286</sup> *Ibid*, 218.

<sup>287</sup> *AM v Benes et al* (1997) 166 DLR (4<sup>th</sup>) 658, 722 (Ont Gen Div) per Sutherland J. In making this statement the judge relied on affidavit evidence provided by psychiatrist Dr Paul Poser. Of interest is that with respect to alteration of brain structure or damage to brain cells, the Dr provided an article concluding that there was no evidence that ECT causes damage to cells. However, it was acknowledged that “This is strong evidence, despite the fact that the authors have noted in general *that absence of proof does not constitute the proof of absence.*” [Emphasis added]

<sup>288</sup> *Fleming v Reid* 82 D.L.R. (4<sup>th</sup>) 310.

reject their doctor's advice and refuse, for instance, to take insulin or undergo chemotherapy."

17.4 The Health Care Consent Act 1996 (Ont)<sup>289</sup> codifies the presumption that a person is capable to decide to accept or reject medical treatment. Patients with mental disorders are presumptively entitled to make their own treatment decisions. The presumption of capacity can be displaced only by evidence that a patient lacks the requisite elements of capacity provided by the Act.

17.5 Capacity involves two criteria: first a person must be able to understand the information that is relevant to making a treatment decision and second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. The legislative mandate of the Consent and Capacity Board when called upon to adjudicate on a question of capacity relates solely to a patient's capacity and the Board's conception of the patient's best interests is irrelevant to that determination.<sup>290</sup>

17.6 The means of authorising treatment for an incapable patient in Ontario is provided by a relative or other privately appointed or court appointed "substitute decision-maker". The hierarchy of substitute decision-makers is legislated pursuant to the Health Care Consent Act 1996.<sup>291</sup> Substitute decision-

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<sup>289</sup> S.O. 1996, Sch.A.

<sup>290</sup> In *Starson v Swayze* 2003 SCC 32 it was held in the Supreme Court of Canada that the determination of the consent and capacity board which held that a physicist suffering from bipolar disorder was in denial of his mental disorder and failed to appreciate the consequences of his decision and was therefore incompetent was unreasonable on the evidence. The patient had been detained after making death threats of which he was found not criminally responsible. The patient had acknowledged that he had mental health problems, but not that he suffered from an illness. He believed that medication had previously dulled his thinking and prevented his work as a physicist. He preferred his altered state to what he viewed as the boredom of normalcy. It was held that the onus of proving incapacity rested on the physician. The court differentiated the *ability* to appreciate the consequences of a decision from having *actual* appreciation of those consequences. Failure to demonstrate actual appreciation does not lead inexorably to a conclusion of incapacity. A finding of incapacity is justified only if those reasons demonstrate that the patient's mental disorder prevents him from having the ability to appreciate the foreseeable consequences of the decision. "The Board's....conclusions appear to be based on its perception that Professor Starson *failed* to understand the information or appreciate the consequences as evidenced by his refusal to agree that he should have the recommended treatment, rather than any evidence that his mental disorder prevented him from being *able* to understand and appreciate." A patient's failure to recognise consequences does not necessarily reflect an inability to appreciate consequences. There was an absence of evidence that the proposed medication was likely to ameliorate Starson's condition, and the wisdom of Professor Starson's treatment decision was irrelevant to that determination.

<sup>291</sup> The list of persons in priority who may give or refuse consent on behalf of an incapable person are; the guardian of the person with authority to give consent; attorney for personal care with authority to give consent; representative requested by the person and appointed by the review board to consent; spouse or partner, child or parent (or child's guardian) entitled to consent; parent who only has right of access, brother or sister, any other relative; and the public trustee if no other person can be found. See Health Care Consent Act 1996 SO 1996 c2, Sch A, s20.

makers must be approached in order of the list.

17.7 The case of *Fleming v Reid*<sup>292</sup> was heard in the Ontario Court of Appeal and involved two schizophrenic involuntary incompetent patients who had been found not guilty by reason of insanity for criminal offences. The state wished to administer neuroleptic medication in non-emergency circumstances to the patients. Both patients when mentally competent had expressed the wish not to be treated with such drugs. Their personal opinions were that the drugs were non-beneficial and harmful. The professional opinion was that medication would be likely to improve the deteriorating mental condition of the patients.

17.8 The patients challenged the finding that they were incompetent, but were unsuccessful in the review board hearing. Hence the responsibility of consenting to treatment fell to the substitute decision-maker. When a substitute decision-maker made a decision, the then Mental Health Act required the decision to be in accordance with the apparently capable expressed wishes of the person, if these were known.<sup>293</sup> The Official Guardian who became the substitute decision-maker refused treatment on the basis of the prior expressed capable wishes.

17.9 However, the review board had a legislative mandate to make decisions deemed to be in the best interests of the patient. The Appeal case was concerned with whether the provisions of the Act which permitted the review board to authorise the physician to administer neuroleptic drugs to an involuntary incompetent patient notwithstanding the refusal of the patient's substitute decision-maker to consent to the proposed treatment on the basis that the patient had expressed a prior competent wish not to be treated with neuroleptics was constitutional under the Canadian Charter of Rights and Freedoms.<sup>294</sup>

17.10 It was held that the Ontario Mental Health Act provisions for overturning treatment refusals were unconstitutional and breached Article 7 of the Canadian Charter of Rights and Freedoms which guarantees the right to security of the person. This right was held to encompass the fundamental common law right to bodily integrity and personal autonomy. It was held that neither the review board nor the patient's physician had the right to totally disregard the previously expressed wishes of the capable patient without due process. It was held that the Ontario legislation was ultra vires as it did not instruct the board to consider the previously expressed wishes of the patient

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<sup>292</sup> (1991), 4 O.R. (3d) 74 (C.A.)

<sup>293</sup> The mechanism for authorising treatment has been removed from the Mental Health Act and rests in the Health Care Consent Act 1996.

<sup>294</sup> The Canadian Charter of Rights and Freedoms is supreme law in Canada, and is part 1 of the Constitution Act 1982. The Charter guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. All mental health laws in Canada must be applied in accordance with the Charter.

when capable.

17.11 It was held that a competent patient's right to be free from non-consensual invasions of his or her person is not diminished by subsequent incompetency or subordinated to his or her "best interests" where the prior competent wishes of the patient are known. The legislature had given paramountcy to the "prior wishes" test and in keeping with the patient's common law and constitutional rights, the "best interests" test comes into play only if the patient has no known competent wishes as to his or her psychiatric treatment. It was not then lawful to overrule such wishes.

17.12 The case exhibits how seriously Canadian courts have viewed wishes and advance directives as signs of the patient's autonomy and as more important than the patient's best interests, judged by others.<sup>295</sup> It has been noted that there is a danger of according advance directives such a degree of paramountcy. "Although Mr Reid had refused neuroleptic medications earlier in his illness while apparently, mentally capable, it is difficult to believe that he would have envisioned the possibility that he would become psychotic, kill someone, be held in a maximum security psychiatric facility and in solitary confinement indefinitely because he repeatedly exhibited psychotic and dangerous behaviour when he was not given neuroleptics. This case speaks loudly to the danger of advance directives being applied in circumstances that a person could not foresee."<sup>296</sup>

17.13 It has also been suggested that adhering to a previously expressed wish which refuses treatment may result in serious harm to the patient, including continued suffering and long periods of unnecessary detention. It may be that other mechanisms, such as second medical opinions on treatment or review boards are a more effective way of guarding against errors in treatment than the method chosen for authorising treatment.<sup>297</sup>

17.14 In some other Canadian jurisdictions review boards may overrule a decision by a competent patient or a substituted decision-maker to refuse treatment based upon what is perceived to be in the best interests of the patient.<sup>298</sup> However in Ontario the known competent applicable wishes regarding treatment consent or refusal must be followed by the review board.<sup>299</sup>

17.15 Under the Ontario legal regime if the substitute decision maker does not know of a wish applicable to the circumstances that the incapable person

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<sup>295</sup> See Hoffman B, *The Law of Consent to Treatment in Ontario*, 2<sup>nd</sup> Ed (Toronto: Butterworths, 1997) 84 cited in J Gray, M Shone, P Liddle, *Canadian Mental Health Law and Policy* (Butterworths, Toronto Canada; 2000) 194.

<sup>296</sup> *Ibid*, 194.

<sup>297</sup> *Ibid*, 26.

<sup>298</sup> For example in Manitoba, a substitute decision-maker is bound by a previously expressed capable wish except when "following a patient's expressed wishes would endanger the physical or mental health or safety of the patient or other persons".

<sup>299</sup> Health Care Consent Act, S.O. 1996, c.2, s.36.

expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish the person shall act in the incapable person's best interests.<sup>300</sup> In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration;

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of the subsection (1); and
- (c) the following factors:

1 Whether the treatment is likely to,

- i improve the incapable person's condition or well-being,
- ii prevent the incapable person's condition or well-being from deteriorating, or
- iii reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.

- 3 Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without treatment.
- 4 Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
- 5 Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

17.16 If a capable involuntary psychiatric patient refuses treatment in Ontario, the Health Care Consent Act 1996 contains no provision for review or appeal. The hospital is obliged to detain the patient until he or she no longer meets the committal criteria.

17.17 However, if an incapable involuntary patient has previously expressed a wish to refuse treatment, the substitute decision may apply to the board in restricted circumstances for permission to consent despite the wish. Amendments to the Act allow the health practitioner who proposes a treatment to apply to the review board to direct the substitute decision-maker to consent despite the wish.<sup>301</sup> The test the board uses to decide to overturn the refusal is;<sup>302</sup>

“The Board may give the substitute decision-maker permission to consent to the treatment despite the wish if it is satisfied that the incapable person,

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<sup>300</sup> Health Care Consent Act, S.O. 1996, c.2, Sch A, s21(1).

<sup>301</sup> Health Care Consent Act, 1996 SO 1996 c2 Sch A, ss36(1).

<sup>302</sup> Ibid, s36(3).

if capable, would probably give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed.”

17.18 The physician also has the opportunity to ask the board to review the manner in which the substitute decision maker reached the decision. In *AM v Benes et al*<sup>303</sup> a psychiatrist recommended ECT for a psychotic patient admitted to a psychiatric facility. The patient’s mother was her substitute decision-maker under s20(1) of the Health Care Consent Act. The mother refused to give her consent to the proposed ECT. On previous occasions, the patient had been under the psychiatrist’s care and had received ECT on a number of occasions with the substitute decision maker’s consent.

17.19 The substitute decision-maker refused ECT on the grounds that she believed that repeated ECT treatments posed greater long-term threat to the patient’s brain than did continued treatment with neuroleptic medications. The psychiatrist made an application under s37 of the Act to the Consent and Capacity Board to determine whether the decision-maker complied with the statutory principles governing the giving or withholding of consent under section 21 of the Health Care Consent Act.

17.20 The Board found that the SDM had not in fact complied with s21, which required her to act in accordance with a previously expressed wish, or, in the absence of one, in the patient’s best interests. The Board substituted its own opinion and directed her to consent to ECT, failing which she would lose the right to make a substitute decision on behalf of the patient. The mother appealed, questioning the constitutional validity of the provision which permitted the board to substitute the decision.

17.21 The court found that permitting review and substitution of a treatment decision was not unconstitutional. Section 37(3) did not infringe the Charter because an independent board is authorised to substitute its own opinion of the best interests of the incapable patient.

17.22 An incapable person did not have a constitutional right to have her or his best interests decided in the first instance by a substitute decision-maker. But on the other hand a person did have a constitutional right to have the person’s applicable prior wishes expressed while capable given effect to whenever possible. The board could only substitute its decision in regards to this by determining whether as a matter of fact, there was an applicable prior capable wish.

17.23 The court found that there was no evidence of a prior competent expressed wish, and that determination of a patient’s best interests was an objective inquiry. However, failure by the medical personnel to supply the substitute decision maker with information regarding their obligations under

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<sup>303</sup> 166 DLR (4<sup>th</sup>) 658.

s21 did infringe s7 of the Charter.<sup>304</sup>

17.24 Although the administration of ECT is not statutorily controlled it is regulated to an extent in Ontario pursuant to s27 of the Regulated Health Professions Act 1991<sup>305</sup> which prohibits the provision of ECT except by, or under direction of, a member of the College of Physicians and Surgeons of Ontario.

17.25 In *Re T and Board of Review for the Western Region*<sup>306</sup> it was argued that ECT should be equated with psychosurgery. This would result in its use being effectively banned. However, this argument was not successful as it was held that there was insufficient evidence provided to the court that ECT caused permanent damage to brain cells or to the continuity of normal brain tissue.

17.26 The emphasis in Ontario is on autonomy and self-determination.

## CHAPTER 18: CANADA - QUEBEC

18.1 Consistent with most Canadian states the Quebec legislature has not defined specific regulations for treatments such as ECT and psychosurgery, nor has it enacted specific legislation in regard to the consent process in psychiatry in general. The consent process for medical procedures is governed by the Civil Code of Quebec.

18.2 Only a patient competent to make a decision may consent to treatment.<sup>307</sup> Article 11 of the Civil Code of Quebec provides that no person shall be made to undergo care, treatment, or any other act except with his or her consent.<sup>308</sup>

18.3 If the person is incapable of giving or refusing consent to care, a person authorised by law or by mandate given in anticipation of his or her incapacity may do so in his or her place. Article 15 provides a hierarchy of persons

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<sup>304</sup> In *Supplementary Reasons to 166 DLR (4<sup>th</sup>) 658, 17 DLR (4<sup>th</sup>) 758* Sutherland J was scathing of what he described as "eager and uncritical deference to the views of the medical practitioner" by the Board. This was in relation to the adoption of belittling views of the Dr as to the motivation of the mother in withholding consent, which it was claimed was a fear of the patient being sent home too soon if ECT was given. The second imputed motivation was that the mother was afraid to consent because of threats made by the daughter. Whilst it was appropriate to defer to medical opinion on strictly medical matters, it is not appropriate or safe in dealing with related matters such as prior capable wishes or the substitute decision maker's motivations. "the board should be, and be seen to be, truly independent of the health practitioners and manifestly aware of its key role in the protection of constitutionally enshrined rights, however awkward that may sometimes be for those who are primarily concerned with getting on with what they honestly perceive to be the medically indicated treatment."

<sup>305</sup> SO 1991, c 18 in combination with ss 5(1) of O Reg 107/96 of the Act.

<sup>306</sup> (1983), 44 O.R.(2d) 153, 3 D.L.R. (4<sup>th</sup>) 442 (HC).

<sup>307</sup> Civil Code of Quebec, articles 11, 20.

<sup>308</sup> This codifies the common law position, see *Malette v Schulman*(1990) 72 OR (2d) 417.

authorised to give consent in the case of the person's incapacity. Treatment that is required for the person to recover enough to be discharged from involuntary status is authorised by the court where a legal substitute decision maker is not approved.<sup>309</sup>

18.4 The Civil Code of Quebec<sup>310</sup> states that "the authorization of the court is necessary where the person who may give consent to care required by the state of health of a minor or a person of full age who is incapable of giving his consent is prevented from doing so or, without justification, refuses to do so; it is also required where a person of full age who is incapable of giving his consent categorically refuses to receive care, except in the case of hygienic care or emergency."<sup>311</sup> Hence it is necessary to apply to the court for authorisation of treatment when an incapable person categorically refuses to receive treatment to which the substitute has assented. In these circumstances the court will determine whether a finding of incapacity is well-founded, and whether the proposed treatment is necessary. This essentially provides an independent review mechanism.<sup>312</sup>

18.5 Only in the case of emergency may care be administered without the consent of the patient or in the case of incompetency by the substitute decision maker. However emergency administration of ECT is extremely rare in Quebec.

18.6 Quebec has recently conducted and published a substantial review and report on ECT. After claims that the practice of ECT was undergoing a resurgence<sup>313</sup> the Minister of Health and Social Services<sup>314</sup> commissioned the Agence d'évaluation des technologies et des modes d'intervention en sante (AETMIS)<sup>315</sup> to assess the practice of electroconvulsive therapy in Quebec. The report examined the efficacy and risks of the treatment as well as the conditions of its use in Quebec, and was published in February, 2003.<sup>316</sup>

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<sup>309</sup> See Code of Civil Procedure, R.S.Q., c. C-11, s 776, art 23 (1991, c. 64, art.23) and the Certain Personality Rights Act, 1991 CCQ 1991, c64, art 16.

<sup>310</sup> Civil Code of Quebec, RSQ 1991, c64, art 16.

<sup>311</sup> Civil Code of Quebec, Article 16.

<sup>312</sup> See K Brown, E Murphy, "Falling Through the Cracks: The Quebec Mental Health System" (2000) 45 *McGill Law Journal* 1037.

<sup>313</sup> An article published in *Quebec Science* in 1997 reported a significant increase in the use of ECT almost doubling since 1988, its use by a minority of physicians, affirmations by a number of experts on the danger of the treatment, and allegations of abuses in elderly women.

<sup>314</sup> This is the provincial health department.

<sup>315</sup> The mission of the AETMIS is to contribute to improving the Quebec health-care system. The Agency advises and supports the Minister of Finance, the Economy and Research, as well as the decision-makers in the health-care system with respect to the assessment of health services and technologies. The Agency makes recommendations based on scientific reports assessing the introduction, distribution and application of health technologies as well as the modes of providing and organising services. The assessments take into account multiple factors, such as efficacy, safety and efficiency, as well as ethical, social, organisational and economic implications.

<sup>316</sup> See [www.aetmis.gouv.qc.ca/en/mod.php](http://www.aetmis.gouv.qc.ca/en/mod.php)

18.7 The essential conclusions made by the group were that the evidence of ECT efficacy may be weaker than claimed by several proponents of the treatment, but the risks were not as significant as alleged by ECT opponents. However, there were significant uncertainties pertaining to the risks of the treatment. It was stated that ECT decision-making and consent process must take into account the evidence of the efficacy of this treatment as well as the knowledge and uncertainties regarding its associated risks. A “rational use” of this treatment mode had to be based on scientific knowledge pertaining to its efficacy and risks and on an integration of the various treatment modes for the illnesses concerned.<sup>317</sup>

18.8 The authors of the report considered that a top priority of research on ECT efficacy should be the duration of the treatment’s efficacy and its effectiveness in groups of patients suffering from multiple health problems. Research on risks should examine the risk of permanent retrograde amnesia, impacts on cognitive functions other than memory, in particular right hemisphere functions, and the possibility of an impact on the cell structure of the brain.

18.9 The findings of the review were that there was an absence of uniform, effective institutional and professional regulation of ECT in Quebec. The recommendations in the report involved strengthening the existing institutional and professional regulatory measures. This required involvement by all stakeholders<sup>318</sup> and included the granting of specific privileges to physicians who administer ECT and concomitant requirements to partake in continuing education.

18.10 It also required improved quality assessment of the medical procedure as recommended by the professional body, and formulation of clinical practice guidelines. It was recommended that patient and user groups participate in the strengthening of institutional regulatory mechanisms, developing and implementing quality control programmes with regard to medical services involving ECT.

18.11 It was recommended that particular emphasis be placed on the consent process, considering the uncertainties regarding the risks of ECT. Also, community mental health groups should be given the means to inform patients and the public regarding the evidence concerning ECT and the means to support patients, their families and friends in the treatment process.

18.12 Robust monitoring was recommended to improve the quality of services, with setting up of registers to record the use of ECT both in hospitals and in

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<sup>317</sup> *The Use of Electroconvulsive Therapy in Quebec*, Report prepared for Aetmis by Reiner Banken, (2003) 66.

<sup>318</sup> These stakeholders were described as the College des Medecins de Quebec, the various medical associations involved, the health department, the regional boards, the hospital association as well as the various community groups and associations.

outpatient clinics.

## CHAPTER 19: CANADA - ALBERTA

19.1 Competence for the purpose of consenting to treatment is defined in section 26 of the Mental Health Act, (RSA)<sup>319</sup> as “a person is mentally competent to make treatment decisions if he is able to understand the subject matter relating to the decisions and is able to appreciate the consequences of making the decisions”.

19.2 The Act permits a substitute decision maker to make treatment decisions on behalf of an incompetent involuntary patient in accordance with what the person believes to be the best interests of the patient.<sup>320</sup> In determining best interests, a person must have regard to whether or not the mental condition of the patient will be or is likely to be improved by the treatment; whether the patient’s condition will deteriorate or is likely to deteriorate without the treatment; whether or not the anticipated benefit from the treatment outweighs the risk of harm to the patient; and whether or not the treatment is the least restrictive and least intrusive treatment that meets the first two requirements listed above.

19.3 If the physician believes that an involuntary patient is incompetent, and the patient objects to treatment, treatment cannot be given on the basis of a substitute decision-makers consent unless a second physician is also of the opinion that the patient is not mentally competent to make the decision.<sup>321</sup>

19.4 If an involuntary patient who is competent to make treatment decisions objects to any treatment the patient is receiving or will receive, the physician may not administer treatment unless the review panel makes an order under the Mental Health Act. Where a board or a physician considers it in the best interests of an involuntary patient to administer treatment to which the patient objects, they may apply to a review panel for an order directing that the treatment be administered.<sup>322</sup>

19.5 The considerations that the board must be guided by are the same as the principles that a substitute decision maker must follow when making a decision based on best interests. In addition, the review panel must be satisfied that the physician has examined the patient.

### *Case Law*

19.6 In *B(M) v Alberta (Minister of Health)*<sup>323</sup> an involuntary patient became catatonic while being treated for bipolar affective disorder. The doctor

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<sup>319</sup> Mental Health Act RSA 2000, c M-13 as in force Jan 2002. See [www.canlii.org](http://www.canlii.org)

<sup>320</sup> Mental Health Act RSA 2000, c M-13, s28.

<sup>321</sup> Mental Health Act RSA 2000, c M-13, s28(5)(1)(2).

<sup>322</sup> Mental Health Act RSA 2000, c-M13, s29.

<sup>323</sup> (1997) 149 DLR (4<sup>th</sup>) 363.

determined that the patient was mentally competent to make treatment decisions, but could not determine whether the patient objected to or consented to ECT. The matter was referred to a review panel.

19.7 It was decided that when a patient's physical condition makes it impossible to determine if the patient consents or objects to a treatment, it should deem the patient to be objecting to treatment. The panel therefore ordered a course of ECT pursuant to s29 of the Mental Health Act (Alb).

19.8 The ECT was effective in bringing the patient out of her catatonic state. After being released from hospital, the patient appealed the order of the review panel. She stated that she objected to electroconvulsive therapy, although she preferred it to neuroleptic medication which caused side effects.

19.9 Her appeal was based on the claim that the panel did not have a legislative mandate to intervene as the Act only dealt with consent or objections and consequently she should not have been treated.

19.10 It was held that when mental health patients can neither express their consent nor their objection to a proposed course of treatment, they should not be deemed to be objecting to it. "Where the treatment is highly invasive and has significant side effects, as is the case with electroconvulsive treatment, the state must be extremely reserved in making treatment decisions. The state should not have gone ahead with such treatment without knowing whether the patient consented or objected".<sup>324</sup>

19.11 Veit J stated "although there was no evidence led on the point, the court can take judicial notice of the fact that while electroconvulsive treatment is effective in treating serious, florid forms of bipolar disease, especially in the depressed range of the disease, it is a highly invasive treatment (compared for example to psychotherapy, behaviour therapy and even psychotropic medication) which leaves long-lasting memory deficits as one negative side effect".<sup>325</sup>

## **CHAPTER 20: EUROPE**

20.1 An in depth analysis of European or United States' practice in relation to ECT was not undertaken as it was decided by the Review Group to limit our study to commonwealth jurisdictions as part of our mandate to review "other like nations". However, the following is a brief overview.

### *European practice*<sup>326</sup>

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<sup>324</sup> (1997) 149 DLR (4<sup>th</sup>) 363 per Veit J.

<sup>325</sup> Judicial notice is when something is so widely and commonly known that a judge may take it into consideration even though no evidence is led to prove the fact.

<sup>326</sup> Taken from Philpot et al, "Barriers to the Use of Electroconvulsive therapy in the Elderly: a European Survey" (2002) 17 *European Psychiatry* 41.

20.2 ECT is available only in specialist centres in Belgium and Germany, and is limited by the availability of anaesthetic services in Latvia, Poland and Romania.

20.3 ECT is prohibited in some cantons in Switzerland, but patients can travel to different cantons to receive treatment. Since the National Board of Psychiatry decree in 1994, ECT can no longer be given in Slovenia although “a few patients are referred each year to a psychiatric clinic in neighbouring Croatia for treatment”.<sup>327</sup>

20.4 In Italy, where Cerletti and Bini first introduced the treatment, ECT is effectively prohibited by the Italian Ministry of Health. Private clinics are not able to offer ECT, which is only administered as an emergency procedure in government hospitals after other treatments have failed and if the patient is in a “life-threatening” situation.

20.5 ECT cannot be given to non-consenting patients in Belgium, Czech Republic, Poland and Sweden. It may be given to non-consenting patients when an additional form of consent is obtained in some European countries. In Greece and Finland a similar process to the United Kingdom and New Zealand is adopted requiring the consent of another independent psychiatrist formally appointed to give a second opinion, although this is not pursuant to statute.

20.6 In France, Iceland, Latvia, the Netherlands, Norway, Portugal, Romania, Spain, Switzerland and Turkey all that is required to authorise ECT in these circumstances is the written consent of the nearest relative or the legally appointed guardian. If the patient has no relatives a hospital board of senior clinicians has to authorise treatment in Romania, and Latvia. The cantonal medical officer must authorise treatment in Switzerland. The local court or procurator has to be involved in Austria and Germany.

## **CHAPTER 21: UNITED STATES - CALIFORNIA**

21.1 A comprehensive survey of regulation of ECT was conducted in the United States in the early 1980's. At that time specific legislation concerning ECT existed in 26 of the 50 states.<sup>328</sup> The most restrictive legislation was enacted in California in 1974.

21.2 In 1998, an Electroconvulsive Therapy Background Paper prepared for the US department of Health<sup>329</sup> stated that 43 States have enacted legislation that in

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<sup>327</sup> Ibid, 43.

<sup>328</sup> Winslade et al, “Medical, Judicial, and Statutory Regulation of ECT in the United States” 141 (1984) 1349.

<sup>329</sup> *Electroconvulsive Therapy Background Paper*, prepared for the US Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services by RESEARCH-ABLE, INC, Virginia, (1998). Available at

some way regulates the use of ECT. Most of the State statutes directly address the administration of ECT; others regulate psychiatric treatment generally without specific reference to ECT. The most common approach, adopted in 20 States, requires either informed patient consent before the administration of ECT, or in the absence of informed consent, court determination of patient incompetency. There is a strong emphasis in the USA on the principle of due process, partly as a result of the civil rights movement and partly as a result of the American Constitution<sup>330</sup>. There is substantial variation among requirements from one State to another.

#### *California*<sup>331</sup>

21.3 The California Welfare and Institutions Code provides that every person, whether voluntary or involuntary, has the right to refuse convulsive treatment.<sup>332</sup> The Code provides that no convulsive treatment shall be performed if the patient is deemed to be able to give informed consent and refuses to do so. The physician shall, in these circumstances, indicate in the patient's notes that the treatment was refused despite the physician's advice and that he has explained to the patient the patient's responsibility for any untoward consequences of his refusal.<sup>333</sup>

21.4 The Code sets out the requirements of voluntary informed consent. The following information must be given to the patient in a clear and explicit manner:

- (a) The reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect.
- (b) The nature of the procedures to be used, including probable frequency and duration.
- (c) The probable degree and duration of improvement or remission, expected with or without such treatment.
- (d) The nature, degree, duration and the probability of the side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent they may be controlled, if at all.
- (e) That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works and its commonly known risks and side effects.
- (f) The reasonable alternative treatments, and why the physician is recommending this particular treatment.

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[www.chiefpsychiatrist.health.wa.gov.au/ECT.cfm](http://www.chiefpsychiatrist.health.wa.gov.au/ECT.cfm) Citing S Johnson, "Regulatory Pressures Hamper the Effectiveness of Electroconvulsive Therapy" *17 Law and Psychology Review* 155.

<sup>330</sup> Due process has been described as a principle founded upon the general right to a determination by a court of law concerning the need for deprivation of liberty or self-determination.

<sup>331</sup> Sourced from [www.leginfo.ca.gov](http://www.leginfo.ca.gov). Note that in California, ECT is referred to as "convulsive therapy".

<sup>332</sup> California Welfare and Institutions Code, s5325.

<sup>333</sup> California Welfare and Institutions Code, s5326.85.

- (f) That the patient has the right to accept or refuse the proposed treatment, and that if he or she consents, has the right to revoke his or her consent for any reason, at any time prior to or between treatments.<sup>334</sup>

21.5 A standard written consent form is promulgated by the State Department of Mental Health, and the treating physician is required to utilize this form and supplement it in writing with additional details pertaining to the particular patient.<sup>335</sup> The resulting information must be orally and clearly and in detail explained to the patient. The consent form must be witnessed. It is expressly stated that “written informed consent” means as a person knowingly and intelligently, without duress or coercion, clearly and explicitly manifests consent to the proposed therapy to the treating physician and in writing in the standard consent form prescribed.<sup>336</sup> A person confined shall be deemed incapable of written informed consent if such person cannot understand, or knowingly and intelligently act upon, the information specified. Written informed consent shall be given only after 24 hours have elapsed since the information described has been given.<sup>337</sup>

#### *Involuntary patients*

20.12 Convulsive treatment may be administered to an involuntary patient only if all the following requirements are met:

- (a) The treating physician enters adequate documentation in the patient notes of the reasons for ECT, that all reasonable treatment modalities have been carefully considered, and that the treatment is definitely indicated and is the least drastic alternative available for this patient at this time. This statement in the treatment record must be signed by the treating physician or physicians.
- (b) A review of the patient’s treatment record is conducted by a committee of two physicians, at least one of whom must have personally examined the patient. One physician shall be appointed by the facility and one shall be appointed by the local mental health director. Both shall be either board-certified or board eligible psychiatrists or neurologists. This review committee must unanimously agree with the treatment physician’s determinations pursuant to subdivision (a). Such agreement shall be documented in the patient’s treatment record and signed by both physicians.
- (c) A relative of the person’s choosing, if the patient wishes it, or guardian has been given the oral explanation by the treating physician.
- (d) The patient gives written informed consent. Consent shall be for a specified maximum number of treatments not to exceed 30 days, and shall be revocable at any time before or between treatments. Such withdrawal of consent may be either oral or written and shall be given effect immediately. Additional treatments require a renewed written informed consent.
- (e) The patient’s attorney, or if none, a public defender appointed by the court,

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<sup>334</sup> California Welfare and Institutions Code, s5326.2.

<sup>335</sup> California Welfare and Institutions Code, s5326.3.

<sup>336</sup> California Welfare and Institutions Code, s5326.5.

<sup>337</sup> California Welfare and Institutions Code, s5326.5(e).

agrees as to the patient's capacity or incapacity to give written informed consent and that the patient who has capacity has given written informed consent.

- (f) If either the attending physician or the attorney believes that the patient does not have the capacity to give a written informed consent, then a petition shall be filed in superior court to determine the patient's capacity to give written informed consent. The court shall hold an evidentiary hearing after giving appropriate notice to the patient, and within three judicial days after the petition is filed. At such hearing the patient shall be present and represented by legal counsel. If the court deems the above-mentioned attorney to have a conflict of interest, such attorney shall not represent the patient in this proceeding.
- (g) If the court determines that the patient does not have the capacity to give written informed consent, then treatment may be performed upon gaining written informed consent from the responsible relative or the guardian of the patient.
- (h) At any time during the course of treatment of a person who has been deemed incompetent, that person shall have the right to claim regained competency. Should he do so, the person's competency must be re-evaluated according to subdivisions (e), (f), and (g).

21.6 It has been observed that most courts in California have been reluctant to declare a patient incompetent, and that significant delays may occur despite the statutory time restriction. "Only if a patient utterly lacks comprehension of what is being proposed will he or she be found incompetent".<sup>338</sup>

21.7 It has also been observed that even when incompetent patients were finally administered ECT after delays, the amount of time spent in litigation and in determining that treatment was appropriate had serious effects on the patients' psychological, social, and financial well-being.<sup>339</sup>

#### *Voluntary patients*

21.8 The requirements of subsections (a), (c), and (d) above must be met in the case of voluntary patients. In addition, a board certified or board-eligible psychiatrist or neurologist other than the treating physician must examine the patient and verify that the patient has the capacity to give and has given written informed consent. This must be documented in the patient's notes and signed by the treating physician.<sup>340</sup> If there is not this verification or if the patient does not have the capacity to give informed consent, then subdivisions (b), (e), (f), (g) and (h) of the provisions relating to involuntary patients must also be met.

21.9 California restricts the provision of ECT to minors. ECT is prohibited for children under 12. Minors between the ages of 12 and 15 may only receive ECT if in addition to the other provisions authorising convulsive treatment the

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<sup>338</sup> Ibid.

<sup>339</sup> Ibid citing P Roy-Byrne et al "Legal Restrictions on the Use of ECT in California: Clinical Impact on the Incompetent Patient" (1981) 42 *J Clinical Psychiatry* 300, 301.

<sup>340</sup> California Welfare and Institutions Code, s5326.75.

circumstances are life threatening and the unanimous opinion of three child psychiatrists appointed by the Mental Health Commissioner are in favour of ECT.<sup>341</sup> The procedure must be documented and reported immediately to the Director of Mental Health.

21.10 In addition, any facility administering convulsive treatment must appoint a qualified committee to review all treatments and to verify the appropriateness and need for convulsive therapy.<sup>342</sup>

21.11 Quarterly mandatory reporting to the local mental health director and thereon to the Director of Mental Health is required under the code. Reports must include the number of persons who received ECT in the following categories: involuntary patients who gave informed consent, involuntary patients who were deemed incapable of giving informed consent and received convulsive treatment against their will, voluntary patients who gave informed consent, and voluntary patients deemed incapable of giving consent.<sup>343</sup>

21.12 In 1982, citizens of Berkely, California, voted to “outlaw” the use of ECT in a local referendum. However, the courts ruled the result of the referendum to be unconstitutional 40 days later.

#### *Texas*

22.13 In Texas, amendments to the legislation in 1993 resulted in the prohibition of ECT in regards to patients under the age of 16. Requirements were also introduced in respect of monitoring of treatment, and reporting of deaths up to two weeks post ECT administration was made a statutory requirement.

21.14 Mortality data collected in Texas after this legislation was passed has resulted in claims that the ECT mortality rate has been under reported.<sup>344</sup> However, it has been cautioned that a monitoring system that associates deaths with ECT temporally, but not necessarily causally requires that validation studies of clinical information be conducted to measure the secondary mortality rate associated with ECT.<sup>345</sup>

21.15 For example, in the period between September 1993 and April 1995 eight deaths in the two weeks following ECT were reported out of treatments administered to 2,583 patients.<sup>346</sup> However, an analysis of the circumstances of these deaths on the basis of medical records affirmed the possibility of a causal

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<sup>341</sup> California Welfare and Institutions Code, s5326.

<sup>342</sup> California Welfare and Institutions Code, s5326.91.

<sup>343</sup> California Welfare and Institutions Code, s5326.15.

<sup>344</sup> Weitz D, “Electroshocking Elderly People: Another Psychiatric Abuse” (1997) 15 *Changes: An International Journal of Psychology and Psychotherapy*.

<sup>345</sup> See *The Use of Electroconvulsive Therapy in Quebec* Report prepared for AETMIS, Reiner Banken, Montreal, (2003) 15.

<sup>346</sup> *Ibid*, citing WH Reid, S Keller, M Leatherman, M Mason, “ECT in Texas: 19 Months of Mandatory Reporting” (1998) 59 *Journal of Clinical Psychiatry* 8.

link for two of the eight deaths between the anaesthesia used for ECT and the death.

22.16 In 1997 two bills to prohibit ECT for patients over the age of 65 were proposed in Texas, but neither were approved.

*Vermont*

21.17 A bill approved in 2000 established new responsibilities for the Mental Health Commissioner in Vermont in regards to ECT, who assumed responsibility for establishing uniform consent processes, regulating the establishments administering ECT, monitoring its application and setting up an advisory committee concerning its use in patients under guardianship.<sup>347</sup>

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<sup>347</sup> State of Vermont No 92. An Act Relating to Electroconvulsive Therapy (H.12), Sec 1. 18 VSA 7408 available at <http://www.leg.state.vt.us/docs/2000/acts/ACT092.HTM>. Site accessed 19/3/04.

## PART III

### CHAPTER 22: INSTITUTIONAL AND PROFESSIONAL REGULATION, RAISING CLINICAL STANDARDS

#### *Clinical Audits*

22.1 Right 4(1) of the Code of Health and Disability Services Consumers' Rights provides that every consumer has the right to have services (such as ECT) provided with reasonable care and skill. This is essentially a right to non-negligent care. Right 4(2) expressly provides that every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards. Hence, Right 4(2) encompasses and requires adherence not only to the Mental Health (Compulsory Treatment and Assessment) Act 1992, but also with professional standards such as the Royal College of Psychiatrists guidelines on ECT. The article *Electroconvulsive Therapy: Law History and Practice* by Freckleton and Wilson (annexed) has provided a comprehensive review of audits and surveys undertaken in relation to ECT.<sup>348</sup> A common theme of these audits is that regardless of the formulation of guidelines, follow-up surveys often reveal that standards of administration have not improved to the standard set by professional bodies.

22.2 In 1981, the practice of ECT in Britain was described as "a shameful state of affairs".<sup>349</sup> This followed the audit conducted by the Royal College of Psychiatrists which revealed that fewer than half the clinics met minimum standards set by the College.<sup>350</sup> Many treatments failed to induce seizures and more than a quarter of clinics had obsolete machines. It was clear that doctors administering the treatment were not being adequately taught. Consequently guidance on the practical administration of ECT was produced.

22.3 A subsequent audit in 1991 carried out in two NHS regions showed improvement in the some aspects of ECT administration. Eighty per cent of ECT administrations were rated as "excellent" or "reasonably satisfactory" compared with fifty per cent in 1980. However, half the clinics surveyed had not updated their machines and training and supervision remained unsatisfactory in many clinics.<sup>351</sup>

22.4 Pippard, a Mental Health Act Commissioner and Second Opinion

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<sup>348</sup> It is not the purpose of this section to repeat the content of Freckleton and Wilson's article, although some material will be common to both, but to supplement it with material published since its publication, or with material not cited in that article.

<sup>349</sup> Editorial "ECT in Britain: A Shameful State of Affairs" (1981) 2 *Lancet* 1207.

<sup>350</sup> J Pippard, L Ellam "Electroconvulsive Treatment in Great Britain" (1981) 131 *British Journal of Psychiatry* 563.

<sup>351</sup> J Pippard, "Auditing the Administration of ECT" (1992) 16 *Psychiatric Bulletin* 59, 60.

Appointed Doctor who conducted the audit criticised the way in which ECT equipment was being used. Nearly all clinics used standard stimulus dosage, with “little grasp of the concept that there is a ‘trade-off’ between the extent of cognitive impairment and the efficacy and speed of recovery with ECT, which is related to the electrical stimulus used. Too low a stimulus and treatment is less effective and slower, too high and cognitive impairment increases.”<sup>352</sup>

22.5 Pippard stated that “the administration of ECT, being in principle simple, has generally been considered to require little skill or training and so has usually been left to a rota of SHO’s [senior house officers] and registrars who will often have neither....Today, consultants often feel out of touch with new apparatus, use it too rarely, if at all, to be skillfull with it, and in any case feel that they are too busy with other things to attend to the ECT personally.... I fear that without constant vigilance by the consultants there will be a drift back to the unacceptable state to which so many clinics had sunk in 1980”.<sup>353</sup>

22.6 Perhaps most telling is his comment that “It is not, therefore, surprising that I would personally have had considerable reservations about accepting ECT, had I needed it, in about half of all clinics in which I saw ECT administered.”<sup>354</sup>

22.7 In 1997 an audit undertaken by the Royal College of Psychiatrists of 53 clinics carrying out ECT in England and Wales found that 70% were below standard.<sup>355</sup> This third audit which was undertaken after the publication of detailed College standards highlighted continuing deficiencies in both the equipment used and in the training and supervision of junior psychiatrists.<sup>356</sup>

22.8 It was the third large scale audit of ECT covering equipment, supervision and training, and anaesthetic practice. Whilst it showed there had been some improvements since the previous audit, only sixteen clinics were rated as good or exemplary, 26 as deficient in some areas of practice, and 11 as poor.

21.9 Half the clinics were not using machines recommended by the college, and two thirds of the doctors giving ECT were senior house officers in psychiatry or GP vocational trainees. Duffet and Lelliott who conducted the audit suggested that a system of accreditation of doctors who delivered ECT was needed to improve standards.

22.10 During the period between 1999 and 2001 the Mental Health Act Commission surveyed 230 ECT facilities in England and Wales and reported that there were substantial departures from best policy, practice or training in

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<sup>352</sup> Ibid, 60.

<sup>353</sup> J Pippard, “ECT Custom and Practice” (1993) 17 *Psychiatric Bulletin* 473.

<sup>354</sup> Op cit n 339, 61.

<sup>355</sup> See J Wise, “ECT Clinics are Below Standard” (1997) 314 *British Medical Journal* 248.

<sup>356</sup> R Duffet P Lelliott, “Auditing Electroconvulsive tThrapy. The Third Cycle” (1998) 172 *British Journal of Psychiatry* 401.

205 of the centres surveyed.<sup>357</sup>

22.11 In New Zealand a survey carried out in 1999 assessed the clinical practice of ECT by psychiatrists, and the influence on practice of the *Royal College of Psychiatrists' ECT handbook*.<sup>358</sup> The analysis used the same method as Pippard and Ellam, and Benbow.<sup>359</sup>

22.12 Postal questionnaires were sent to 307 psychiatrists with a response rate of 60%. Questions addressed attitudes to, range of experience of and practice of ECT. In one question respondents were asked to rate how appropriate they considered ECT to be for a number of psychiatric conditions. Eighty seven per cent of respondents were aware of guidelines to ECT practice. The *ECT Handbook* was the most nominated set of guidelines used by psychiatrists despite the majority being New Zealand trained.

22.13 Forty nine per cent were strong advocates of ECT, 45% were generally in favour, 5% were generally opposed but would use it as a last resort. One respondent said it should never be used. 60% of respondents had prescribed ECT in their current post, 62% could identify a consultant responsible for their ECT service, and 34% could not. Eighty respondents never gave the ECT they prescribed. Three deaths were reported in the combined experience of the 184 respondents. They were a ruptured cardiac aneurysm, extension of a CVA and presumed ventricular fibrillation during treatment where a defibrillator was not available. 17% had experience of what they described as a major medical complication occurring during ECT. Seven respondents had personal experience of a defibrillator being used.

22.14 Although there are no absolute contraindications to ECT in the Royal College of Psychiatrists Guidelines, and the RANZCP guidelines nominate only raised intracranial pressure, most respondents indicated many conditions to be absolute contraindications. NZ psychiatrists were more in favour of reducing or stopping all classes of psychotropic medication during ECT compared with psychiatrists in north west England.

22.15 It was stated that given that ECT is used primarily for depression it was of concern that 20% of psychiatrists would not routinely put a patient on an antidepressant post ECT. It was reported that the findings of the survey suggested that guidelines were having an insufficient impact on practice.

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<sup>357</sup> Mental Health Act Commission (2001) Ninth Biennial Report 1999-2001: London Stationery Office cited in S Eranti, D McLoughlin, "Electroconvulsive Therapy - State of the Art" ed (2003) 182 *British Journal of Psychiatry* 8.

<sup>358</sup> J Strachan, "Electroconvulsive Therapy - Attitudes and Practice in New Zealand" (2001) 25 *Psychiatric Bulletin* 467.

<sup>359</sup> S Benbow "Old age Psychiatrists' Views on the Use of ECT" (1991) 6 *International Journal of Geriatric Psychiatry* 317. S Benbow, D Tench, S Darvill, "Electroconvulsive Therapy Practice in North-west England" (1998) 22 *Psychiatric Bulletin* 226. Both of these surveys are discussed by Freckleton and Wilson, p 402.

22.16 In the mid 1990's Scottish Scotmeg/Clinical Research and Audit Group (CRAG) initiated a large scale survey of ECT usage and practice to facilitate good practice within Scotland.<sup>360</sup> The findings were similar to that of Pippard. Few consultants had sessional time allocated for ECT, and in 26% of clinics SHO's administered their first ECT unsupervised. Recommendations included a national system of collecting ECT data.

22.17 The Scottish National audit commenced in 1996. The final report on the National audit of ECT in Scotland was published in 2000. The audit was divided into three phases, and provided a detailed examination of the practice of ECT in Scotland. The standard of facilities, equipment, staffing, training and supervision were measured. Clinical outcome was also measured as was nursing levels. The last phase of the Scottish audit involved unannounced visits to each ECT site, to view treatment sessions and to check if safe and correct procedures were used. The final report found that the standard of ECT in Scotland was high. Facilities and equipment at ECT centres were up to date and of a generally high standard.

22.18 The Scottish audit reinforces the importance of the audit cycle. Reasons for failure to improve practices need to be documented, addressed and reassessed. The areas highlighted for improvement related to the ongoing supervision of trainee doctors and the lack of co-ordinator sessional time.

#### *New Zealand – Institutional and Professional Regulation*

22.19 The recent audit carried out in New Zealand measured ECT providers against the standard that each ECT service needed to have an identified consultant psychiatrist with overall responsibility for ECT services, training and supervision, and best practice policy/protocol development and review. This is consistent not only with the recommendations of the RANZCP *Clinical Memorandum*, but also with the opinion of the Health and Disability Commissioner.<sup>361</sup> The psychiatrist with over-all responsibility should have completed a recognised ECT training programme.

22.20 The audit showed that eighteen of the 20 sites providing ECT services in New Zealand had a consultant psychiatrist (or senior registrar in an acting consultant position) in a position of responsibility for ECT.<sup>362</sup> At two sites responsibility for ECT services was shared between several consultant psychiatrists or between a senior registrar and the psychiatrists on the ECT committee. However only three District Health Boards had filled positions for an ECT consultant with protected ECT sessional time.<sup>363</sup>

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<sup>360</sup> C Robertson, C Freeman, G Fergusson, "ECT in Scotland" (1997) 21 *Psychiatric Bulletin* 699.

<sup>361</sup> See opinion 00HDC07173 where a hospital providing ECT services was held to have breached rights 4(1) and 4(5) by failing to have appropriate policies and procedures in place for providing ECT on an outpatient basis. This included omitting to have a clinician appointed as care co-ordinator with overall responsibility for clinical surveillance.

<sup>362</sup> Nineteen out of 21 New Zealand District Health Boards were identified as ECT service providers. One DHB provided ECT at two sites.

<sup>363</sup> Sessional time includes overseeing all aspects of delivery of ECT, including policy and

22.22 The project group considered that failing to have an identified consultant psychiatrist and a mental health nurse with protected time will impede the delivery of high quality services in New Zealand. Without such measures, including facilitating access to the latest developments in technique and evolving research, and a means of ensuring such information is disseminated to those delivering ECT, it is possible that practice levels may fall short of scientific updates.

22.23 One site surveyed had not administered ECT for two years despite having a modern machine. It was noted by those responsible for the audit that District Health Boards may need to balance local availability with the viability of smaller services treating infrequently. It may be better for small district health boards to have formal arrangements with larger district health boards.

22.24 This is consistent with the RANZCP *Clinical Memorandum* which states that “consideration should be given to the ongoing maintenance of skills and the frequency with which operators are likely to be giving ECT. Giving an occasional ECT may not be adequate to maintain the necessary skills”. It also states that as far as possible, the number of clinicians involved in giving ECT on a regular basis should be limited, to avoid loss of skills from infrequent practice.

22.25 The audit reported that ECT was prescribed by a consultant psychiatrist although at some sites medical officers of specialist scale were permitted to prescribe ECT. Administration of ECT at all sites was performed by a consultant psychiatrist or a trained or supervised psychiatric registrar or medical officer. Psychiatrists involved in ECT administration at ten sites had attended recognised advanced ECT training programs in Australia, the United States of the United Kingdom.

22.26 This falls short of the RANZCP memorandum that practicing psychiatrists who wish to administer ECT are strongly recommended to undergo specific training in modern methods of ECT, including the use of EEG at a recognised ECT training program.

22.27 Psychiatric registrars were involved in ECT administration at 13 sites. At these 13 sites a registrar training program in ECT was provided.

22.28 The Royal Australia New Zealand College of Psychiatrists has recently updated the Training and Assessment Regulations for the RANZCP fellowship programme. The regulations state in regards to ECT that attendance and participation in the delivery of a minimum of ten ECT treatments under the direct supervision of an appropriately trained psychiatrist is necessary. At least one of these treatments must be the first received by a person who has not

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procedure development, supervision and quality control, clinical consultation, and training of medical and nursing staff.

previously been treated with ECT. At least three of the ten people treated should be directly managed under appropriate supervision throughout their ECT course by the trainee.<sup>364</sup>

#### *Psychiatrists training*

22.29 According to a relatively recent survey carried out on 91 Canadian psychiatric residents in their final year of training, about their experience with ECT, only 18% of respondents felt completely competent regarding the administration of ECT.<sup>365</sup> The study followed up a survey of 158 psychiatric residents carried out by the same institution, Toronto's Centre for Addiction and Mental Health in 1988 which showed similar results.

22.30 After the first survey, the Canadian Psychiatric Association put forward a position paper and the American Psychiatric Association issued guidelines for training residents in ECT. The new study suggested that despite these guidelines there has been no improvement with respect to ECT training in Canada. In fact, fewer respondents had administered the minimum number of ten ECT treatments recommended in the American Psychiatric Association guidelines.

22.31 The studies into the training, confidence and competence of trainee psychiatrists carried out by Hillam et al and Duffet and Lelliott both published in 1997 which have been described at length in the article by Freckleton and Wilson highlighted concerns regarding the adequacy of training.<sup>366</sup> In the study by Duffet and Lelliott forty five percent of doctors answered incorrectly one or more of the first three questions pertaining to the delivery of ECT which were considered by the authors to be essential knowledge for anyone administering ECT. This was despite seventeen years of audit.

#### *Nurses training*

22.32 In the audit carried out by Pippard in 1991 it was found that nursing administration of ECT clinics was generally good or excellent, as was patient care in 75% of clinics. The Royal Australian and New Zealand College of Psychiatrists guideline recommends ECT nurses be appropriately trained in anaesthetics and resuscitation techniques and modern ECT practice. However, it has been observed that existing educational programs in ECT and anaesthesia often target medical staff, making it difficult for mental health nurses to access adequate training.<sup>367</sup>

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<sup>364</sup> See regulations 4.4, 5.12 and 8.11 of the RANZCP Training and Assessment Regulations.

<sup>365</sup> J Manzer, "Young Psychiatrists Struggling with Electroconvulsive Therapy: Lack of Comfort with Procedure may Compromise Access to Care for Patients" (2001) 37 *Medical Post Toronto* 1.

<sup>366</sup> See discussion of the studies of Hillam et al, and Duffet and Lelliott, in I Freckleton, B Wilson "Electroconvulsive Therapy: Law, History and Practice" (2001) 8 *Journal of Law and Medicine* 389, 406.

<sup>367</sup> See J Munday, C Deans, J Little "Effectiveness of a Training Program for ECT Nurses" (2003) 41 *Journal of Psychosocial Nursing and Mental Health Services* 20 citing R Duffet, P Lelliott "Junior Doctors' Training in the Theory and Practice of Electroconvulsive Therapy" (1998) 14 *Journal of ECT* 127.

22.33 Results from a study involving ninety two nurses from forty two different health agencies in Australia indicated a major knowledge deficit in key components of ECT among nurses having responsibilities regarding ECT.<sup>368</sup> This was despite sixty-four of the participants being of clinical nurse specialist scale, nineteen were nurse managers, and eight were ECT coordinators.

22.34 Participants knowledge and confidence levels about the ECT procedure were measured pre and post the provision of a training programme which included increasing knowledge and practical skills in key components of ECT, an understanding of the medical technology in anaesthesia and recovery, awareness of legal issues surrounding the procedure, and medical emergency interventions.

22.35 The training programme significantly improved nurses' confidence relating to key areas of ECT administration and technical knowledge. It was recommended that appropriate training programmes be made available for nurses involved in ECT which are specifically designed for nurses, and that some means of credentialling should be introduced to ensure prescribed competence standards are attained.

22.36 The New Zealand audit indicated that the majority of ECT (but not all) is administered within the general hospital theatre complex. In all sites where ECT was administered an anaesthetic assistant and recovery nurse was present. However, this does not negate the need for training as nurses are involved in the provision of ECT at some sites as well as providing education for patients and families, developing nursing policies, co-ordinating services, and ensuring patients' physical welfare before and after ECT.

22.37 A possible draw back of the New Zealand audit was the fact that the administration of ECT was not viewed. The audit involved looking at protocols, and interviewing key staff at each site. However, as observed in previous studies it is not uncommon that providers may deliver ECT inconsistently with guidelines or protocols.<sup>369</sup> It was also stated by the auditors that the standard and content of the ECT protocols varied widely.

22.38 Licensing of practitioners providing ECT, and ECT clinics may provide greater certainty of quality service. The RANZCP *Clinical Memorandum* has recommended that hospitals consider the granting of specific ECT privileges. These specific privileges would require a sufficient treatment volume to maintain skill maintenance as well as further training for those who use ECT. It is not clear whether any hospitals in New Zealand have implemented this

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<sup>368</sup> J Munday, C Deans, J Little "Effectiveness of a Training Program for ECT Nurses" (2003) 41 *Journal of Psychosocial Nursing and Mental Health Services* 20.

<sup>369</sup> See I Freckleton, B Wilson "Electroconvulsive Therapy: Law, History and Practice" (2001) 8 *Journal of Law and Medicine* 389, 403-408. See also G Brookes, R Barnes, J Rigby, "Implementing the Royal College of Psychiatrists' Guidelines for the Practice of Electroconvulsive Therapy" (2000) 24 *Psychiatric Bulletin* 329.

recommendation.

*Variations in usage*

22.39 Concerns about wide variations in professional practice were raised regarding the 1991 audit undertaken by Pippard, which revealed a twelve-fold difference in rates of administration of ECT between districts in the same region.<sup>370</sup>

22.40 Pippard proposed a number of factors that might have accounted for this wide variation including; differing therapeutic orientations between consultants, significant differences in the incidence of depressive illness between rural and urban areas, patient and family choice, and practical administrative difficulties in low-use areas.

22.41 Scotland has also reported widespread variation in the rate of use of ECT across the country. A thirty-fold variation was reported in the recent audit undertaken.<sup>371</sup>

22.42 Claims of huge regional variation in the administration of ECT have also been made in New Zealand, and have been linked to failure of regulatory controls in some areas.<sup>372</sup> The New Zealand audit as presented currently does not give a breakdown as to the incidence of ECT in different regions. However, many variables may effect ECT provision. More information would need to be gathered to determine what may be influencing variation in New Zealand if this is the case.

22.43 An American study into the variation of ECT use found that this procedure is among the highest-variation procedures in medicine.<sup>373</sup> The study analysed data received from 17 729 psychiatrists from 317 urban statistical areas.<sup>374</sup> Factors most strongly affecting ECT provision were provider variables, such as the number of psychiatrists and primary care physicians in the region. It was thought that primary care physicians may influence ECT rates by detecting cases of psychiatric illness and referring patients for treatment. State regulation significantly predicted ECT use.

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<sup>370</sup> See Pippard J "Audit of Electroconvulsive Treatment in Two NHS Regions" (1992) *British Journal of Psychiatry* 160.

<sup>371</sup> See G Fergusson, J Hendry, C Freeman, "Do Patients who Receive Electroconvulsive Therapy in Scotland Get Better? Results of a National Audit" (2003) 27 *Psychiatric Bulletin* 137, 138.

<sup>372</sup> See Dr J Read, verbal submission to the select committee.

<sup>373</sup> R Hermann, R Dorwart, C Hoover, J Brody, "Variation in ECT Use in the United States" (1995) 152 *The American Journal of Psychiatry* 868.

<sup>374</sup> Surveys were sent to 34,164 psychiatrist members of the American psychiatric Association and 10,091 nonmember psychiatrists identified from the American Medical Association's Physician Masterfile. Response rate from APA members was 67.7% and non members response rate was 28.9%. The final sample consisted of "active psychiatrists" excluding retired, residents or fellows. The survey asked all respondents to report the number of patients to whom they had administered ECT in the preceding month.

22.44 Another American study researched the characteristics of psychiatrists performing ECT. It found that psychiatrists graduating from a medical school outside the United States were more likely to use ECT than those who did not, and training characteristics were significantly associated with differences in the use of ECT.<sup>375</sup> Clinical orientation were predictors of ECT use. Compared with psychiatrists who used both psychotherapy and psychopharmacology, psychiatrists who used psychotherapy only were less likely to administer ECT while psychiatrists who used psychopharmacology only were more likely to use ECT. Psychiatrists working at public hospitals were less likely to use ECT than those at private hospitals. Psychiatrists who used ECT had caseloads involving a higher proportion of patients with affective disorders and organic disorders than other psychiatric disorders. Psychiatrists with an academic medical centre in their county were more likely to provide ECT. It was also found that female psychiatrists were only one-third likely to administer ECT as male psychiatrists.

22.45 The Scottish national audit provided a mechanism for the central collection of data providing a valuable database to determine the validity of some adverse claims. For example, the higher figures for use of ECT in females in Scotland reflected the higher incidence of female admissions for depressive disorder, (F:M-1.6:1 in Scottish Health Statistics 1998). There was no evidence that male psychiatrists prescribed ECT preferentially to female patients. ECT was not given disproportionately to the elderly.

22.46 Several innovations are underway in England to ensure better provision of ECT services, including both professional and quasi-governmental regulation. The National Institute of Clinical Excellence has published guidelines in regard to ECT. The guidance links efficacy and side effects of ECT to its delivery.<sup>376</sup>

22.47 The UK *ECT Handbook* is currently under review, and the Royal College of Psychiatrists have launched an ECT accreditation service (ECTAS) to “assure and improve the quality of the administration of ECT”.<sup>377</sup> The Royal College of

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<sup>375</sup> R Hermann S Ettner, R Dorwart, C Hoover E Yeung “Characteristics of Psychiatrists who Perform ECT” (1998) 155 *American Journal of Psychiatry* 889. The survey was sent to 34,164 psychiatrist members of the APA and 10,091 nonmember psychiatrists identified from the American Medical Association’s Physician Masterfile. The response rate as 67.7% for APA members and 28.9% for nonmembers. Of 26,045 respondents, the final sample consisted of 14,285 psychiatrists living in the US who were not retired, residents, or fellows, were actively treating patients and who fully completed the survey.

<sup>376</sup> It has been reported that traditional methods for upholding the quality of medical practice, through professional self-regulation, are under attack because of perceived failures. (Self-regulation is described as peer-review, audit, continuing professional development and clinical governance). Funding from the Health Department which was previously allocated to professional organisations for guidelines and audit may now be directed to the National Institute. See P Lelliott, “Clinical Standards and the Wider Quality Agenda” (2000) 24 *The Royal College of Psychiatrists* 85.

<sup>377</sup> It is stated that the full set of standards are “aspirational” and it is unlikely that any clinic would meet all of them. The standards are graded by three levels: standards that it would be desirable for a clinic to meet, standards that an accredited clinic would be

Psychiatrists have withdrawn their patient information guide and are reviewing it since the NICE guideline was published.

22.48 The accreditation standards have been drawn from the *ECT Handbook*, the Nice appraisal of ECT, the Scottish National Audit of ECT, and the two systematic reviews on safety and efficacy of ECT and patient perspectives on ECT. The standards cover ECT clinic and facilities, training, assessment and preparation, consent, anaesthetic practice, administration of ECT, recovery, monitoring and following up, and special precautions.

22.49 In the report carried out on ECT in Quebec, emphasis was placed upon all stakeholders involved in ECT being included in strengthening the institutional and professional regulatory measures. Similarly in Western Australia, members of the Chief Psychiatrist Advisory Group on ECT who are charged with developing best practice guidelines includes representatives not only from the Health Consumer's Council but also representatives from Carers WA. In the field of research, it is becoming more commonplace that service users are involved.<sup>378</sup>

22.50 In mental health, user-led research has been carried out, but has not been accepted by the academic mainstream. It has constituted the "grey" literature which has not been accepted by peer-reviewed journals. However, there is reportedly a change in attitude which has seen research funding bodies require evidence of user involvement in research proposals or in the research itself.<sup>379</sup>

22.51 The review of consumers' perspectives on electroconvulsive therapy undertaken for the UK Department of Health involved the empirical part of the project being conducted by people who had themselves received ECT. It was stated that without compromising scientific rigour, a different light was shed on this topic.<sup>380</sup>

22.52 The New Zealand Ministry of Health has accepted the recommendation of the Select Committee in their *Report on the petition of Anna de Jonge and Other Against Electroconvulsive Therapy*<sup>381</sup> that national technical standards be established. The Standards Act currently establishes the technical standard for ECT equipment.<sup>382</sup>

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expected to meet, and the standard that breach of which would result in a significant threat to patient safety or dignity and/or would breach the law. The ECT accreditation standards are available at [www.rcpsych.ac.uk/cru/ECTAS](http://www.rcpsych.ac.uk/cru/ECTAS).

<sup>378</sup> In some clinical specialties, such as cancer, HIV AIDS and Alzheimer's disease, collaborative research is beginning to be established. D Rose "Collaborative Research Between Users and Professionals: Peaks and Pitfalls" (2003) 27 *Psychiatric Bulletin* 404.

<sup>379</sup> There are three levels of involvement of user involvement in research, consultative, collaborative and user-led.

<sup>380</sup> Op cit, n375.

<sup>381</sup> *Report on the petition of Anna de Jonge and Other Against Electroconvulsive Therapy*, Health Committee, Wellington, (2003).

<sup>382</sup> NZS/AS3200.2.14-92.

22.53 Under the Health and Disability Services (Safety) Act 2001 mental health services are required to meet the National Mental Health Sector Standard<sup>383</sup> by October 2004. This standard sets out at 16.13 the requirement that “medication and other medical interventions are prescribed, stored, transported, administered, recorded and reviewed by authorized persons in a manner consistent with legislation, regulations and professional guidelines and reflect current best practice standards”. The RANZCP *Clinical Memorandum #12* is to be added to the list of Relevant Acts and Regulations and Related Documents that appears in the Standard when it is reviewed during 2004. However, the challenge is to ensure that the guidelines are followed in practice. Both the RANZCP *Clinical Memorandum* and the *Mental Health Sector Standard* are professional standards for the purposes of Right 4(2) of the Code of Consumers’ Rights which provides that “every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards”.

22.54 The Government has agreed that the Ministry of Health will advise designated auditors under the Health and Disability Services (Safety) Act 2001 of the expectation that they should include in their audits of DHB mental health services consideration of ECT use in accordance with the *Clinical Memorandum*. The memorandum may need to be supplemented in the context of medico-legal information as a result of this review.

22.55 It has also been agreed that the Ministry of Health will produce an annual report on the number of patients who receive ECT, and the number of ECT treatments per patient, by each District Health Board. This will include the number of patients who receive ECT under compulsion and the number of compulsory ECT treatments per patient by District Health Board.

22.56 Age, gender, diagnosis, and clinical circumstances would also be valuable data to collect. We have no data as to the incidence of Maori receiving ECT, hence ongoing audit needs to take account of consumers’ ethnicity.<sup>384</sup>

22.57 It would seem most desirable that some form of outcome measures are also undertaken, which has been recommended by those responsible for the New Zealand audit. It may be pertinent to survey trainee psychiatrists perceptions of adequacy of training, and comfort with delivering ECT, and assessment of the standard of ECT administration in practice.

22.58 Freckleton and Wilson have stated, “quality improvements require good equipment, effective training and supervision, and accurate diagnosis”.<sup>385</sup> It also requires the establishment of adequate policies and procedures, adhered

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<sup>383</sup> NZS8143:2001. The Standard was approved by the Standards Council on 20 April 2001 to be a New Zealand Standard pursuant to the provisions of section 10 of the Standards Act 1988.

<sup>384</sup> Dr John Read has stated that Maori receive ECT, but not in disproportionate numbers. Verbal submission to the select committee.

<sup>385</sup> I Freckleton, B Wilson “Electroconvulsive Therapy: Law, History and Practice” (2001) 8 *Journal of Law and Medicine* 389, 406.

to by practitioners and informed consent that accurately reflects the current evidence available in regards to safety and efficacy. It may also require heightened participation by consumers.

## **PRIMARY AND SECONDARY LEGISLATION,**

Mental Health (Compulsory Assessment and Treatment) Act 1992 as amended

Code of Health and Disability Services Consumers' Rights Regulations 1996

## **OFFICIAL GOVERNMENTAL GUIDELINES**

Ministry of Health, Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, June 1997

Technical standard for ECT equipment, (NZS/AS3200.2.14-92)

National Mental Health Sector Standard, (NZS 8143:2001)

## **PROFESSIONAL GUIDELINES**

Royal Australian and New Zealand College of Psychiatrists, Clinical Memorandum # 12, Electroconvulsive therapy: Guidelines on the administration of electroconvulsive therapy (ECT) 1999 (GC1/99, R40)

Royal Australian and New Zealand College of Psychiatrists, New Public Information Sheet - Electroconvulsive Therapy Explained, 1999

Royal Australian and New Zealand College of Psychiatrists, Training and Assessment Regulations, October 2002

The Australian and New Zealand College of Anaesthetists, Professional Documents, In particular PS7 (2003), PS4 (2000), PS18 (2000), T1 (2000), T2 (2000)

## **BRITISH PROFESSIONAL GUIDELINES<sup>386</sup>**

Royal College of Psychiatrists, ECT Handbook, 1995 (under revision)

Royal College of Psychiatrists, The Royal College of Psychiatrists Patient Fact sheet on ECT, 1993 (under revision)

## **PROPOSED REGULATORY CHANGES BY SELECT COMMITTEE - ACCEPTED BY GOVERNMENT**

Health and Disability Services (Safety) Act 2001 - under the Act mental health service providers are contractually required to meet the National Mental Health Sector Standard. The Select Committee has recommended that the RANZCP *Clinical Memorandum* be explicitly included in the list of Relevant Acts and Regulations and

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<sup>386</sup> (Included as some New Zealand psychiatrists refer to the British guidelines)

Related Documents when the Standard is reviewed during October 2004.

Ministry of Health will advise designated auditors under the Health and Disability Services (Safety) Act 2001 that they should include in their audits of DHB mental health services consideration ECT use in accordance with the RANZCP *Clinical Memorandum*.

## CHAPTER 23 APPENDICES

- Appendix 1:** United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)
- Appendix 2:** I Freckleton, B Wilson “ Electroconvulsive Therapy: Law, History and Practice” (2001) 8 *Journal of Law and Medicine* 389