

Mental Health Legal Centre Inc.

Reg. No: A0013662S

A Position Paper on the Law and Electro Convulsive Therapy in Victoria

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Acknowledgments

The Centre would like to thank all those people we have worked with whose experiences have contributed to this position paper.

We would also like to thank attendees at our Consumer Rights and Law Reform Forum, members of the Committee of Management, and Danny Sullivan and Joel Gerschman for their invaluable assistance.

Further, we are grateful to Dr Ruth Vine, Deputy Chief Psychiatrist, Julian Gardner, President of the Mental Health Review Board, Beth Wilson, Health Services Commissioner and the Mental Health Branch, Department of Human Services for the time and care taken in commenting on drafts of the Paper.

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Preface

From where we stand as an organisation committed to advocating Consumer views, Electro Convulsive Therapy (ECT) is a controversial subject. That is not to say that its use is generally regarded as contentious by the medical profession. According to medical orthodoxy it is clearly a treatment of benefit in many instances where other treatments have failed. However, there is considerable disquiet amongst the people we work with about the lack of legal safeguards surrounding ECT.

The Mental Health Legal Centre (Centre) makes no judgement as to validity of this treatment. The Centre's expertise is mental health law - not medical research. This position paper is about process and law reform. The Centre has been questioned on why it has picked this treatment modality for review whilst other treatments are equally as controversial. ECT is governed by specific provisions under the Mental Health Act 1986 (Vic) that set it apart from other treatment regimes. ECT is similarly granted specific status in most other States of Australia. What is lacking in Victoria is the same level of procedural safeguards as exists in a number of other Australian and overseas jurisdictions.

It is true that other treatment modalities cause concern amongst the people with whom we work. Indeed, the United Nations Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care¹ provide that, even where people are receiving treatment involuntarily, they should be able to appeal to an independent arbiter in relation to treatment generally. We have not, however, chosen to seek that level of safeguard for all modes of treatment, but focused on ECT because of its specific legislative status and the nature of concerns people bring to us about this treatment in particular. It was recognised in the 1986 Departmental Discussion Paper (Victoria's Mental Health Services Proposed

¹ The Principles were adopted by the Assembly Resolution on November 1991.46th Session Item No.98b

Amendments to the Mental Health Act 1986) around the amendments to the Act that there is a requirement to ensure that “a patient receives an independent review of the decision to perform ECT” and the process “complies with the UN Principles”. The proposal at that time was to require second written psychiatric opinions.

Our position has been informed by Consumer participation in the Consumer Rights and Law Reform Forum and from casework, policy and education work over the past 10 years. The Centre sought all views and received a range of responses from Consumers and others. Our position reflects that range, with the vast majority of those with whom we work expressing concern rather than approval. We acknowledge that those who come to our organisations are more likely to feel disquiet over treatment. However, we do not believe this means that such views should not be given full and serious consideration. It is our role to ensure this occurs.

The aim of this Paper is to raise discussion in the community about legal safeguards and ECT. It is also our aim to inform readers at a Forum where groups, individuals and organisations can to discuss this issues. We hope our recommendations will be a useful starting point for discussion.

Ultimately, this Position Paper is about the law, and we would ask that, whatever the views of different readers, the focus is on legal process and Consumer rights. The Mental Health Act 1986 was a major initiative in more rights focused mental health care. Amendments in 1995 introduced further change – some enhancing rights, and some detracting.

The 1995 amendments included some further safeguards in relation to the use of ECT. The following are of note:

- Firstly, after 1995 all premises in which ECT may be preformed have to be licensed

- q Secondly, license holders for both private and public settings must submit monthly reports the Office of the Chief Psychiatrist on the use of ECT

- q Thirdly, the factors to be considered before ECT can be given without consent to people incapable of consenting were expanded to include:
 - q Beneficial alternative treatments; and
 - q Whether the person is likely to suffer a significant deterioration without the ECT.

The Mental Health Act is clearly in transition. Consumers and Carers indicate to us that ECT regulation is an area requiring further reform. Standards set by the United Nations and other jurisdictions comparable to ours support this call. We hope that, in this area and others, mental health law in Victoria will continue to metamorphosise as the community and human rights law demand.

Introduction

Part of the disquiet in relation to ECT is because of its invasive nature. ECT is a process whereby a person receives a general anaesthetic and muscle relaxant, has electrodes placed on the head and a current passed through the brain until a seizure is induced. Though there are many more invasive procedures, the community's concern about the serious nature of the procedure is understandable.

Also, due to inappropriate uses of ECT in the past, the community is sceptical about its worth. In fact, many people are surprised that ECT is still commonly used in modern psychiatry.

This may in part be because of the sensationalist approach of movies and fiction. Whatever the medical research, there will always be controversy because of the historical, cultural and political elements of this treatment.

The Centre neither recommends nor discourages ECT, but focuses on matters of legal process.

We believe that law reform and ECT are important subjects for public debate for four reasons.

- § First, Consumers report to the Centre a level of disquiet and apprehension in regard to ECT that is unparalleled in intensity by most other legal concerns at the Centre,
- § Second, common law in relation to informed consent has changed with the decisions of Rogers V Whitaker and Chappel V Hart,
- § Third, the third wave of mental health reform should further enhance Consumer rights,
- § Fourth, Victoria with some degree of self-assurance prides itself on a Consumer rights focus in mental health. However, other jurisdictions are now at the forefront in developing Consumer orientated ECT protocols.

The experience of the people that the Centre works with indicates that the Consumer concerns about the Victorian system are:

- (a) The lack of effective appeals mechanisms, due process and public accountability;**
- (b) The perceived failure in practice of the informed consent requirement of the Mental Health Act and;**
- (c) The perceived failure to apply appropriate limits to the use of ECT.**

This Position Paper is aimed at a multi-faceted audience with expertise in a variety of areas thus some information may be less relevant to particular readers.

Section

The History of ECT

Induced seizure has a long history. As early as the 1470's missionaries in Ethiopia used electric catfish to cast out demons. In the 1400's camphor oil was also used to help those with what may be considered manic episodes in Europe. In the 1700's herbs were used to cause seizures (Endler & Persade: 1988).

However, in modern usage seizure was first used during the 1930's. Treatments were consolidated into four main therapies for the mentally (dis) ordered, of which ECT was one². In modern medicine, seizure was performed for the first time in 1934 in Budapest by Van Meduna who induced a seizure via injection of camphor oil with Consumers who experienced schizophrenia like symptoms (Endler Persade: 1988). The Camphor oil was eventually considered unreliable, so Cardiazol or Metrazol was used. In 1938 electricity was used to produce seizures in Consumers with psychotic (dis) orders.

² Dis is placed in brackets to emphasise a person's order, function or ability. This term does not take away from the pain and experience of such illness but rather represents the person as a whole. The Centre considers this linguistic ploy as empowering for Consumers of psychiatric services. Furthermore Consumer is spelt with a capital 'C' because it is now considered a proper noun.

The modern use of ECT comes mainly from two Italian doctors, Cereleti and Bini, who believed that electrically induced seizures had a therapeutic effect. In 1945 anesthesia was used and during the 1950's muscle relaxants were introduced to lessen or reduce the risk of multiple fractures occurring during convulsions. (Endler & Persade 1988). During the 1950's a chemical, Indoloken, was introduced to cause seizures but did not become popular because it was not viable. (Endler & Persade: 1988)

Currently in Victoria, ECT is used with new brief pulse machines - the most advanced machines available (instead of sine wave machines) - and these are believed to have less detrimental effects on memory. The dosage is titrated to produce a seizure that is found to be most clinically effective. The new ECT machines have EEG monitoring capabilities for a seizure, which further reduces the risk of the side effect of memory loss.

In Victoria all premises that give this treatment have to be licensed under the Mental Health Act and comply with Guidelines from the Department of Human Services.

The Process – Legal and Clinical

This section will be broken up into two parts. Firstly, the Centre will discuss the legal process and secondly the centre will discuss the current Guidelines of the Royal Australian and New Zealand College of Psychiatrists (“College”).

Legal process

There are three categories under which ECT can be given in Victoria. It may be given:

- with informed consent,
- in an urgent situation under section 73 (4).
- under section 73(3) where involuntary or security patients cannot consent to treatment and will suffer significant deterioration in their physical or mental condition without the ECT,

This Position Paper will first discuss informed consent and then second consider the circumstances that indicate use of non-consensual ECT.

Informed consent

Pursuant to section 53(B), informed consent requires:

- ü A clear explanation containing sufficient information to make a balanced judgement.
- ü An adequate description of the benefits discomforts and risks without exaggeration or concealment.
- ü Advice about beneficial alternative treatments.
- ü Any relevant questions must be answered and the answers understood.
- ü A full disclosure of financial relationships between the person seeking informed consent and the relevant hospital or clinic.
- ü A Consumer who gives consent, only gives consent to not more than 6 treatments and must be told they can withdraw consent at any time (section 72).
- ü A person must be provided with the requisite written information, with information on the right to legal and medical advice, the right to a second opinion, the right to withdraw consent at any time and “any other information relating to the treatment the Department considers relevant”.
- ü A person must be provided with an oral explanation of the written statement.

Non-consensual

Under Victorian legislation there are two situations in which informed consent is not required (section 73 (3) & (4)). Under these sections the Authorised Psychiatrist consents on behalf of a Consumer with the following provisos.

Section 73(4) allows ECT without consent if the treatment is urgently required.

As figures on use of ECT are not currently publicly available, we are unsure how often this provision is used. However, we understand its use is very infrequent, and involuntary ECT is predominantly pursuant to section 73(3), below.

The section which is most used, section 73(3) requires that the Authorised Psychiatrist be satisfied that:

- ü The ECT has clinical merit and is appropriate.
- ü Regard must be had to the discomfort and benefit or risks of the procedure.
- ü Consideration is given to beneficial alternatives.
- ü A patient is likely to suffer significant deterioration in their physical or mental condition without the ECT.
- ü All reasonable efforts have been made to notify the person's guardian or primary carer of the proposed performance of electroconvulsive therapy.

Clinical guidelines

The current Guidelines by the College are contained in Clinical Memorandum #12 of the College, and provide that:

- ü Side effects must be fully explained.
- ü Full medical examination, both physical and psychological, is required.
- ü A dedicated suite must be available for the use of ECT.
- ü ‘It is now well established that unilateral placement of electrodes over the non-dominant hemisphere causes less severe cognitive side effects than bilateral placement. However, the relative efficacy of right unilateral and bilateral ECT is still controversial. Some studies have found superior efficacy with bilateral ECT. Given the uncertainty, it is recommended that electrode placement be determined on a case by case basis”.
- ü The doses of electricity should be determined on a case-by-case basis.
- ü A seizure threshold should be established.
- ü The initial dose of electricity should be based on an algorithm – including age and gender.
- ü An EEG should be used to monitor the quality, end point and duration of the seizure.
- ü EEG monitoring should be in place from initial anesthetic to complete recovery.

- ü Recovery should be in a specialist area with appropriately trained nursing staff.

How is ECT Believed to Work?

The exact process by which ECT works is unclear. Many believe that ECT works in a similar way to antidepressants in that it affects the number of neurotransmitters and the effectiveness of neurotransmitters in transmitting the chemicals that affect mood disturbance. Most doctors and medical researchers believe that a convulsion of adequate duration affects the process and gives better outcomes (RANZCP, Clinical Memorandum #12).

ECT has shown efficacy, according to the College, with the following categories of mental (dis) order or diagnosis

- q **Severe Melancholia,**
- q **Psychotic depression,**
- q **Acute schizophrenia (in the early stages of the development of the illness),**
- q **Parkinson's disease,**
- q **Mania**

(RANZCP, Clinical Memorandum #12)

EFFICACY OF ECT

ECT has many advantages that include remission and improvement of distress or disturbance. It is comparatively rapid compared with other treatments for the relevant (dis) orders.

ECT has shown great efficacy and, according to United States studies, has an overall response rate of 75% to 85% in the area of depression ((Ed) Sederer, Lloyd, I. & Rothschilds, Anthony, 1997).

ECT may be indicated for:

- q **Consumer who do not respond to medications,**
- q **Consumers who are unable to tolerate the side effects of pharmacotherapy,**
- q **Consumers with a History of response to ECT,**
- q **Consumers who need rapid intervention.**

Consumers who have psychosis and mania account for 20% (in total) of treatments. Psychotic depression may require ECT as a first line treatment. (Ed Sederer, Lloyd, I. & Rothschilds, Anthony, J: Acute Care Psychiatry 1997)

ECT may be more effective and safer for elderly persons than other comparable treatments ((ed) Sederer, Lloyd, I. & Rothschilds, Anthony, J 1997).

Side effects of ECT

The Paper refers to a range of research and literature as to side effects of ECT. We raise a breadth of material, including some, which may be dismissed by medical orthodoxy, because people we work with have access to and are concerned by it.

The College Guidelines (Clinical Memorandum #12) referred to above suggest that many of the minor side effects include headache, muscle soreness, nausea, drowsiness and myalgia.

The College also notes in Clinical Memorandum #12 that cognitive side effects are of concern to clinicians and patients. They note that evidence for much of this is based on use of the older ECT machines and bilateral placement of electrodes. They also note that severe depressive illness itself is associated with cognitive impairment.

The College acknowledges a range of post ECT delirium, from impaired comprehension and disorientation, to severe psychomotor restlessness that may require intravenous antipsychotics. They say that in a small proportion of patients a persistent post-ECT delirium may be observed. Other serious side effects noted by the College are amnesia, normally minimal and completely resolved after six months with unilateral ECT. They note that bilateral ECT is associated with greater levels of amnesia, which may be more persistent. Retrograde memory loss, especially for autobiographical events up to 6 months before ECT, may continue to be noted. The College notes that in some cases persistent memory disturbance may be correlated with residual depression (RANZCP: Clinical Memorandum #12).

The main purpose of this paper is to discuss the law and ECT. We do not have medical expertise. However, we do believe that the persistent claims of more

significant side effects need to be fully considered especially in the light of the requirement to obtain informed consent.

Whilst the more extreme views expressed on the subject may be dismissed by many in the medical profession, we believe they should be acknowledged, as their influence is not insignificant, especially on Consumers.

For example:

- q Claims of very serious memory loss, (Freeman, Weeks and Kendell: [http: www.ECT.org.com](http://www.ECT.org.com) & Breggin: Toxic Psychiatry 1991).
- q Claims that ECT is only of short term efficacy, (Milstein: 1986 & Breggin: Toxic Psychiatry: 1991)
- q Claims that its effects are very similar to Anti-depressants, (Breggin: Toxic Psychiatry 1991)³

The Centre acknowledges that other treatments have adverse side effects. Many of the complaints with which we deal are about the often serious side effects of medications. However, for reasons stated above the focus of this Paper is ECT, considered by Consumers and acknowledged by legislation to be in a category of its own.

³ Consumers have expressed the opinion that if ECT is no more effective than anti depressants then they should have the choice between the treatment regimes.

Consumer Views

The following views come from the work the Centre has done with Consumers over 10 years. The Centre expresses these views not in an attempt to discredit ECT but to show the apprehension in the Consumer community, both from those who have had ECT and those who have not.

Consumers' views are highly divergent. However, opinions on ECT are always strong. Some Consumers report that ECT is the only thing that has saved them from a life of depression. However, there is also a high level of disquiet by both Consumers and Carers about ECT. We have contact with a great many more concerned Consumers and Carers than those who are approving or indifferent.

Where we quote individual Consumer views we do so because they are representative of the views brought to our attention.

The issues contributing to the considerable apprehension experienced by Consumers and Carers can be broken down into three aspects:

- q **Appeals Mechanism and Public Accountability**

- q **Side-effects, Informed Consent and Uses of ECT**

- q **Prohibition.**

Appeals Mechanism and Public Accountability

Many Consumers and Carers are concerned that there is no independent arbitrator on ECT. Many Consumers and Carers contact the Centre and suggest that when ECT is proposed under section 73(3) of the Mental Health Act (Vic) they feel powerless in trying to convince the authorised psychiatrist about the criteria which the Act states must be considered when a doctor administers ECT. They are complex criteria. Questions such as a person's capacity to consent are not straightforward. The authorised psychiatrist's position of relative power makes it difficult for Consumers to effectively advance their position. Many Consumers and Carers feel intimidated by the psychiatrist and would feel more at ease with an independent body.

As one Consumer stated:

'There is no point having guidelines or laws if there is no one to go to.'

A great many Consumers and Carers who contact the Centre share the view that there is little value in elaborate criteria for the use of ECT when there is no effective forum for challenging their applicability in a given case.

It is true that there are avenues of complaint such as the Health Services Commissioner and Office of the Chief Psychiatrist. The Health Services Commissioner has conciliation and investigation powers. The Chief Psychiatrist can make directions about provision or cessation of treatment, and has a range of broad quality assurance and monitoring powers. However, neither is required by statute to reach a determination in a matter, and neither has the procedural safeguards of a tribunal. Consumers express concern about the perceived powerlessness and perceived lack of independence of these bodies relative to a tribunal. Furthermore, the only way to ensure people will have the opportunity to have their wishes considered by an independent authority is to require approval by an external body. Many people will not be in a position to initiate such a process themselves when they are potential candidates for ECT.

The resounding message from Consumers is concern that their wishes can be so apparently easily overridden in relation to ECT, without recourse to an effective forum of challenge.

To address these concerns, the Centre recommends that the Mental Health Review Board hear appeals on ECT for involuntary Consumers, as occurs in a number of other Australian states.

Publicly Accessible Information

Linked to concerns about lack of due process is Consumer disquiet about publicly accessible information in the area of ECT. The Mental Health Act requires monthly returns documenting all uses of ECT to be lodged with the Office of the Chief Psychiatrist. However the returns are not currently collated and published in an accessible format. We are aware that publication of this information is planned by the Office of the Chief Psychiatrist. In the Centre's experience through work with Consumers the unavailability of such information only serves to heighten the already high level of anxiety and concern around the procedure. Due to the special status of ECT under the Mental Health Act, we encourage and applaud the Office of the Chief Psychiatrist in its initiative to make this information publicly accessible.

Side effects, Informed Consent and Use of ECT

Many Consumers and Carers are perturbed by the current use of ECT. A Consumer reported to the Centre that after six months he would wake up at night with flashbacks of the ECT. One Consumer stated that it was the clearest example of 'psychiatry is in the Stone Age' compared with other medical specialisations. Other Consumers question the practice of 'maintenance' ECT and wonder why pharmacotherapy could not be used if it is just as effective.

The Mental Health Legal Centre Inc. advice line receives calls from Consumers who are interested in civil remedies to redress their perceived

cognitive impairment caused by ECT. Loss of autobiographical memories is of great concern to Consumers.

Many consumers express concern that ECT is not used because the section 73(3) criteria are met, but for other reasons. They express the view that other treatments are not sufficiently explored before ECT is proposed, or that it is prescribed where there is not the requisite risk of significant deterioration without it. There is a perception amongst Consumers that ECT may be a 'quick fix' required when bed numbers are low in inpatient facilities and require quick turnover. Many Consumers are concerned that other, possibly more time or resource intensive treatments should be used rather than ECT, be they pharmacological, psychotherapy, psychoeducation or other. Almost all Consumers feel that ECT assisted the symptomology only and not what they perceive to be the real cause of their experience of depression. They expressed concern that ECT is just another example of psychiatry's undue focus on biological rather than psychosocial or other factors.

We receive calls from Consumers who are uneasy about the unclear nature of how the treatment works.

As well as independent review, the people we work with are clearly calling for better information in compliance with the informed consent requirements. There are two issues here.

- Firstly, that people report they are not provided with information about risks and benefits at all.

- α Secondly, that even if some information is available, it is not provided in a manner or format that is comprehensible to the person, given their mental state at the time.

Consumers report that they are not informed about the sorts of side effects documented in the memorandum of the College referred to above. The Department of Human Services has a pamphlet on ECT, however Consumers report that this pamphlet does not provide adequate information about risks.

Whilst there will always be a need for individually tailored oral information, basic information such as that provided by the College should be available in an accessible printed format.

We believe that best practice requires access for people to adequately trained independent people to facilitate informed consent. We acknowledge that Consumers have the right to anyone of their choice with them whenever they discuss their treatment with a doctor, or not have anyone with them if that is their preference. However, we believe that availability of people such as community visitors may be the most effective way of ensuring that information is provided and understood as required under the Act. The role of such people is not to intervene or influence decision-making, but to facilitate communication, ensure information is provided in such a way that it is understood, and ensure that people understand their rights. Though the situations are entirely different, this is the role played by Independent Third Parties required in police interviews with Consumers. They are an important acknowledgment of the disadvantage people with mental illness may experience in understanding important information about their rights in certain contexts.

PROHIBITION

There is a group of Carers and Consumers who believe that there is no place for ECT in modern psychiatry at all. Others are of the view that there should be no ECT, consensual or not, without approval by an independent statutory authority. There is a strong view by some Consumers that ECT should not be performed without the Consumer's consent under any circumstances. This position paper does not adopt these positions. However, we must acknowledge the strong views on this treatment.

Informed Consent

Does the Obtaining of Informed Consent in Practice Meet the Requirements of the Mental Health Act and Common Law?

Given the controversial nature of ECT in the eyes of many, the area of 'Informed Consent' becomes particularly important. Informed Consent is defined in the Mental Health Act 1986 (Vic) as set out in **section 3** above.

The Centre recognizes that common law does not override legislation however we believe that the advances in common law should inform the Mental Health Act.

Common law incorporates informed consent within the similar concept of a 'duty to warn' (Olbourne 1998). The duty is defined as an,

'Obligation, recognized by law, to avoid conduct fraught with unreasonable risk of danger to others. (Olbourne: 1998)

Duty to warn was first tested in Australia in the Supreme Court of South Australia (S v R (1983) 33 SASR 189.); Justice King stated that on the duty to disclose information,

“What is in question is the scope of the doctor’s care. He [sic] is required to act reasonably not only in his actual treatment of the patient but also in relation to the disclosure of information . . . the duty extends not only to the real risks of the treatment but also any risks of misfortune inherent in the treatment especially if it involves major surgery . . . (Olbourne 1998).’

Justice King also stated that the doctor is not liable for information that a client does not seek or want. However in the Case of Rogers V Whitaker (1992) 175 CLR 479) the High Court of Australia made a variation on this ruling and stated that a Consumer should have information that a reasonable person would want to know, whether they asked for information or not (Freckelton 1999). The judge found that a remote risk would not have to be disclosed. However, the more serious or risky the procedure, the higher the onus to warn.

The only exception to this rule is therapeutic privilege – a principle that states that information need not be provided when it would have an adverse effect or cause serious harm to clients with a mental (dis) order. (Freckelton: 1999).

Though the Informed Consent provisions of the Mental Health Act require disclosure of “discomforts and risks without exaggeration or concealment”, many Consumers claim not to have been made aware of the risks, and come to the Centre for this information.

A question also arises as to the role the psychiatrist has in disclosing information about side effects, which, though less common according to the College, are still referred to in its literature, and less tentatively documented in the more radical critiques.

The extent to which Informed Consent under Division 1AA is implemented in practice should be reviewed in light of the advances in common law and reports that information provision is not adequate. The Centre believes that community discussion needs to focus on:

(a) Guidelines around ECT on consent;

(b) What do doctors and allied health staff do when a Consumer is considered incompetent? and

(c) How should the information be given?

- **Staged consent**
- **Independent Person to facilitate informed consent**
- **Printed material that includes a Consumer being informed of their legal rights, as well as a statement on risks and benefits of ECT.**

Other Models/Jurisdictions

We have not included a comprehensive survey of all comparable jurisdictions. Rather, we have presented situations in Australian States that provide greater legal protection than Victoria.

There are jurisdictions that provide fewer legal safeguards than Victoria, including some Australian states. Also, there are those, such as some of the States of the U.S., where there is an even more legalistic model in the sense that Courts, not Tribunals, are the arbiters.

The purpose of this Position Paper is to present a realistic model for reform in Victoria, and other Australian states, we believe, do provide the most useful comparators.

**Model Mental Health Legislation Produced by
Australian Health Ministers Advisory Council
(AHMAC)⁴**

The model mental health legislation produced by AHMAC requires that ECT generally not be provided without informed consent.

Section 61 of the model legislation then provides it may be performed with the approval of a Tribunal if the person is incapable of giving informed consent, as follows:

61 The Tribunal may approve the performance of Electro-convulsive therapy upon a person who is an involuntary patient, a forensic patient, a patient under supervision or is subject to a community treatment order but it must not give it approval unless satisfied that:

- (a) the person is not capable of giving informed consent;
- (b) Two medical practitioners (at least one of whom is a psychiatrist) have formed the opinion after considering the person's clinical condition, history of treatment and any appropriate alternative treatments that Electro-convulsive therapy is reasonable and proper treatment to be administered to the person and that without that treatment the person is likely to suffer serious mental or physical deterioration.

⁴ The model legislation was developed by AHMAC's National Mental Health Working Group and released for public comment but not endorsed by AHMAC.

Section 62 provides for

Electro-convulsive therapy in life saving emergencies.

- 62 (1) The authorised psychiatrist may authorise the performance of Electro-convulsive therapy upon a person who is an involuntary patient, a person under supervision or a forensic patient without having obtained the approval of a tribunal if the authorised psychiatrist is of the opinion that Electroconvulsive therapy is necessary to save life of a person or to prevent the person from suffering irreparable harm.
- (2) The authorised psychiatrist must report Electroconvulsive therapy performed under sub-section (1) to the tribunal.

Other Australian Jurisdictions

Queensland

Neither the Mental Health Act 1974 Qld nor the regulations contain a specific disclosure prohibition or restriction on the use of ECT. The medical superintendent may consent on behalf of the patient.

However, legislation currently in the form of a draft Bill will introduce provisions similar to New South Wales, with Tribunal approval for involuntary ECT.

South Australia

Consensual

ECT must be authorised by a psychiatrist who examines the patient. The Consumer, if capable of giving consent, must give informed consent in writing.

Non Consensual

If the person is deemed incapable of consenting, either the person's medical agent must give consent, if there is one, or the Guardianship Board.

Consent of the medical agent or the Board need not be obtained if the ECT is urgently required for the protection of the patient or others and it is not practical to gain consent.

Western Australia

Consensual

- ü Patient must freely and voluntarily consent to ECT.
- ü Patient must be given sufficient time to consult and ask for advice and assistance.
- ü A clear explanation about treatment must be given including adverse effects.
- ü Patient must understand the matters involved in the decision.
- ü The extent of the information required is limited to that which a reasonable person in the patient's position would be likely to regard as significant.

Non Consensual

- ü Must be recommended by treating psychiatrist and another psychiatrist who is satisfied that the treatment has clinical merit.
- ü If the second psychiatrist does not agree then the matter goes before the Mental Health Review Board. The test the Board must apply is that the treatment is required 'to protect the health or safety of the person or another person.'

A.C.T.

Consensual

- ü The person must be given a clear explanation of the procedure.
- ü The person must be given an adequate description of the benefits and risks.
- ü The person must be advised of all reasonably available alternative treatments.
- ü An opportunity to ask questions and answers must be given to the level that the patient understands.
- ü A person must have read a notice and understood that notice (of their rights to a detailed independent opinion and legal advice and the right to withdraw consent).
- ü Informed Consent must be given in writing and witnessed by a person not offering the treatment.

Non Consensual

Where somebody cannot give consent then the matter must be referred to the ACT Mental Health Review Tribunal. Another psychiatrist who is not making an application must provide evidence for the procedure.

The Tribunal will only consent to the treatment if it will bring about substantial benefit to the patient

N.S.W

General

- ü Only a doctor experienced in ECT and anesthesia may administer ECT.
- ü Two doctors (one a psychiatrist) must, on the basis of the medical history, certify that the procedure and the treatment are reasonable and proper and desirable for the safety and welfare of the client.

Consensual

For people who are not involuntary patients ECT may be administered with the Consumer's consent, subject to:

- ü A fair explanation of the procedure and techniques;
- ü A full description of the discomforts and risks;
- ü Full disclosure of benefits and alternative treatments;
- ü Offer to answer any queries regarding the procedure;
- ü Notice of a right to withdraw consent and discontinue procedure;
- ü Full disclosure of any financial relationships between the person seeking informed consent and relevant hospital/clinic;
- ü Notice of right to obtain legal and medical advice before giving consent; and

- ü Answer any questions relating to the procedure that are raised so, as the patient can understand.

Non Consensual

ECT may only be administered to involuntary patients with the consent of the Mental Health Review Tribunal where the Tribunal has deemed it proper and necessary for the benefit and safety of the person. The Tribunal will determine:

- (a) Whether the person is capable of giving informed consent and if they have so consented; and
- (b) If person is not capable of consenting, or is but has refused, whether the treatment is reasonable and proper, and necessary or desirable for the safety or welfare of the person.

Victorian Legislation in comparison to the Model Legislation and Regimes in Other Jurisdictions

The Victorian legislation does not provide the same level of legal safeguard as the AHMAC model legislation and a number of other Australian regimes.

Unlike the Victorian situation, the model legislation and a number of State regimes require that an application be made before a tribunal in relation to proposed involuntary ECT. In Victoria, the “urgent ” ECT provision contains no express statement comparable to that in the AHMAC model that the ECT be limited to the saving of life and prevention of irreparable damage. In New South Wales, even in an emergency situation the Tribunal must consider ECT.

It is not only the existence of more rights oriented legislative provisions that suggest Victoria’s laws should be changed. The experience in one highly comparable jurisdiction, New South Wales, indicates that a Tribunal structure is desirable and workable in a practical sense.

New South Wales in Practice

How Does an Application Occur?

An application can occur in one of three ways;

- q Firstly, if the matter is not urgent then a hearing is set at the hospital.
- q Secondly, if the matter is 'urgent' and in business hours, a Board sits 4 days a week at the Boronia Parks office. A hearing is organized via video or telephone conference by adding to the list of the day hearings. The requisite paper work is faxed including doctors' reports. A decision is then made.
- q Thirdly if the matters are on day that a Tribunal is not sitting or after hours there is an out of hours contact. The documents are faxed to the three members deciding the matter. Members are allocated to speak to the doctor(s), Consumer and other relevant persons. The members then consult and there is a decision made.

The Tribunal - Perceived advantages:

According to the Registrar of the NSW Tribunal, the following are the advantages of their procedure:

- q A level of protection for hospitals and medical staff,

- q ECT remains much misunderstood. ECT has special status as a treatment and is reviewable which gives Consumers and Carers a perception of higher - guards and accountability.
- q The hearing is often an important opportunity to have questions answered.

The Tribunal - Perceived Disadvantages

According to the Registrar, there was a fear that this style of legal safeguard was costly, however the Tribunal does not believe that this cost is unjustifiably high.

The Tribunal believed initially that delay might be an issue however with an out of hours Tribunal, and having a central contact point for the Tribunal delays are kept to a minimum.

The Registrar expressed the view that there was no real disadvantage to their procedure for review of ECT.

Decisions

Year	Approved	Determination or opinion not Required	Not approved	Total
1996	197	25	10	232
1997	231	20	7	258
1998	279	34	2	315

An Overview

This overview of the NSW provisions shows that independent review of ECT is not only desirable but also achievable in practice.

The Tribunal had an efficient way of dealing with even urgent and out of hours ECT through an informal process.

Even though in a great majority of decisions the Consumer had ECT, the independent review led to greater confidence on the part of Consumers and society in natural justice and the important principle that justice is seen to be done. Also, we note that there is a high level of adjourned cases where treatment options may be fleshed out on a more informal basis, and perhaps with greater satisfaction to both parties.

One weakness in the N.S.W legislation in terms of Consumer safeguards is that the Tribunal authority is for a 'natural' course without limit. The Tribunal requires that a new consent be made only when the course is broken. The Centre strongly disagrees with this position and the Centre advocates the position currently in Victoria that single consent be limited to six treatments.

We acknowledge that a break in treatment may be detrimental to Consumers. Thus, the Centre suggests that, on the sixth treatment after the appropriate period, to determine the overall benefit of the course that an 'impromptu' Board may be scheduled either on a day that the Board is sitting at the relevant hospital, at an out patient setting or via the telephone conference so that treatment if approved can continue.

The Centre adopts with some caution, the Board making decisions not in the Consumer's presence in the case of emergencies. The Centre believes this should be kept to a minimum.

Appeal mechanisms are an important safeguard for Consumers and the Area Mental Health Services. In New South Wales all Consumers can appeal the decisions of the Tribunal in relation to ECT to the New South Wales Supreme Court.

Justice delayed or inappropriately formal in its procedure is not justice. Therefore in this case the Centre does not recommend a Supreme Court appeal process for Victoria. The Centre believes there should be right of appeal to VCAT. VCAT would have to be able to hear urgent matters expediently. However, urgent hearings already take place in the Guardianship List of VCAT.

Recommendations

Non Consensual

It is recommended that

- 1) Mental Health Review Board approval must be given for ECT without informed consent.**
- 2) ECT should only be given to Consumers without consent if, without that treatment, the person is likely to suffer serious mental or physical deterioration, in line with the Model AHMAC Legislation. The Board must also apply the existing criteria of sub-sections 73(3)(a) (i), (ii) and (iii).**
- 3) Informed consent should be a three-step process. First, the Doctor must attempt to gain consent. If this is unsuccessful it should go before the Board. If the Board determines that the person is incapable of consenting and approves ECT, the person's capacity to consent should be reviewed at regular intervals, including during the course of treatment that has been approved, as capacity to consent may fluctuate.**
- 4) The existing section on urgent ECT be repealed so that it is only in the situation outlined at 2) above, and with Board approval, that ECT can be given without consent.**

- 5) The requirements for obtaining informed consent in section 53B be retained and considered by the Board when making decisions in relation to ECT, and the requirement remain that each consent, and accordingly each Board approval, be for 6 treatments only.

Consensual

- 6) As well as information about the right to medical and legal advice and to withdraw consent as required by section 53B(2)(a), risks and benefits of ECT should be explained and given in writing to the standard of common law in appropriate language for Consumers. A standardised statement of rights and information should be developed in consultation with consumers.
- 7) Consideration should be given to the right to have an appropriately trained independent person present to ensure that information is understood and to facilitate informed consent.

Public Accountability and Transparency

- 8) The use of ECT in private and public hospitals is publicly reported.

Concluding Remarks

Thirteen years ago Victoria introduced an imaginative and rights focused piece of legislation. -The Mental Health Act 1986. It is with some sorrow we note that many take this legislation for granted or forget how hard it was fought for. The Act introduced a number of safeguards that Consumers could only have dreamed of a few years earlier. At the time many advanced the argument that a Mental Health Review Board would place further strain on patients (as Consumers were referred to then) and ‘ **that Doctors got it right most of the time.**’ And to some extent these critics are partly right.

However, for Consumers and Carers, the rights under the Act have changed mental health services fundamentally.

Within Australia, the states have tackled the difficult issues in a variety of ways leading to discrepancies between states as to the level of rights protection provided. However, all states have worked to some degree to assist Consumers to empower themselves from a position of extreme social disadvantage. In the end the most important changes are those that lead services to listen to the voices of Consumers.

Appendices

Appendix One: Informed Consent: *Mental Health Act 1986 Vic.*

Appendix Two: ECT & Informed Consent: *Mental Health Act 1986 Vic.*

Appendix One

PART 5—CARE AND TREATMENT OF PEOPLE WITH A MENTAL DISORDER

Division 1AA—Informed consent

53B. Requirements for obtaining informed consent

- (1) For the purposes of this Part (other than section 83(2)), a person is to be taken to have given informed consent to the performance on him or her of treatment only if the person gives written consent to that treatment 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 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; and
 - (f) sub-sections (2) and (3) have been complied with.
- (2) The person on whom the treatment is to be performed must be given the appropriate prescribed printed statement—

- (a) advising the person as to his or her legal rights and other entitlements including—
 - (i) the right to obtain legal and medical advice (including a second psychiatric opinion) and
 - (ii) the right to refuse or withdraw his or her consent and to discontinue all or any part of the treatment at any time; and
 - (b) containing any other information relating to the treatment that the Department considers relevant.
- (3) In addition to the statement, the person must be given an oral explanation of the information contained in the statement and, if he or she 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 he or she is most likely to understand.
- (4) The statement may be printed in different languages so that, whenever possible, a person can be given a copy of the statement in a language with which he or she is familiar.
- (5) It is the duty of the authorised psychiatrist to ensure that this section is complied with in the approved mental health service.
lesion in the person's brain for the purpose of

Appendix Two

Division 2—Electroconvulsive Therapy

72. Electroconvulsive therapy

- (2) For the purposes of this Division, a reference to “**electroconvulsive therapy**” includes a reference to a course of electroconvulsive therapy consisting of not more than 6 treatments given over a period with not more than 7 days elapsing between any 2 treatments.
- (3) A person who gives informed consent in accordance with Division 1AA to having electroconvulsive therapy performed on him or her is to be taken to have consented to the administration of an anaesthetic to enable the electroconvulsive therapy to be performed.

73. Informed consent required

- (1) Unless sub-section (3) or (4) applies a person who—
 - (a) causes to be performed; or
 - (b) permits the performance of—

electroconvulsive therapy on any person who has not given informed consent in accordance with Division

1AA to the performance on him or her of that electroconvulsive therapy is guilty of an offence against this Act

- (2) Unless sub-section (3) or (4) applies a registered medical practitioner who performs electroconvulsive therapy on any person who has not given informed consent in accordance with Division 1AA to the performance on him or her of that electroconvulsive therapy is guilty of professional misconduct unless the registered medical practitioner satisfies the Medical Practitioners Board of Victoria that there were valid reasons for not obtaining that consent.
- (3) If a person who is a patient is incapable of giving informed consent the electroconvulsive therapy may be performed if—

- (a) the authorized psychiatrist has authorized the electroconvulsive therapy proposed to be performed after being satisfied that—
 - (i) the electroconvulsive therapy has clinical merit and is appropriate; and
 - (ii) having regard to any benefits, discomforts or risks the electroconvulsive therapy should be performed; and
 - (iii) any beneficial alternative treatments have been considered; and
 - (iv) unless the electroconvulsive therapy is performed, the patient is likely to suffer a significant deterioration in his or her physical or mental condition; and
 - (b) all reasonable efforts have been made to notify the patient's guardian or primary carer of the proposed performance of the electroconvulsive therapy.
- (4) Informed consent is not necessary if the nature of the mental disorder that a person has is such that the performance of the electroconvulsive therapy is urgently needed.

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