Electroconvulsive therapy, law and human rights

PBU & NJE v Mental Health Tribunal [2018] VSC 564, Bell J

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In a number of jurisdictions, a senior clinician or a tribunal is enabled to order ECT when a person does not have the capacity to give informed consent to the treatment and in the circumstances there is no less restrictive way for the patient to be treated. In Victoria, Australia, there have been a number of challenges to orders permitting ECT orders made by the Mental Health Tribunal. In a landmark decision by Bell J of the Victorian Supreme Court, *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, on appeal from the Victorian Civil and Administrative Tribunal ('VCAT'), in turn on appeal from the Mental Health Tribunal, the human rights ramifications of the evaluation of whether a person has capacity to consent were scrutinised at length. Deficiencies in the reasoning by VCAT, including resort to impermissible extra-legislative considerations, such as insight, best interests and the giving of careful consideration, were highlighted by Bell J. This commentary reviews the reasoning of Bell J and discusses the ongoing consequences of his decision for both clinician reports and tribunal reasoning so that decision-making about ECT complies with legislative requirements, is not discriminatory against those with mental illnesses and is more sophisticated in its analysis of the adverse impact that mental illness symptomatology has at the relevant time on capacity to give informed consent to ECT.

Key words: best interests; electroconvulsive therapy; human rights; insight; paternalism; rationality.

Introduction

Electroconvulsive therapy (ECT) as a treatment for mental illness has a troubled and controversial history.¹ It has been the subject of distressing exposés² and multiple expostulations of concern about its potential for misuse and its side-effects. Because it employs electric currents to reduce the symptomatology of severe depression and psychotic symptoms, and because it continues to be portrayed in emotive ways which in fact have been superseded by the passage of decades, (such as in

the 1975 film *One Flew Over the Cuckoo's Nest*), ECT continues to generate fear. In turn, the bad media coverage it has attracted³ and consequent resistance from patients have been hypothesised as reducing its deployment below levels that are therapeutically advisable.⁴

There have been claims that in some countries ECT has been used as a punishment, and it was portrayed in this way in the film *The Changeling* (2008).

This is unfortunate because multiple studies have found a gap between empirically

established findings of efficacy and safety and public perceptions of ECT, no doubt influenced by such depictions.⁵ This is in spite of the fact that it has been employed in many countries with significant reports of therapeutic success.⁶ As a back-up (or even alternative) to pharmacotherapy, the clinical evidence is that ECT can achieve therapeutic breakthroughs for persons with severe and otherwise unresponsive psychiatric disorders.⁷ The Royal Australian and New Zealand College of Psychiatry, for instance, says of ECT that only a small number of patients experience short-term memory loss and that it is rare for such memory loss to be more extensive – it is used because:

- It works. ECT can improve or clear depression in nearly 70% of patients, and has been proven to help with other conditions like mania and schizophrenia.
- It works quickly. ECT can be a life-saving treatment for people who are at risk of suicide, or who are not eating or drinking because of their depression.
- It's safe and there are few side effects.
- It provides another treatment option if medication is not working or if a patient has had reactions to their medication.⁸

Over 7500 Australians and 300 New Zealanders receive ECT treatment each year.⁹

Because of its resonances, in many jurisdictions, ECT as a treatment is subject to particular forms of regulation. In New Zealand this commenced in 1992 with legislative provisions devoted to it in the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ). Similarly, in Australia it is the subject of diverse regulation under state and territory mental health legislation, a number of states requiring the provision of informed consent by voluntary patients capable of giving it or an order by independent tribunals for patients not able to provide informed consent.

In Australia three jurisdictions have enacted human rights legislation – in the ACT, the *Human Rights Act 2004* (ACT); in

Victoria, the *Charter of Human Rights and Responsibilities Act 2008* (Vic); and in Queensland, the *Human Rights Act 2019* (Qld), expected to commence on 1 January 2020. These enactments have major ramifications for the interpretation of mental health legislation and, in particular, for how ECT provisions should be construed.

In two Australian cases, decisions by administrative tribunals were challenged during 2018/2019. In the Northern Territory, the Mental Health Review Tribunal authorised a decision that a woman undergo 12 sessions of ECT against her wishes. She was an involuntary mental health patient on a six-week admission at Royal Darwin Hospital. The argument to be pursued in the Supreme Court of the Northern Territory was that the woman had shown herself capable of giving informed consent and that the Tribunal had failed to consider whether other treatments were available. Ultimately, the case did not proceed, as, while the patient was awaiting the outcome of her appeal, she completed her involuntary admission and was discharged from the hospital. This meant that a judgment from the Supreme Court was not handed down.¹⁰

In Australia's most significant human rights decision on mental health law, *PBU & NJE v Mental Health Tribunal*,¹¹ Bell J of the Victorian Supreme Court delivered an extensive judgment (283 paragraphs) in 2018 on two appeals from decisions of the Victorian Civil and Administrative Tribunal ('VCAT'), which had affirmed decisions by Victoria's Mental Health Tribunal ('the Tribunal') which had authorised the administration of ECT to two unrelated patients. Justice Bell's decision is important for clinicians, as well as for administrative bodies exercising decision-making powers in relation to ECT, but also for the evolution of mental health law in Australia, particularly in light of the likelihood that human rights considerations will exercise increasing influence over mental health law.

This case commentary summarises the facts of the *PBU/NJE* case and analyses the

judgment, reflecting on its human rights, clinical practice and tribunal oversight repercussions.

The Victorian legislative requirements for ECT

Australia's mental health legislation varies significantly amongst its states and territories.¹² In jurisdictions such as New South Wales,¹³ Queensland,¹⁴ Tasmania,¹⁵ Victoria¹⁶ and Western Australia,¹⁷ the issue of 'informed consent' is explicitly stated to be a precondition to the provision of certain forms of treatment, such as ECT and neurosurgery for mental illness, non-ablative neurosurgical procedures and psychosurgery.

For ECT to be administered to an adult patient in Victoria, it is necessary under the *Mental Health Act 2014* (Vic) ('the Act') for the patient to have given 'informed consent' in writing, or the Tribunal must have granted an application for ECT.¹⁸

An authorised psychiatrist can make an application to the Tribunal to perform a course of ECT on an adult patient if the patient does not have the capacity to give informed consent to the performance of a course of ECT and the authorised psychiatrist is satisfied in the circumstances that there is no less restrictive way for the patient to be treated.¹⁹ In determining whether there is no less restrictive way for the patient to be treated, the authorised psychiatrist is obliged, to the extent it is reasonable in the circumstances, to have regard to all of the following:

- (a) The views and preferences of the patient in relation to electroconvulsive treatment and any beneficial alternative treatments that are reasonably available and the reasons for those views or preferences, including any recovery outcomes the patient would like to achieve;
- (b) The views and preferences of the patient expressed in his or her advance statement;
- (c) The views of the patient's nominated person;

- (d) The views of a guardian of the patient;
- (e) The views of a carer of the patient, if the authorised psychiatrist is satisfied that the decision to perform a course of electroconvulsive treatment will directly affect the carer and the care relationship; and
- (f) The likely consequences for the patient if the electroconvulsive treatment is not performed; and
- (g) Any second psychiatric opinion that has been obtained by the patient and given to the psychiatrist.²⁰

Section 68 of the Act states that a person has the capacity to give informed consent (under the Act) if the person:

- (a) understands the information he or she is given that is relevant to the decision; and
- (b) is able to remember the information that is relevant to the decision; and
- (c) is able to use or weigh information that is relevant to the decision; and
- (d) is able to communicate the decision he or she makes by speech, gestures or any other means.²¹

The following principles are specified by s 68(2) of the Act to be intended to provide guidance to any person who is required to determine whether or not a person has the capacity to give informed consent under the Act:

- (a) a person's capacity to give informed consent is specific to the decision that the person is to make;
- (b) a person's capacity to give informed consent may change over time;
- (c) it should not be assumed that a person does not have the capacity to give informed consent based only on his or her age, appearance, condition or an aspect of his or her behaviour;
- (d) a determination that a person does not have capacity to give informed consent should not be made only because the person makes a decision that could be considered to be unwise;

- (e) when assessing a person's capacity to give informed consent, reasonable steps should be taken to conduct the assessment at a time at, and in an environment in, which the person's capacity to give informed consent can be assessed most accurately.

In addition, the Act provides that a person gives informed consent if he or she:

- (a) has the capacity to give informed consent to the treatment or medical treatment proposed; and
- (b) has been given adequate information to enable the person to make an informed decision; and
- (c) has been given a reasonable opportunity to make the decision; and
- (d) has given consent freely without undue pressure or coercion by any other person; and
- (e) has not withdrawn consent or indicated any intention to withdraw consent.²²

It is provided that for these purposes a person has been given adequate information to make an informed decision if the person has been given:

- (a) an explanation of the proposed treatment or medical treatment including—
- (b) the purpose of the treatment or medical treatment; and
- (c) (ii) the type, method and likely duration of the treatment or medical treatment; and
- (d) an explanation of the advantages and disadvantages of the treatment or medical treatment, including information about the associated discomfort, risks and common or expected side effects of the treatment or medical treatment; and
- (e) an explanation of any beneficial alternative treatments that are reasonably available, including any information about the advantages and disadvantages of these alternatives; and
- (f) answers to any relevant questions that the person has asked; and

- (g) any other relevant information that is likely to influence the decision of the person; and
- (h) in the case of proposed treatment, a statement of rights relevant to his or her situation.²³

For the purposes of determining whether a person has been given a reasonable opportunity to make a decision, the requirement is met if, in the circumstances, the person has been given a reasonable:

- (a) period of time in which to consider the matters involved in the decision; and
- (b) opportunity to discuss those matters with the registered medical practitioner or other health practitioner who is proposing the treatment or medical treatment; and
- (c) amount of support to make the decision; and
- (d) opportunity to obtain any other advice or assistance in relation to the decision.²⁴

Section 70(1) of the Act states that "Before treatment or medical treatment is administered to a person in accordance with the Act, the informed consent of the person must be sought. In addition, section 70(2) stipulates that the person who seeks the informed consent of a person in relation to treatment or medical treatment "must presume that the other person has the capacity to give informed consent." The presumption is rebuttable but the starting position, importantly, is that of capacity.

The *PBU* case

PBU had been involuntarily detained in a psychiatric unit of a hospital since December 2016, having been first diagnosed with schizophrenia in 2011. He had been admitted to hospital on a number of occasions and was subject to a temporary treatment order as an inpatient under s 45(3) of the *Mental Health Act 2014* (Vic) ('the Act'). He had little family

support or social engagement and not much by way of insight into his psychiatric disorder.

In February 2017, the Mental Health Tribunal ('MHT') made an order made an order for a course of ECT to be administered to PBU on six occasions. They were given in early to late February. The outcome was that PBU's condition improved dramatically. He commenced to demonstrate a level of insight into his current psychotic episode although not in relation to his overall condition. After the fifth administration of ECT he was agreeable to further ECT and was reviewed by an authorised psychiatrist who concluded that he had capacity to make the decision. However, he changed his mind and ECT was stopped.

This led the authorised psychiatrist to make a further application for ECT to the MHT in March 2017. The hospital contended that PBU's condition had declined. However, the MHT decided that PBU did not at that stage require urgent ECT and that the treatment team should offer more information to him and explore other treatment options.

On 19 April 2017, on a further application by hospital staff, the MHT ordered that PBU have a further course of up to 12 ECTs between April and May 2017. This order was stayed by VCAT when PBU applied for review of the MHT's decision. VCAT²⁵ affirmed the decision of the Mental Health Tribunal, concluding that ECT was the only currently available appropriate treatment for PBU, that his mental state was deteriorating, that he had refused pharmacological treatment (Clozapine) and that only ECT would allow him to become well enough to engage in his treatment and to improve sufficiently to leave hospital.

PBU was self-represented before VCAT. However, he wrote a letter and attended the hearing. He stated that he did not agree that he had schizophrenia but agreed that he had mental health problems; he was of the view that he was suffering from depression, anxiety and post-traumatic stress disorder. He was willing to receive psychiatric and psychological

treatment for these conditions but he did not want ECT or anti-psychotic medication or treatment, which he did not believe were necessary for his condition. Significantly, in 2013, 2014, 2015 and 2016 PBU had relapsed and required hospitalisation after ceasing taking his prescribed medication. He wished to be discharged from hospital to a prevention and recovery facility and then return home. VCAT found that PBU spoke 'very clearly and capably about his views and experiences'.²⁶

VCAT found that PBU had been given information about ECT and that he understood it in the way described in s 68 of the Act: he was aware that ECT is used to treat patients with depression and psychosis, how it works, and the fact that it can have negative effects and disadvantages. That understanding came in part from his earlier experience with ECT.

However, before VCAT, Dr B contended that PBU did not have capacity to give informed consent to ECT in circumstances where he did not accept the diagnosis of schizophrenia. Dr B said that, while PBU understood the nature and effects of ECT in relation to others, he could not assess it in relation to himself because he did not accept the diagnosis or the possible clinical benefits of the treatment for his condition.

Ultimately VCAT was satisfied that:

PBU had an understanding about ECT treatment as required by section 68 and had been given adequate information about that treatment as required in section 69. However, it found that, as at the hearing date, he did not have capacity to give informed consent to whether ECT should be performed in circumstances where he did not accept the diagnosis for which the treatment was intended to be given: PBU has consistently disputed the diagnosis and the suggestion that ECT might be beneficial for him. I note that, even when PBU seemed to consider the February 2017 treatments might have been positive for him, he related that only to depression – a condition he has not been diagnosed as having.²⁷

VCAT accepted that PBU's right to freedom from medical treatment without consent and his rights to freedom of movement and privacy were engaged by the application for ECT. However, citing the judgment of Bell J in *Kracke v Mental Health Review Board*,²⁸ it concluded that the limits imposed by the ECT order were reasonable and justified under s 7(2) of the *Charter of Rights and Responsibilities Act 2006* (Vic) ('the Charter'). It rejected the proposition that it should apply the MHT's decision in *Re NLK*²⁹ and delay the decision to permit further discussions to take place with PBU's clinical team.

VCAT found that PBU understood information he was given about ECT but did not specifically apply paras (b)–(d) in s 68(1), instead accepting the contention of the clinical director that PBU did not have capacity because he did not accept the diagnosis of schizophrenia in relation to him: 'PBU has consistently disputed the diagnosis and the suggestion that ECT might be beneficial for him'. Specifically, VCAT did not discuss in its reasons for discussion how PBU's refusal to accept the diagnosis for schizophrenia related to his ability to remember, use and weigh information and communicate his decision. VCAT went on to determine that there were no less restrictive treatment options available:

The evidence before me supports a finding that PBU's mental health will not improve if he continues as is. ... PBU is demonstrably very ill and unable to be discharged from hospital in his current condition. Continuing hallucinatory or like experiences are consistent with the evidence that PBU is very unwell despite his current treatment regime. On the evidence before me it seems to me that continuing in the same way amounts to an indefinite stay in hospital with limited leave options and no prospect for progression in health or life for PBU ... I accept the professional opinions of Dr A and Dr B that PBU's mental state is slowly deteriorating. No medical evidence to the contrary has been produced. In my view, PBU has already had the opportunity to take the course of waiting

and seeing ... On the evidence before me, I consider that continuing in that vein would amount to a failure to provide the treatment the MH Act requires. It seems to me that maintaining the status quo would amount to abandoning PBU to an indefinite admission and the risk of him harming himself or others and/or experiencing very significant distress of the kind that led to his admission³⁰.

The NJE case

NJE too suffered from treatment-resistant schizophrenia. Since 2004 she had received voluntary and involuntary treatment both in the community and in hospital. In 2016 she had been particularly unwell and had several extended stays in hospital. In January 2017 she was placed on a community treatment order, but it was revoked and she was made the subject of an inpatient treatment order. She was transferred to a secure extended care inpatient unit.

Three applications for ECT were made in relation to NJE. The first was in early March 2017. It was refused by the MHT because of uncertainties about her detention in hospital. The second was in late March; it was refused because the MHT was not satisfied that NJE lacked capacity to give informed consent or that no less restrictive options for treatment were available. The third was in April 2017. It was granted by the MHT, which ordered a course of 12 ECTs. She applied to VCAT for a review and obtained a stay over the MHT's order.

By the time the application for review came before VCAT in June 2017, NJE's oral medications had been changed and there had been a slight improvement in her condition. She was compliant with her oral and depot medication regime. However, the medical evidence was that NJE still needed ECT and lacked the capacity to give or refuse informed consent, especially because of her grandiose delusions and her behaviour. VCAT found

that NJE met the criteria in paras (a), (b) and (d) of s 68(1) of the Act Bell J observed that:

It is reasonable to infer that VCAT accepted that, in doing so, NJE understood that ECT was a procedure that would result in her having seizures and that she was concerned that it may cause her to have memory problems, as her legal representative submitted. It is reasonable to infer that, in doing so, VCAT also accepted the submission made for NJE that her preferred alternative to ECT was remaining in hospital for an extended period and the trialling of alternative medications, possibly Clozapine.³¹

VCAT accepted medical evidence that NJE's capacity to give informed consent would not be enhanced by the provision of more or differently formatted information, which, in fact, aggravated NJE. VCAT also found that NJE could not use and weigh information relevant to the decision:

To *use and weigh* requires a person to carefully consider the advantages and disadvantages of a situation or proposal before making a decision. NJE could not apply herself in that way. Her decision to refuse ECT was made without prior consideration of the advantages or disadvantages. NJE could not *use and weigh* the information because she could not conceive that it applied to her situation because it was her belief that she did not have a mental illness. ... It was not that NJE did not understand but rather that she could not be persuaded that the information was relevant to her.³²

Notably the Tribunal employed the expression "use and weigh", rather than "use or weigh", as found in section 68(c) of the Act. The evidence showed that NJE did not need immediate treatment to prevent a serious deterioration of her health or harm to herself or others. VCAT found that ECT was the only treatment that had a chance to address both the positive and negative symptoms of NJE's schizophrenia. It stated that it took into account her wishes and fears that ECT would

interfere with her psychic powers which were important to her, but treated her views about such powers as positive symptoms of her illness (hallucinations and delusions that she was able to treat and cure others). However, it noted that the requirement was for it to take into account 'beneficial alternative treatments', namely treatment that remedied or alleviated symptomatology or which reduced the effects of the person's mental illness. VCAT accepted the medical evidence that multiple anti-psychotics had been unsuccessful in treating NJE and that Clozapine had not comprehensively alleviated her symptoms.³³ It did not accept the submission made on behalf of NJE that the least restrictive treatment option was to act on her improved mental state and allow her current medication regime to continue. It determined that NJE was still experiencing both positive and negative symptoms by reason of her mental illness and accepted the clinical evidence that in applying for NJE to undergo a course of ECT, 'the treating team hoped it would bring about the best possible therapeutic outcomes and to promote recovery and full participation in community life'.³⁴ It authorised a course of 12 ECT treatments within nine weeks.

The judgment of Bell J

Justice Bell permitted the Secretary of the Department of Health and Human Services to participate in the case as an *amicus curiae*, but not as an intervener, with the Mental Health Tribunal not playing an active role in the appeal. The appeals of both PBU and NJE resulted in notices being served on the Victorian Attorney-General and the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) as a result of the appeal grounds raising issues under the *Charter of Human Rights and Responsibilities Act 2008* (Vic).

Justice Bell considered that the words 'use or weigh' required meaning to be given to each of the words, with the verb 'use' meaning

‘to employ for some purpose; to put into service, turn to account’ and ‘to avail oneself of; apply to one’s own purposes’ and the verb ‘weigh’ meaning ‘balance in the mind’. He concluded that the expression ‘use or weigh’:

requires the person to be capable of using or weighing information relevant to the decision depending upon the circumstances, particularly the nature, purpose and effect of the treatment decision and the nature and content of the information. Depending upon those circumstances, it may be necessary for the person to be capable of doing one or the other or both.³⁵

He noted that in the case of *NJE*, VCAT approached the application of the test in s 68(1)(e) of the Act on the basis that *NJE* needed to be able to use and weigh the information. He found that in the circumstances *NJE* needed to be able to do so – the relevant information could not be used without being weighed, so in this regard VCAT made no error.

Justice Bell held that ‘it would be discriminatory and a grave violation of human rights to regard a person having mental illness as lacking capacity to give informed consent merely because the person has that illness and the legislation does not operate upon this basis’.³⁶ He observed that when it comes to deciding questions such as assessment of capacity and provision of compulsory treatment to persons with mental disability, ‘a one-dimensional focus ignores the fact that human rights are not just universal but “indivisible, interdependent and interrelated”’.³⁷ He commented that the *Convention on the Rights of Persons with Disabilities* (CRPD) is relevant to understanding the meaning of human rights under the Charter – ‘That might especially be so in relation to the emphasis in the CRPD on providing persons with disability access to the support they need to exercise their legal capacity and on respecting the rights, will and preferences of persons with disability when

proportionate measures relating to the exercise of that capacity are necessary, subject to review and safeguards, as a last resort’.³⁸

Justice Bell described the compulsory treatment regime under the Mental Health Act 2014 (Vic) as ‘a paradigm shift from best-interests paternalism to the least-restrictive kind of treatment, which draws upon elementary human rights concepts. Where reasonable, the views and preferences of the patient, supported if necessary, must be considered. The treatment decision is not to be based upon purely medical grounds but, where appropriate, is to encompass holistic consideration of patients in their entire personal and social setting. The regime gives effect to the support and participation objective (s 10(d)) and principle (s 11(1)(d)), which reflect the right to self-determination, to be free of non-consensual medical treatment and to personal inviolability.’.³⁹ This approach is consistent with the United Kingdom Supreme Court decision in *Montgomery v Lanarkshire Health Board*⁴⁰ which explicitly recognised that a wide variety of considerations personal to the patient may enter into the decision-making matrix.

Justice Bell noted that in the mental health context, ‘recovery’ is a term of art, reflecting a contemporary understanding of ‘health’ that is broad – ‘One that requires the social and personal circumstances of the person to be considered and one that is not focused exclusively on preventing and curing illness or disease as such. It emphasises the significance of respecting and promoting patients’ self-determination over time and ensuring that patients avoid dependency and institutionalisation’.⁴¹ He noted⁴² that the Minister for Health in the second reading speech relating to the *Mental Health Bill 2014* (Vic) stated that:

Recovery is often described as a journey rather than an outcome. The term ‘recovery’ in the mental health context does not necessarily mean that the person no longer has mental illness or is no longer experiencing any symptoms of mental illness. Instead, recovery in mental

health encompasses the often fluctuating nature of mental illness where some people will not have a recurrence of mental illness, others will have some further episodes and some will experience repeated episodes of illness over time.

Recovery is about maximising individual choice, autonomy, opportunity and well-being during a person's life and accordingly is a self-defined process that is highly individual.⁴³

He emphasised that the concept of health under the Victorian legislation is broad and recognises what he termed:

the two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and the person's health on the other. Mental health treatment decision-making is not a simple best-interests trade-off between the person's autonomy and health because health is a broad concept that relates to the whole person of which the person's autonomy, while not absolute, is a constitutive element.⁴⁴

Justice Bell emphatically rejected the argument that an assessment under s 68(1) that a person does not have the capacity to give informed consent does not engage human rights:

[It] is both the foundation of the system for compulsorily imposing ECT upon patients and an interference with the person's human rights as such. It has the immediate consequence of compelling the person to be assessed for ECT under s 96(1)(a)(ii) when the person would otherwise be free of that assessment. More importantly, it takes away the person's fundamental right to refuse that treatment, which in and of itself constitutes an immediate injury to their individual dignity. Because human rights protect a person's fundamental interest in self-determination, freedom from non-consensual medical treatment and personal inviolability, laws and decisions that limit the exercise of legal capacity engage the application of the rights that protect those interests.⁴⁵

He concluded that the relevant rights involved in the context of the provision of ECT are:

- the right to equality before the law;
- the right not to be treated in a cruel, inhuman or degrading way;
- the right not to be subjected to any treatment, including medical treatment, without full, free and informed consent;
- the right not to have their privacy unlawfully or arbitrarily interfered with;
- the right to liberty and security of the person; and
- when deprived of liberty, the right to be treated with humanity and respect for the inherent dignity of the human person.⁴⁶

He affirmed the significance of the freedom from non-consensual treatment, reiterating statements of principle he had articulated in *Kracke v Mental Health Review Board*⁴⁷ in relation to the importance of personal autonomy and privacy in the form of self-determination and personal inviolability. He confirmed that VCAT and the Mental Health Tribunal are authorities under s 38(1) of the Charter and thereby obliged to interpret the Act in ways that are compatible with human rights, so far as possible, consistent with their purpose.⁴⁸

In this regard, he emphasised the principle of self-determination which he commented 'is at risk when decisions about capacity are being made, including in relation to people with mental disability. While a person may need access to medical treatment, a person having capacity can decide to refuse the treatment even if it is medically necessary. ... If medical treatment is compulsorily administered to the person because the person's capacity for self-determination is incorrectly not recognised or denied, this "severely infringe[s] upon [the] person's right to self-determination", because "[t]he right to refuse unwanted medical treatment is fundamental to a person's dignity or autonomy". For the individual, capacity decisions therefore involve very high stakes'.⁴⁹

Allied with the right to self-determination is the principle of personal inviolability which, amongst other things, precludes the provision any form of medical treatment when a patient has not consented, unless another mechanism exists enabling its provision. Justice Bell emphasised the position at common law and under s 70(2) of the Act that a person is to be presumed to have capacity to make decisions. He noted too that capacity is ‘issue-specific’ or, put another way, depends upon the decision to be made, as a person may have capacity for some decisions but not others. Moreover, capacity can fluctuate. This led his Honour to observe that contemporary disability law has ‘emphasised the fundamental importance of relationships, context and support for the effective exercise of legal capacity by persons with mental disability in relation to medical treatment and other matters’.⁵⁰ Amongst other things, it is recognised by the principle expressed in s 68(2)(c) of the Act:

[W]hen assessing a person’s capacity to give informed consent, reasonable steps should be taken to conduct the assessment at a time at, and in an environment in which the person’s capacity to give informed consent can be assessed most accurately.

In light of the fact that capacity is issue-specific, fluctuating and context-dependent, the question of whether, and what kind of, support has been provided to the patient was held by Bell J to be relevant to determining under s 68(1) whether the s 70(2) presumption of capacity has been rebutted. He applied the analysis of Baroness Hale (Lord Hope, Lord Rodger, Lord Brown and Lord Mance agreeing) in *R v Cooper*⁵¹ which identified three approaches to assessment of capacity:

- ‘the status approach’, excluding people with a certain disability from capacity;
- ‘the outcome approach’, focusing on the final content of a decision; and
- ‘the functional approach’, which asks whether at the time a decision is made

the person could understand its nature and effects.

Justice Bell observed that the ‘functional approach’ might be better termed ‘the capabilities approach’. He noted that what is required under s 68(1)(a) is whether the person ‘understands the information he or she is given that is relevant to the decision’: ‘The ordinary and natural meaning of the word “understand” is to “perceive the meaning of”, “grasp the idea of” or “comprehend”, with the consequence that the level of understanding required is “only a general kind of understanding that relates to the nature, purpose and effect of the treatment”’.⁵² Thus, he concluded that s 68(1) specifies a functional test in terms of the person’s understanding and ability to remember, use or weigh and communicate the relevant information: ‘the question is whether the person has the relevant understanding and abilities, not whether the person’s cognitive functioning is impaired in these respects’.⁵³ He observed that the decision to consent to or refuse medical treatment ‘may be so subjectively anchored in the individual values, relationships and life’s experience of the person as to make it difficult for another even to comprehend the decision; or even if properly comprehended, it may be so subjectively anchored in those respects as simply to defy objective characterisation at all. This is so whether the person has capacity to consent or refuse or not’.⁵⁴ He emphasised too that more should not be expected of those with a mental disability, explicitly or implicitly, than of ordinary patients – there should not be discrimination.⁵⁵ He held the capacity test under the Act to be low, and the decision to be not whether the person can function to the standard of being able to make a balanced, sensible, rational or well-considered decision.⁵⁶

On the issue of personal identity, he reiterated that choices about treatment are informed by the values, life experiences and relationships of the individual:

Some people make this choice as if it were the next note to sound in the song of their

life. Choosing to consent to or refuse medical treatment is therefore a fundamental expression of the individual identity of the person and has an ontological dimension. When respect is afforded to the choice of the person to consent to or refuse medical treatment, the person is recognised for who they are. Respect of the choice is usually experienced as affirmation of the person's individual identity in the context of their own body and private life.⁵⁷

Justice Bell reviewed the history of the consultative process leading to the Act, including the removal from the draft of the requirement for a person 'to appreciate' information relevant to a decision. He noted too that there is international authority, in particular from Canada, that a person lacking belief or insight in relation to the need for treatment can have capacity to refuse treatment. In particular, in *Starson v Swayze*⁵⁸ the patient was a brilliant untrained physicist with bipolar disorder who was a compulsory inpatient. Starson acknowledged he had psychiatric problems but did not agree he was suffering from an illness or accept the need for medication. He refused medication because, in the past, it had significantly dulled his thinking and prevented him from working. He considered that the normalising effects of the medication 'would be worse than death'. He was found to be lacking in capacity by the Consent and Capacity Board of Ontario, the equivalent to the Victorian Mental Health Tribunal.

Upholding the final appeal, the plurality of the Supreme Court of Canada stated:

The enforced injection of mind-altering drugs against [Professor Starson's] will is highly offensive to his dignity and autonomy, and is to be avoided unless it is demonstrated that he lacked the capacity to make his own decision.⁵⁹

The Supreme Court held that the presence of a mental illness was not to be equated with incapacity, even for someone in psychiatric detention,⁶⁰ that Professor Starson had valid reasons for refusing medication (he 'preferred

his altered state to what he viewed as the boredom of normalcy')⁶¹; and that the Board had placed primary importance upon what it thought was in his best interests, at the expense of failing adequately to consider whether '[he] had the capacity to make up his own mind as to whether he wanted medication or not'.⁶²

Applying the reasoning in the *Starson* decision led Bell J to the pivotal conclusion that the presence of delusional thinking and irrational fears, as well as lack of belief or insight, is capable of depriving a person of capacity but it need not: 'This means giving due consideration to a relevant fact, not (in effect) applying a determinative normative criterion'.⁶³

Fundamental to Bell J's decisions about *PBU* and *NJE* was the fact that a person is presumed to have capacity to give or refuse informed consent to medical treatment, and therefore that approval for ECT can only be given if VCAT is satisfied that the patient does not have capacity. He accepted that VCAT had correctly determined that it should apply the *Briginshaw* standard,⁶⁴ having regard to the seriousness of the issue, namely the fundamental human rights of the persons to self-determination, to be free of non-consensual treatment and to personal inviolability.

Justice Bell distinguished between giving informed consent and the capacity to give informed consent, emphasising that the issue arises in relation to proposed treatment, not at large. He held that what is required is for a patient to be provided with advice and information to enable them to understand in general terms the nature, purpose and effect of treatment.⁶⁵ This having been done in relation to a capacitous patient, it is up to the patient what decision they make in relation to treatment. He observed that the purpose of ss 69(1)(b)–(c) and 69(2)–(3) is 'to facilitate and maximise effective participation by persons with mental illness in treatment decision-making, to support and enhance the exercise of the person's legal capacity and ultimately to give effect to

the person's right to self-determination, to be free of non-consensual medical treatment and to personal inviolability'.⁶⁶

He identified the following applicable principles:

- (1) The primary purpose of the Mental Health Act is to ensure that people with mental illness, including those lacking the capacity to give informed consent, receive treatment for that illness (s 1(a); see also ss 10(a), 10(f), 11 and especially 72). But the legislative intention is that this is to be done in a manner that affords equal respect for their human rights and particularly their right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, as recognised in the Charter.
- (2) Consistently with affording that respect and the position at common law for people generally, there is a (rebuttable) presumption that people with mental illness (as for people without that illness) have the capacity to give informed consent (s 70(2)). Capacity to give informed consent is issue-specific (s 68(2)(a)), can fluctuate (s 68(2)(b)) and may be enhanced with support, all of which may have significant implications for the capacity-assessing process and the ultimate determination.
- (3) Reflecting the common law, the test of capacity in s 68(1) is primarily a functional one in which the question is whether the person has the ability to remember and use or weigh relevant information and communicate a decision, not whether the person has actually done so (paras (b), (c) and (d)). The purpose of the functional test (as distinct from a status or outcome-based test) is to ensure that, in relation to capacity to give informed consent, people with mental illness are afforded the same respect for their inherent dignity and autonomy-space as people not

having that illness. In relation to s 68(1)(a), the question is whether the person understands the information.

- (4) The capacity test must be applied in a non-discriminatory manner so as to ensure that people with mental illness are not deprived of their equal right to exercise legal capacity upon the basis of contestable value-judgments relating to their illness, decisions or behaviour, rather than upon the basis of the neutral application of the statutory criteria (s 68(2)(c)). In short, the test is not to be applied so as to produce social conformity at the expense of personal autonomy.
- (5) A person with mental illness is not to be found lacking the capacity to give informed consent simply by reason of making a decision that could be considered unwise (s 68(2)(d)), which recognises that self-determination is important for both dignity and health and that people with mental illness should have the same dignity of risk in relation to personal healthcare decision-making as other people. This reflects the two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and personal health and wellbeing on the other.
- (6) Reflecting human rights consideration, the Mental Health Act rejects the best-interests paradigm for healthcare decision-making. Those assessing capacity under s 68(1)–(2) must vigilantly ensure that the assessment is evidence-based, patient-centred, criteria-focussed and non-judgmental, and not made to depend, implicitly or explicitly, upon identification of a so-called objectively reasonable outcome.
- (7) The threshold of capacity in s 68(1)(a)–(d) is relatively low and requires only that the person understands and is able to remember and use

or weigh the relevant information and communicate a decision in terms of the general nature, purpose and effect of the treatment. The threshold is not that the person understands the information sufficiently to make a rational or well-considered decision, is able make such a decision or has actually done so. The person does not need to have an understanding and possess those abilities in terms of the actual details of the proposed treatment but only the salient features.

- (8) Acceptance of, belief in and insight into the diagnosis of illness and need for treatment varies significantly depending upon the person and the situation. It is not a normative criterion in s 68(1)(a)–(b). Depending upon the facts of the case, a person with mental illness may lack that insight or otherwise not accept or believe that the person has a mental illness or needs treatment yet may have the capacity to give informed consent when assessed under the statutory test. The opposite may be so.
- (9) Lack of the capacity to give informed consent must be established according to the *Briginshaw* standard.
- (10) The provisions of the Mental Health Act are predicated upon the central purpose of ensuring that persons with mental illness have access to and receive medical treatment, consistently with the person's right to health. Where, consistently with the above principles, it is established that the patient does not have the capacity to give informed consent and there is no less restrictive way for the patient to be treated, VCAT must grant an application for ECT (s 96(1)(a)) because, under the legislative scheme and subject to its safeguards, this is a necessary means of ensuring that the patient is given that treatment.⁶⁷

Justice Bell found error in VCAT's acceptance of the clinical director of the hospital that

PBU did not have capacity to give informed consent because he did not accept the diagnosis of schizophrenia in relation to him. Justice Bell accepted that PBU's views meant that he did not accept that he had a mental illness and that he had no insight into his need for treatment, but he did accept that he had mental health problems (depression, anxiety and post-traumatic stress disorder) for which he was prepared to accept treatment other than ECT. This meant that PBU's situation had parallels with the patient in *Starson*, and the issue arose of whether such an interpretation was improperly discriminatory against PBU by reason of treating his decision-making differently from the decision-making by a person without mental illness.

A further defect in VCAT's reasoning identified by Bell J was the fact that it did not explicitly consider the domain of the ability to remember, use or weigh and communicate in the specified respects in s 68(1)(b)–(d). In particular, VCAT did not examine how non-acceptance of the diagnosis affected PBU's ability to function in these respects. Thus, Bell J found VCAT to have erred in law in the interpretation of s 68(1)(a)–(d) or in the application of those statutory criteria by reasoning that because PBU did not accept he had schizophrenia he did not have capacity to make an informed decision on the proposed ECT.

In respect to NJE, Bell J held that VCAT erred by interpreting s 68(1)(c) wrongly in two respects:

- (1) it focussed upon whether NJE had actually considered the advantages and disadvantages of the decision, not whether she had the ability to use or weigh relevant information; and
- (2) it applied a threshold of capacity that required the person 'to carefully consider the advantages and disadvantages of the situation or proposal', which was too high.⁶⁸

He warned of the need for assessors to be careful not to allow the mandated functional

assessment to degenerate into a best-interests or reasonable-outcome test.⁶⁹ ‘the criterion in para (c) is whether the person has the ability to “use or weigh” relevant information, not whether the person has actually done so, to a careful-consideration standard or at all’.⁷⁰ As an example of the best interests considerations he found VCAT to have taken wrongly into account, Bell J noted the ‘concern’ expressed by VCAT about NJE spending several nights a week without sleep because she was working with psychic healing powers. He made the point that evidence might establish such behaviour to arise from delusions but that the capacity assessment needs to go into the relationship (if any) between the delusion and the ability to use or weigh the relevant information, this being what both the statutory criteria and human rights require.⁷¹

Justice Bell also drew attention to the importance of there being no less restrictive way for the patient to be treated than by ECT, this engaging a number of human rights principles. In addition to constituting a shift away from the paternalistic model of decision-making that applied under ‘legacy mental health legislation’, which permitted such treatment compulsorily if warranted in a patient’s ‘best interests’, he commented that: ‘It is a shift towards recognition of persons with mental disability as dignified rights-bearers, not welfare cases, whether or not they have the capacity to give or refuse informed consent. It gives effect to the statutory purpose of ensuring that persons have access to needed treatment in a way that brings recognition of that dignity and respect for those rights into the frame of reference in mental health treatment decision-making’.⁷² He noted that the least restriction principle corresponds to the one element of the proportionality requirement which applies under human rights law (including by s 7(2)(e) of the Charter) to ensure that interference with the exercise or enjoyment of human rights only occurs where it is justified.

This operates very differently from the former best interests test:

It involves a different conception of the relationship between medical authority and the patient: it is one that respects, to a much greater degree, the patient’s right to self-determination, to be free of non-consensual medical treatment and to personal inviolability; one that is intended positively to promote patient participation and supported decision-making; and one that, in appropriate cases, incorporates recovery (and not simply cure) as an important therapeutic purpose in a holistic consideration of the person’s health (broadly understood).⁷³

Justice Bell also offered some observations about the importance of taking the patient’s views and preferences into account:

Approaching the application of s 96(1)(a)(ii) in a way that focusses upon medical considerations to the exclusion of personal and social considerations, and doing so in a way that does not enable effective participation by or support of the patient where this is reasonable and possible, may ... be too narrow in a particular case. As a patient’s health, medical treatment and self-determination are interrelated, this can cut both ways: discriminatory denial of capacity and paternalistic medical treatment can undermine patients’ dignity, autonomy and prospects of recovery in the long term; but, subject to safeguards, compulsory medical treatment may presently be necessary as a last resort to improve those prospects and contribute to the realisation of patient autonomy and self-actualisation.⁷⁴

However, he accepted that the assessment of whether there is a less restrictive way for the patient to be treated under s 96(1)(a)(ii) does not require consideration of the purposes of the treatment criteria (in s 5(b)). The requirement that a treatment be the least restrictive available does not mean that the patient is to be treated to a minimum threshold

or receive minimal treatment to address or prevent serious deterioration of health or serious harm⁷⁵.

Justice Bell found that VCAT's central error of law with respect to PBU was that it found he did not have capacity to give informed consent because he did not accept or believe, or have insight into, the diagnosis of his mental illness. However, there can be a variety of personal, social and medical reasons for both those with a mental illness and those who do not have a mental illness to deny or diminish their illness and the need for treatment:

In both cases, lack of acceptance, belief or insight may be relevant when determining whether a person has the capacity to give informed consent, but it is only one consideration. It would be discriminatory to treat this consideration as determinative in relation to people having mental illness when it is not determinative in relation to people not having mental illness. In fact, PBU did accept that he had a mental illness for which he needed non-ECT treatment, but VCAT gave this little weight.⁷⁶

In respect of NJE, the central error of law found by Bell J with the decision of VCAT was that it determined that she did not have the capacity to give informed consent because she had not actually given careful consideration to the advantages and disadvantages of ECT:

To have the capacity to give informed consent, it is not required of persons having mental illness, nor of persons not having mental illness, that they give, or are able to give, careful consideration to the advantages and disadvantages of the treatment. It is not required that they make, or are able to make, a rational and balanced decision in relation to the decision. It is enough that the person, like most people, is able to make and communicate a decision in broad terms as to the general nature, purpose and effect of the treatment. Personal autonomy and the dignity of the individual are at stake.

A person does not lack the capacity to give informed consent simply by making a decision that others consider to be unwise according to their individual values and situation. To impose upon persons having mental illness a higher threshold of capacity, and to afford them less respect for personal autonomy and individual dignity, than people not having that illness, would be discriminatory.⁷⁷

Justice Bell upheld the appeals by both PBU and NJE and quashed the orders made by VCAT. As he was informed that both PBU and NJE were being treated in the community and compulsory ECT was no longer being sought, no order was made remitting the cases to be redecided.

The significance of the *PBU* and *NJE* decisions

The decision by Bell J in relation to *PBU* and *NJE* builds upon his analysis of human rights considerations in the mental health context in *Kracke v Mental Health Review Board*.⁷⁸ The decision is likely to be influential throughout Australia in the interpretation of mental health legislation, especially in respect of ECT, but it will be particularly pertinent to the Australian jurisdictions with human rights legislation – the ACT, Victoria and Queensland.

At the heart of Bell J's decision is a requirement for clinicians and bodies such as mental health tribunals and administrative tribunals on review to be rigorous in their analysis of legislation which impacts upon mental health patients' rights. There is a risk that 'best interests' considerations and extra-legislative notions, such as insight and compliance, will intrude into decision-making without legislative warrant.⁷⁹ To use the terminology of Michael Perlin, this can be a perpetuation of 'sanism' and 'pretextuality';⁸⁰ it can operationalise prejudices and be based on paternalistic myths and irrelevancies. A similar point has been made by Bell J in his expression of concern that within the VCAT reasoning processes in the *PBU* and *NJE* decisions was a

wish to avoid persons with mental illnesses engaging in decision-making that was irrational or contrary to their best interests. Integral to his reasoning was that the dignity and autonomy of capacity for error should be extended to those with mental illness as it is to those without mental illness. His point is that the presence of symptomatology of psychiatric pathology, such as paranoia, delusions or hallucinations, may deprive of or substantially impair the capacity for informed consent but that this does not necessarily follow. The question is what the correlation is between symptomatology and capacity, whether or not the capacity is ultimately exercised rationally – there should not be consequentialist drawing of inferences.

This has ramifications for the reasoning processes that are permissible for clinicians and for tribunals. It has always been necessary for reports from clinical teams to do more than identify a psychiatric disorder within the DSM or ICD systems, or even symptoms of such illnesses, before either involuntary status decisions are made or the case is made out for ECT. In the context of ECT, it needs to be shown that a patient's symptoms are so intrusive and influential, by way of distortion of thinking processes or otherwise, that the person does not have the capacity to give informed consent, namely to:

- (a) understand the information the person is given that is relevant to the decision;
- (b) to remember the information that is relevant to the decision;
- (c) to use or weigh information that is relevant to the decision; and
- (d) to communicate the decision the person makes by speech, gestures or any other means.

Thus, what is to the point is evidence that the person's understanding, capacity to recollect, use and weigh information, and to communicate their decision is significantly adversely affected. And the deleterious

impact cannot arise from a statutorily irrelevant designation. Capacity is context-specific, episodic and fluctuating. Just because capacity did not exist on a previous occasion does not mean it is not present at a later juncture. Capacity changes and can be enabled or enhanced by suitable support. Whether this can make a material difference needs to be factored into clinicians' views and tribunals' decisions.

The two cases of PBU and NJE are highly illustrative. Both patients were longstanding mental health patients with schizophrenia. For both, ECT was a very plausible therapeutic option. However, the information provided to VCAT by the clinicians had serious flaws in terms of the extent to which it effectively addressed the statutory criteria for capacity to give informed consent and resulted in defective reasoning from VCAT when it authorised the ECT that the clinicians sought.

PBU had little, if any, insight into the schizophrenia from which he suffered (his view was that his condition was quite different), and what needed to be done to address his symptomatology. He wanted neither of the treatments that had the potential to assist him – ECT or antipsychotics. ECT had previously relieved the severity of his symptoms. He had no contact with his family, who lived interstate, and little or very limited social engagement.⁸¹ His capacity to appreciate the opportunities that ECT gave for alleviating the actual illness that he had was very doubtful but not the subject of clear evidence by the clinical team. It should have been.

NJE was delusional – she believed she was a registered master of the 'Melchizedek Method of Healing' and was unable to sleep normally because of needing to work as a 'psychic healer'. She did not want ECT because it would interfere with her psychic abilities and work as a healer. She wanted medication, including potentially Clozapine, not ECT, although it was her clinicians' view that ECT was the only treatment with a

potential to address both her positive and negative psychotic symptomatology. NJE had previously overdosed on her antipsychotics, requiring hospitalisation.⁸² She had also been trialled on Clozapine, but this had failed because she would not co-operate with blood testing.⁸³ She was very unwell.

In respect of both patients, there were major issues in terms of whether the nature and extent of their symptoms was interfering substantially with their capacity to use and weigh the information provided to them by the clinicians. However, the evidence about this lacked the necessary focus, leaving VCAT in a position where it identified that for each patient, ECT was likely to be clinically advantageous and preferable to the other options. However, this left the absence of insight on the part of PBU playing a role which was not open (in the absence of specific expert evidence) and resulting in discriminatory reasoning on the part of VCAT, because such a consideration can play a role in assessing capacity to give informed consent but it should not be determinative. In respect of NJE, the defect in reasoning was the conclusion by VCAT that the patient lacked capacity because she had not given 'careful consideration' to the advantages and disadvantages of ECT. This was an extra-legislative irrelevancy and was also suggestive of VCAT making a decision based upon best interests and the fact that NJE's stance in relation to ECT appeared unwise – again a consideration which generally should not form a part of the evaluation of whether a person has capacity to agree to ECT.

Justice Bell has not required of clinicians and tribunal members extraordinary acumen, but he has demanded that there be sophistication of reasoning, linking a patient's individual symptoms of mental illness to the consequences relevant to the capacity to provide informed consent. It is not necessary that patients must be able to exercise high levels of percipience, insight or rationality, or be wise or give careful consideration, for them to have

capacity to make informed decisions about their treatment. The rationale for Bell J's decision is that, if information is not provided by the clinical team about the deleterious impact of psychotic symptomatology, such as delusions or hallucinations, upon the statutory criteria for capacity to make an informed decision about ECT and utilised advisedly by a tribunal, the decision-making in respect of matters which fundamentally affect human rights will miscarry. It is also likely to give effect to the presumption of capacity to consent to treatment. Decision-making about imposition of ECT in such circumstances runs the risk of being infected by paternalism, best interests decision-making and discrimination.

The judgment of Bell J in *PBU and NJE v Mental Health Tribunal* utilises human rights principles which are fundamental to the balance that contemporary mental health legislation seeks to achieve in many countries, including Australia and New Zealand, to require strict and intellectually rigorous interpretation of powers to coerce treatment. In doing so, the judgment reinforces the move away from 'best interests decision-making' for persons with mental illness and requires of the application of mental health legislation that it genuinely address not the diagnostic labels that are applied to patients but their actual symptomatology, their wishes and preferences, and the extent to which their mental illness impairs their capacity for decision-making that is informed and supported by pertinent information provided to them by clinicians. It emphasises too that for all of us, whether or not we have a mental illness, a raft of extra-clinical considerations that are personal to us influence important decisions that we make. The judgment of Bell J reminds us that if there is intellectual looseness in application of statutory criteria for coercion of any form of treatment there is a risk that discriminatory and unauthorised considerations will intrude and illegitimately compromise vulnerable persons' ability to make their own decisions about their own lives.

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Ethical approval

This article does not contain any studies with human participants or animals performed by any of the authors.

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Notes

1. See Ian Freckelton and Beth Wilson, 'Electro-convulsive Therapy: Law, Practice and Ethics' (2001) 8(4) *Journal of Law and Medicine* 389; Jonathan Sadowsky, *Electroconvulsive Therapy in America: The Anatomy of a Medical Controversy* (Routledge 2016); Edward Shorter and David Healy, *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness* (Rutgers University Press 2013); Kitty Dukakis and Larry Tye, *Shock: The Healing Power of Electroconvulsive Therapy* (Avery 2007).
2. See in respect of its use with 'de-patterning' the use of ECT by Dr Ewen Campbell, who founded the McGill Department of Psychiatry in 1943: Anne Collins, *In the Sleep Room: The Story of the CIA Brainwashing Experiments in Canada* (Lester & Orpen Dennys Ltd 1988); Joel Paris, *Fads and Fallacies in Psychiatry* (RC Psych 2013); PR Breggin,

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4. See MW Fisher, J Morrison and PA Jones, 'Electroconvulsive Therapy Practice in New Zealand' (2017) 33(2) *J ECT* doi: 10.1097/YCT.0000000000000364
5. See, eg, P Melding, 'Electroconvulsive Therapy in New Zealand: Terrifying or Electrifying?' (2006) 119(1237) *New Zealand Medical Journal* U2051.
6. See, eg, Kari Ann Leiknes, Lindy Jarosh-von Schweder and Bjørg Høie, 'Contemporary Use and Practice of Electroconvulsive Therapy Worldwide' (2012) 2(3) *Brain and Behavior* 283; see too J Unutzer and M Park, 'Older Adults with Severe, Treatment-resistant Depression: "I Got My Mother Back"' (2012) 308(9) *Journal of the American Medical Association* 909.
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8. Australian and New Zealand College of Psychiatrists, 'Electroconvulsive Therapy' <<https://www.yourhealthinmind.org/treatments-medication/ect>>
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10. See Stephanie Zillman, 'Darwin Woman Narrowly Avoids "Shock" Therapy Without Consent' *ABC News* (26 January 2019) <<https://www.abc.net.au/news/2019-01-26/darwin-woman-narrowly-avoids-electro-shock-therapy-no-consent/10751910>> accessed 1 April 2019
11. [2018] VSC 564.
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13. Mental Health Act 2007 (NSW) s 91.
14. Mental Health Act 2016 (Qld) s 232.
15. Mental Health Act 2013 (Tas) s 8.
16. Mental Health Act 2014 (Vic) s 68.
17. See, eg, Mental Health Act 2014 (WA) s 198.
18. *Mental Health Act 2014* (Vic) s 92(1)(a)–(b).
19. *Mental Health Act 2014* (Vic) s 93(1)(a)–(b).
20. Mental Health Act 2014 (Vic) s 93(2).
21. *Mental Health Act 2014* (Vic) s 68(1)(a)–(d). Compare *Mental Health Act 2014* (WA) s 15, which incorporates the capacity to communicate the person's decision.
22. *Mental Health Act 2014* (Vic) s 69(1)(a)–(e).
23. *Mental Health Act 2014* (Vic) s 69(2)(a)–(f). Compare *Mental Health Act 2014* (WA) s 19(1).
24. *Mental Health Act 2014* (Vic) s 69(3)(a)–(d).
25. *PBU v Mental Health Tribunal* [2017] VCAT 781 per Senior Member Dea.
26. *PBU v Mental Health Tribunal* (n 25) at [72].
27. *PBU v Mental Health Tribunal* (n 25) at [80].
28. (2009) 29 VAR 1 at 158 [784].
29. [2016] VMHT 19.
30. *PBU v Mental Health Tribunal* [2017] VCAT 781 at [105]–[108]
31. *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 at [23].
32. *NJE v Mental Health Tribunal* [2017] VCAT 1070 at [63]–[64] per Member Hoysted (*italics in original*).
33. *NJE v Mental Health Tribunal* (n 31) at [86].
34. *NJE v Mental Health Tribunal* (n 31) at [87].
35. *PBU & NJE v Mental Health Tribunal* (n 30) at [54].
36. *PBU & NJE v Mental Health Tribunal* (n 30) at [77].
37. *PBU & NJE v Mental Health Tribunal* (n 30) at [86].
38. *PBU & NJE v Mental Health Tribunal* (n 30) at [89].
39. *PBU & NJE v Mental Health Tribunal* (n 30) at [101].
40. [2015] 1 AC 1430; [2015] UKSC 11.
41. *PBU & NJE v Mental Health Tribunal* (n 30) at [103].
42. *PBU v Mental Health Tribunal* (n 25) at [103].
43. Victoria, *Parliamentary Debates*, Legislative Assembly, 20 February 2014, 471 (Mary Wooldridge, Minister for Mental Health).
44. *PBU & NJE v Mental Health Tribunal* (n 30) at [104].
45. *PBU & NJE v Mental Health Tribunal* (n 30) at [107].
46. *PBU & NJE v Mental Health Tribunal* (n 30) at [110].
47. (2009) 29 VAR 1, 121 [569].
48. *PBU & NJE v Mental Health Tribunal* (n 30) at [130].
49. *PBU & NJE v Mental Health Tribunal* (n 30) at [139].
50. *PBU & NJE v Mental Health Tribunal* (n 30) at [150].
51. [2009] 1 WLR 1786 at 1789 [12].
52. *PBU & NJE v Mental Health Tribunal* (n 30) at [160].
53. *PBU & NJE v Mental Health Tribunal* (n 30) at [163].
54. *PBU & NJE v Mental Health Tribunal* (n 30) at [163].
55. *PBU & NJE v Mental Health Tribunal* (n 30) at [173].
56. *PBU & NJE v Mental Health Tribunal* (n 30) at [182].
57. *PBU & NJE v Mental Health Tribunal* (n 30) at [199].
58. *Starson v Swayze* [2003] 1 SCR 722 at 766 [91]. See too R Sklar, 'Starson v Swayze: The Supreme Court Speaks Out (Not All that Clearly) on the Question of "Capacity"' (2007) 52(6) *Canadian Journal of Psychiatry* 390.
59. *Starson v Swayze* (n 57) at 760 [77].
60. *Starson v Swayze* (n 57) at 766 [92].

61. *Starson v Swayze* (n 57) at 754 [92].
62. *Starson v Swayze* (n 57) at 754 [93].
63. *PBU & NJE v Mental Health Tribunal* (n 30) at [182].
64. See *Briginshaw v Briginshaw* (1938) 60 CLR 336; [1938] CLR 34, determining that while the standard of proof is on the balance of probabilities, considerations such as the importance of the decision and its potential impact upon the person are factors which are relevant to the decision-making process.
65. *PBU & NJE v Mental Health Tribunal* (n 30) at [217].
66. *PBU & NJE v Mental Health Tribunal* (n 30) at [220].
67. *PBU & NJE v Mental Health Tribunal* (n 30) at [206].
68. *PBU & NJE v Mental Health Tribunal* (n 30) at [238].
69. *PBU & NJE v Mental Health Tribunal* (n 30) at [239].
70. *PBU & NJE v Mental Health Tribunal* (n 30) at [239].
71. *PBU & NJE v Mental Health Tribunal* (n 30) at [242].
72. *PBU & NJE v Mental Health Tribunal* (n 30) at [250].
73. *PBU & NJE v Mental Health Tribunal* (n 30) at [252].
74. *PBU & NJE v Mental Health Tribunal* (n 30) at [257].
75. *PBU & NJE v Mental Health Tribunal* (n30) at [269].
76. *PBU & NJE v Mental Health Tribunal* (n 30) at [279].
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78. (2009) 29 VAR 1 at 158 [784]. See also B McSherry, “Electroconvulsive Therapy Without Consent: The Influence of Human Rights Law” (2019) 26(4) *Journal of Law and Medicine* (in press).
79. See, eg, I Freckelton, ‘Distractors and Distressors in Involuntary Status Decision-making’ (2011) 12 *Psychiatry, Psychology and Law* 88.
80. See, eg, Michael Perlin, *The Hidden Prejudice: Mental Disability on Trial* (APA 2000); Michael Perlin, “‘Half-wracked Prejudice Leaped Forth:’ Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did’ (1999) 10 *Journal of Contemporary Legal Issues* 3.
81. *PBU v Mental Health Tribunal* [2017] (n 25) at [41].
82. *NJE v Mental Health Tribunal* (n 31) at [70].
83. *NJE v Mental Health Tribunal* (n 31) at [70].