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Psychiatric advance directives and consent to electroconvulsive therapy (ECT) in Australia: A legislative review and suggestions for the future

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ABSTRACT

Psychiatric Advance Directives (PADs) have been adopted in many jurisdictions around the world and in most Australian states and territories. They are seen as a less restrictive and patient-centered approach to the provision of mental health care. Electroconvulsive therapy (ECT) is a restricted treatment in most jurisdictions in Australia and across the world. This paper explores the history, regulation and use of ECT and PADs and the intersections between them. It provides an overview of the legislative framework in each Australian state and territory and explores some of the issues which have arisen such as complexity of the regulatory framework, making PADs binding for refusing and consenting to ECT, involving treating teams in how PADs are made, using restrictive interventions to implement PADs, and the role of the Tribunal. While PADs are often framed as an important legal tool for allowing patients to refuse psychiatric treatment (especially ECT), the paper emphasizes that they can also be an innovative way for people to consent to psychiatric treatment in advance and an empowering option to access mental health care. It then makes some suggestions for future reform.

1. Clinical vignette

Mary[1] has been diagnosed with a serious but fluctuating mental illness which is resistant to pharmaceutical treatments. However, she has found that Electroconvulsive Therapy (ECT) is a beneficial treatment for her. Like most jurisdictions ECT is strictly regulated and under the Mental Health Act she is only able to obtain it with her informed consent, in a life or severe health threatening emergency, or by order of the Mental Health Review Tribunal. In order to access ECT quickly Mary completed and registered a valid psychiatric advance directive (PAD) consenting to ECT if she lost decision-making capacity in the event of a future mental health crisis. When that crisis occurred Mary became an involuntary patient and refused to fast the night before the ECT. Fasting is an essential pre-requisite for ECT. It would be dangerous for her to be given an anesthetic without fasting first. Rather than forcing Mary to fast, and in light of legal uncertainty, her psychiatrists applied to the Tribunal for an order authorizing the use of force to make her fast, so as to be able to safely give her ECT in accordance with her PAD. Unfortunately convening the Tribunal took seven days which meant that she was detained in hospital considerably longer than if her PAD had been implemented immediately, as ECT may have improved her condition quickly. The delay in implementing her PAD meant that her treatment was likely to have been far more disruptive to her job and life. While waiting for Tribunal approval Mary's mental health deteriorated and she needed to be secluded which she found traumatizing and something she had hoped to avoid by putting the PAD in place. After her ECT Mary was angry that her PAD had not been implemented without delay, notwithstanding her refusal to fast.

2. Introduction

Psychiatric Advance Directives (PADs) are a form of advance care planning for persons with mental ill-health to consent to, or refuse to consent to, hospital admission and psychiatric treatment. A PAD documents a person's wishes and preferences when they are well (and have capacity) in the event that they later lose decision-making capacity. While advance directives are most commonly used in palliative care settings to direct end-of-life medical treatment decisions, they are quite well suited in mental health settings as most mental illnesses (such as mania, psychosis and depression) are characterized by periods of

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[1] Not her real name. The clinical vignette which only includes de-identified information is included in the paper with the patient's consent.

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competence and incompetence (Campbell & Kisely, 2009). Further, recurring episodes of mental ill-health mean that patients have the ability to learn from previous experiences of treatment and can communicate information about what does and does not work for them (Owen et al., 2019).

Over the past forty years, the use of advance directives in psychiatry has attracted waves of innovation and law reform activity worldwide, further intensifying following the entry into force of the international Convention on the Rights of Persons with Disabilities ('CRPD') in United Nations General Assembly (2006). As discussed further below, PADs have many different purposes and potential uses (Maylea, Jorgensen, Matta, Ogilvie, & Wallin, 2018) in both limiting and in giving access to psychiatric treatment (Weller, 2012). They have come to be seen as a way to give individuals a voice in decision-making, of increasing dignity and autonomy in mental health care, reducing coercion in psychiatry and in decreasing anxiety for patients, family and friends.

Electroconvulsive therapy (ECT) involves passing a small, carefully controlled electrical current, stimulating the brain to trigger a brief seizure. A general anesthetic and muscle relaxant drugs are administered prior to the procedure and electrodes (unilateral or bilateral) placed on the scalp. The brief seizure is expected to induce temporary brain chemistry changes and may improve symptoms quickly. ECT has been used in psychiatry since the 1930s and its benefits in treating certain mental health problems – especially depression, mania, some forms of schizophrenia and catatonia – mean that ECT is a well established evidence-based medical treatment option (RANZCP Position Statement 74, 2019). Yet, as discussed below, it remains a controversial treatment in psychiatry, among persons with mental health problems and in the popular imagination (McSherry, 2019). While patient and community activism has not succeeded in banning ECT for adults (Heitman, 1996), in most jurisdictions ECT has become tightly regulated and is available to those adults who consent to it but is restricted with respect to those who are unable or unwilling to consent to it.

While PADs typically record the wishes and preferences of individuals with respect to *all* aspects of mental health treatment, the contested nature of ECT, along with the emphasis on informed consent in most regulatory frameworks, mean that PADs are a promising vehicle to record a patient's consent, refusal and general feelings about ECT (and associated anesthetic procedure requirements). Further, as seen in the clinical vignette above, PADs could offer a way to streamline ECT treatment for those who want it and minimize the disruption of mental health problems in their lives.

The purpose of this paper then, is to consider the regulation of electroconvulsive therapy (ECT) and the law in relation to PADs in Australia, a federation of eight states and territories, most of which have now included PADs into their mental health laws. Examining the legislative framework for PADs raises a number of questions. How are PADs incorporated into and supported by mental health and other legislation? How well can PADs actually reflect the true wishes and feelings of those who make them? What can be learnt from the variations between the way PADs are incorporated into different mental health laws in different states and territories? How can the law be reformed to make PADs more effective? While the focus of this paper is on Australia, the use of PADs internationally means that the paper also has global relevance.

The paper is divided into three parts. The first section considers preliminary matters like terminology, a brief history of PADs and ECT, and the role of PADs in the coercive mental health context and in furthering human rights. Part two provides an overview of the regulation of PADs and ECT in each state and territory in Australia. The third part considers specific issues in trying to legislate PADs and ECT, such as formal requirements, whether they should be legally binding, and whether they should allow persons to consent to restrictive procedures like seclusion and restraint. As part of that discussion, the paper proposes some options for reform. For the sake of simplicity in what is already a very technical area of law, we will focus on adults and will not include the more complicated rules for those under 18. We will also concentrate more on advance directives which express the patient's wishes around treatments like ECT, rather than documents which appoint substitute decision-makers to act as the patient's proxy, such as powers of attorney, although we will consider how these interact with PADs.

3. Preliminary matters

3.1. Terminology

While we have adopted the term "PADs", there are a range of terms which are used to cover different types of future care planning in the mental health literature which come from various sources. These include "psychiatric advance directives" from US legislation (Edan & Maylea, 2021), "mental health advance directives" (Weller, 2012), "advance statements" (Mental Health (Care and Treatment) (Scotland) Act, 2003), "advance agreements" and "advance consent directions" (Mental Health Act, 2015 (ACT)), "advance heath directives" (Mental Health Act, 2016 (Qld), Mental Health Act, 2014 (Vic), Mental Health Act 2014 (WA)), "instructional directives" (Medical Treatment Planning and Decision Act, 2016 (Vic)), "psychiatric wills" (Szasz, 1982) and "self-binding directives" (Scholten, van Melle, & Widdershoven, 2021). Unfortunately, unclear terminology can create confusion (Edan, Hamilton, & Brophy, 2021), especially between those expressions of will and preferences which are best described as informal clinical practice tools such as, joint crisis plans and wellness recovery action plans, as opposed to those which are formal legal instruments recognized by legislation (Edan & Maylea, 2021). In this paper, we are concerned with those advance care plans which are intended to have legal force under legislation (even though they may not be legally binding to a greater degree than requiring clinicians to 'have regard' to them).

PADs come in different types. Some are designed to support the consent or refusal of psychiatric treatment and others to provide information and directions about personal and non-health matters (such as care of dependents and pets). Whereas others called self-binding directives or Ulysses agreements (named after the myth of Ulysses who strapped himself to the mast of his ship so he could listen to the Siren's song without being ruined by it), provide consent in advance to certain kinds of treatment and cannot be revoked in certain circumstances, even if the person later objects to it (Scholten et al., 2021). In the clinical vignette described above, it appears that Mary intended to create a self-binding directive so that clinicians could legally give her ECT when she lost decision-making capacity without Tribunal approval, even if she resisted treatment.

3.2. History of PADs in the context of coercion in mental health

PADs arose out of the anti-psychiatry and civil rights movements in the United States of the 1960s and 1970s which challenged the existence of mental illness and the use of coercion in psychiatry (Weller, 2012). Such movements became the intellectual and social antecedents of the call to abolish mental health law which is still being fiercely debated in the wake of the CRPD (Wilson, 2021). Therefore, PADs need to be understood within the context of coercion in psychiatry, which distinguishes them from advance directives in the end-of–life care and other medical contexts. The normalization of coercion in psychiatry means that the inclusion of PADs into mental health law has an additional role of being seen as an antidote to compulsory care in a health system which has limited opportunities for the participation of users in healthcare decision-making.

The PAD has its origins in 1964 when May Ellen Redford came up with the idea of a will for the living body (Maylea et al., 2018). The concept was picked up for use in psychiatry in 1982, when Thomas Szasz proposed the "psychiatric will" based on the law of wills and estates and "living wills" in end-of-life general medical care. Szasz saw the PAD as offering a middle-ground on which to resolve the conflict between those

who opposed psychiatry and those who supported it (Szasz, 1982). PADs allowed people to refuse psychiatric treatment when they were well, whereas those who believed in psychiatric treatment could give consent in advance (Szasz, 1982). However, this logic is a little simplistic, especially with respect to those who are experiencing their first psychiatric episodes (Wilson, 2021). Nevertheless, PADs give individuals a voice in deciding what is more harmful for them: a mental health condition, or psychiatric interventions (Owen et al., 2019). Since 1982, PADs have been slowly incorporated into mental health laws across the United States so that by 2006 at least 25 states had made specific legislative provisions for PADs and all had included provisions for health care powers of attorney (Weller, 2012).

Similarly, England and Wales gave legislative recognition to advance directives in 2005 for all persons who lose decision-making capacity (apart from those mental health patients detained in hospital under mental health law for compulsory treatment) (Mental Capacity Act, 2005 (England & Wales), s 28). However, clinicians are still encouraged to comply with an involuntary patient's wishes expressed in an advance decision where practicable, and if they cannot, to explain to the patient why (Department of Health (UK), 2015, clause 9.9). Nonetheless, there is an exception which allows involuntary patients to make a binding advance directive with respect to consent to or refusal of ECT (Mental Capacity Act, 2005 (England & Wales), s 28(1A); Mental Health Act, 1983 (England & Wales), s58A(5)I(i)), thereby giving PADs a greater role with respect to ECT than other treatments. In addition, Owen et al. (2019) argue that England and Wales should introduce a statutory scheme for binding advance directives into the MHA (beyond ECT), with exceptions for legitimate public interests such as, life-threatening situations and risk of harm to third parties.

Similarly, in Scotland there has been legislative recognition of non-binding advance statements in the mental health context since 2005 permitting individuals to set out their wishes with respect to their psychiatric treatment in an advance statement to which the Tribunal must 'have regard' (Mental Health (Care and Treatment) (Scotland) Act, 2003, ss275 – 276C).

New Zealand does not yet contain any provisions in its mental health laws with respect to advance directives, although the New Zealand Statutory Code of Health and Disability Consumers' Rights has given some recognition to advance directives since 1996, except where they are overridden by another law such as compulsory treatment under the MHA (Right 7). However, New Zealand has yet to include advance directives in its MHA, although there are indications that New Zealand may be headed towards reform (Lenagh-Glue et al., 2022).

While there was some interest in advance directives in Australia in the late 1990s, and the Select Senate Committee in 2006 (Weller, 2012), the introduction of advances directives into mental health legislation in Australia, did not begin to take place until well after the entry into force of the CRPD in 2008, (from about 2014) as part of various reforms in response to the CRPD (Ouliaris & Kealy-Bateman, 2017) which stopped short of the abolition of involuntary detention and psychiatric treatment.

While the issue of coercion in mental health during the negotiations of the CRPD was rather fraught as the parties were unable to agree whether the CRPD required states parties to go so far as to abolish mental health law, there is no doubt that the CRPD was intended to create a shift away from involuntary detention and treatment towards greater patient participation in mental healthcare and supported decision-making (Wilson, 2021). While supported decision-making encompasses a wide range of formal and informal supports to assist individuals to make decisions, the creation of advance directives has been widely regarded as a form of supported decision-making (United Nations Committee on the Rights of Persons with Disabilities, 2014), even though as Weller (2012) points out it is technically substituted decision-making where the substituted decision-maker is actually the patient's self at an earlier time – that is, the patient's earlier decision when they are competent, binds them when they lose decision-making capacity. Even so, how exactly advance directives might be used in supported decision-making and furthering human rights is unclear, especially as the CRPD Committee (the international body responsible for monitoring the implementation of the CRPD) and those calling for the abolition of mental health law argue that persons with disability *never* lose decision-making capacity, even if they require a high degree of support (General Comment 1). Scholten, Gieselmann, Gather, and Vollman (2019) argue that PADs under the 'radical CRPD model' have a very limited role, applying only when a person is unable to express *any* wishes or preferences or what they are saying is so nonsensical that no will and preferences can be discerned, rather than whenever they lose mental capacity. That is, Mary would not be able to use her advance directive to require her psychiatrists to give her ECT, even with Tribunal approval, if she became more unwell and changed her mind (as a result of her illness), or she refused to fast for her anesthetic, as she in fact did. Her contemporaneous will and preferences, even if she lacked decision-making capacity, would always override the will and preferences in her PAD, unless no will and preferences were evident. Thus, the person is deprived of the benefits of their PAD in facilitating earlier treatment (Scholten et al., 2019).

On the other hand, advance directives do fit in well with a mental capacity with support model of mental health law in which involuntary detention and treatment is only permitted where a person lacks decision-making capacity even after being offered support (and is at risk of harming others) (Wilson, 2021). In that situation, the PAD can be used to ensure that the person's will and preferences expressed when they were well survives their loss of decision-making capacity. In effect, the PAD acts as an extension of their decision-making capacity even after it is lost. Supported decision-making, especially the provision of information and support by supporters, clinicians and advocates, can be given to the person at the time they make their advance directive, in order to ensure that the document accurately reflects the person's true will and preferences at the time it is made (Scholten et al., 2019). The potential use of supported decision-making when making an advance directive is discussed further below.

However, despite the theoretical issues surrounding the use of advance directives, there are also a number of practical issues with their implementation. For instance, how to ensure staff are aware that an advance directive exists, or how to deal with what happens when a person changes their mind, or situations where an advance directive is very old and may not reflect subsequent technological developments or changes in circumstances. Further, even though most persons with mental health problems are attracted to the idea of advance directives, the actual uptake of them is extremely low. For instance, in 2016–2017 only 2.34% of adults in Victorian public hospitals had an advance statement on record (Maylea et al., 2018). This can be explained by a number of factors such as a lack of knowledge of PADs, lack of support for PADs by clinicians and institutions, and a sense among some consumers that PADs are pointless since they can often be overridden by clinicians (Hotzy et al., 2020). While clinicians approve of the idea of advance directives in the abstract, they often have ethical concerns about PADs, especially that PADs may be unclear, or that patients will refuse all treatment, and whether a person refusing treatment really had mental capacity at the time their PAD was completed (Hotzy et al., 2020; Lenagh-Glue et al., 2021; Sellars et al., 2017). It is also understandable that clinicians may not encourage advance directives which would include more work, nursing and resources in implementing something quite different for each individual. However, researchers have found that the use of advance directives to refuse all treatment is very rare, although ECT is the most refused treatment (42%) followed by depot injections (25%), or injections at all (16%) (Lenagh-Glue et al., 2021; Reilly & Atkinson, 2010). Further, often people use their advance directive to request a number of personal preferences such as vegetarian food, not having access to their phone if they lack decision-making capacity, or being treated by staff members of a particular sex while they are in hospital (Maylea et al., 2018). PADs also have benefits in

improving the therapeutic alliance and continuity of care, as even respect for small wishes can give a person a sense of control and aid in their recovery. Some patients have reported that just the act of making an advance directive can feel empowering, even though it may not be followed (Maylea et al., 2018).

3.3. ECT

Early psychiatrists began experimenting with the relationship between mental illness and epilepsy and the use of chemically induced convulsions in the treatment of psychosis in the 1930's (Mitchell & Sengoz, 1995). In 1938 in Italy electroconvulsive therapy was invented by Cerletti and Bini (Clarke, 2019) and the first use of ECT in Australia was recorded Adelaide in 1941 (Mitchell & Sengoz, 1995) in which it was reported to be well tolerated for melancholia and mania (Clarke, 2019). ECT was invented at a time when there were no medical treatments for mental illness and was received enthusiastically as providing hope for people who were previously untreatable and were otherwise condemned to a life in an institution (Tenenbaum, 1983). The breakthrough of ECT was also seen within the profession as lifting the specialty of psychiatry to the same status as physical medicine (Mitchell & Sengoz, 1995). Like much of medicine at the time, psychiatry was viewed optimistically and psychiatrists were given wide discretion, as facilitating treatment was seen as humane (Gostin, 1983). The prevalence of ECT declined in the 1950s and 1960s as other medications became available, although it still continued to be used (Mitchell & Sengoz, 1995).

However, the same anti-psychiatry and civil rights movements in the 1960s and 1970s from which the PAD was born, also caused greater scrutiny of ECT and activism to ban and regulate it. Early versions of unmodified ECT, without anesthesia or muscle relaxants caused pain, muscle and bone injury and accounts from ex-patients tainted the image of ECT (Heitman, 1996). Meanwhile, the influence of film's like *One Flew Over the Cuckoo's Nest* (1975) and *Ordinary People* (1980) created suspicion in the minds of the public and the impression that ECT was used to punish rather than treat patients (McSherry, 2019). Consumer-led studies have raised concerns that the therapeutic value of ECT has not been sufficiently investigated or proven by medical research (Read, Cunliffe, Jauhar, & McLoughlin, 2019) and have highlighted reports from patients about serious negative side effects, especially the loss of autobiographical memories and permanent cognitive deficits which interfere with the patients ability to do everyday tasks like reading a book, socializing and driving a car which are said to outweigh any minimal and short-lived ECT benefits (Ejaredar & Hagen, 2013; Read et al., 2019).

The first statute restricting the use of ECT to only those who gave informed consent was enacted in California in 1974 and was amended after a court challenge in 1976 (Heitman, 1996). The result was that the patient's ability to give informed consent was reviewed by a review committee, although the committee could override a patient's refusal if they believed that the patient lacked the mental capacity to refuse ECT (Tenenbaum, 1983). Regulation of ECT across other American states soon followed and has continued to increase (Livingston, Wu, Mu, & Coffey, 2018).

In the United Kingdom, the Mental Health Act, 1983 (England & Wales), was drafted to allow the creation of regulations to restrict the use of ECT so that it must occur with the patient's consent and with a second psychiatric opinion that it was likely to be suitable and effective for the patient (Gostin, 1983).

In Australia, regulation of ECT soon followed. For example, the first restrictions on ECT in Victoria appeared in the Mental Health Act, 1986 (Vic). In 1981, a legislative review of the Mental Health Act 1959 (Vic) was undertaken which recommended that people 'should be permitted to refuse ECT, unless the administration of ECT is needed urgently for the patient's welfare' (Consultative Council on Review of Mental Health Legislation, 1981, p.83). The recommendations of the Consultative Council made their way into the new Act which provided that ECT could only be provided with the informed consent of the person (s 72 Mental Health Act, 1986 (Vic) (repealed)), but did allow it to be provided with the approval of their authorized psychiatrist, where the person lacked capacity to consent and was an involuntary or forensic patient (s 73, Mental Health Act, 1986 (Vic)). The rationale for the restriction was that 'both electroconvulsive therapy and psychosurgery have valid therapeutic application in appropriate cases but the Bill takes account of the fact that these are potentially controversial treatments and raise emotional issues within the community' (Mental Health Bill, 1985, Explanatory Memorandum, p.2). Restrictions on ECT were further tightened up with the passing of the Mental Health Act, 2014 (Vic), which required Mental Health Tribunal approval for all non-consensual ECT.

It is arguable that the legal restrictions on ECT are outdated and do not match technological advances with the treatment (Cooper, Brakel, & Dinwiddie, 2018; Livingston et al., 2018). ECT can also result in a much faster recovery, less time in hospital, and lower readmission rates in patients with schizophrenia, and from this perspective it can be argued to be a less restrictive alternative than pharmacological therapy (Hermida, Glass, Shafi, & McDonald, 2018; Ying et al., 2021). While the side effects of ECT can include headaches, cardiovascular events and memory loss, research has revealed new techniques to reduce these (RANZCP Position Statement 74, 2019). Nevertheless, ECT is seen as more invasive and is unlikely to be deregulated due to the political reasons outlined above.

4. Overview of the regulation of ECT and PADs in Australia

ECT is strictly regulated in every state and territory in Australia, except Tasmania. While there is much variation between jurisdictions (discussed below), most require that ECT is administered with the person's informed consent, except for emergencies or with approval from the relevant mental health tribunal. Some legislation allows ECT to be performed based on consent in a PAD, or by proxies appointed by the person, or at least require that the person's wishes must be taken into account. Many jurisdictions make administering ECT, other than in accordance with the Mental Health Act ('MHA'), a criminal offence punishable by imprisonment and/or heavy fines. ECT for children and young people is banned in two jurisdictions: for persons under 12 in the Australian Capital Territory (ACT); and persons under 14 in Western Australia (WA).

PADs have been legislated in Queensland, ACT, Western Australia, Victoria and South Australia in various forms in a range of mental health, guardianship and power of attorney/medical decision-making legislation. The Northern Territory has limited recognition of PADs in their mental health law and New South Wales and Tasmania have no legislative provisions related to PADs, although there is some case law. A clear legislative framework for PADs is important because it resolves legal doubts held by patients and practitioners, by giving the patient's will and preferences legal effect and alleviating practitioners' fears that they may be held legally responsible for following (or not following) a patient's wishes (Lenagh-Glue et al., 2022).

All of these legislative schemes require that to be valid a person must make their PAD when they have decision-making capacity, and their PAD only comes into effect when that person loses decision-making capacity. The test for decision-making capacity is more or less the same and is based on the definition in the Mental Capacity Act, 2005 (UK) and English case law – being the ability to understand, remember (at least temporarily) and use or weigh information, and communicate a decision. At a minimum the legislation requires that the person understands what an advance directive is, what they have consented or refused to consent to, and the legal consequences of it.

In Victoria, the Supreme Court has held in PBU and NJE v Mental Health Tribunal (2018) VSC 564 ('the ECT case') that the level of decision-making capacity in relation to ECT ought not be set too high

even where it may involve the refusal of life-saving treatment, so that persons with mental impairments were not expected to have a level of decision-making capacity above that of the relatively low standard generally required of persons without disabilities.

An overview of the relevant legislative provisions for ECT and PADs is described below. In addition, Table 1 sets out a few selected key provisions. However, it should be noted that it is difficult to summarize legislation without losing accuracy, information and nuance.

4.1. Queensland

In Queensland, ECT and PADs are regulated by a complicated framework spread over the Mental Health Act, 2016 **('MHA')**, Power of Attorney Act, 1998 **('POA')**, Guardianship and Administration Act, 2000 **('GAA')** and the *Policies and Guidelines of the Chief Psychiatrist*. Compliance with the policies and guidelines of the Chief Psychiatrist with respect to advance directives and the consent of guardians, or attorneys, is mandatory (s13(2) MHA). It should also be noted that Queensland has a capacity-based civil commitment criteria in that a person can only be treated without their consent if they lack decision-making capacity and are at risk of serious harm to themselves or others or will suffer serious mental or physical deterioration (s12 MHA).

4.1.1. ECT

In Queensland, ECT can only be performed with the person's informed consent (s 236 MHA), which may be given by a PAD (s 233(3) MHA). ECT may also be given in an emergency to save a person's life or prevent them from suffering irreparable harm (s237 MHA), or if an adult lacks decision-making capacity with the approval of the Mental Health Review Tribunal (s 236 MHA). The Tribunal will 'consider' the person's advance directive along with a range of other criteria such as their best interests and whether ECT has been or is likely to be effective for that person (s 509 MHA). The clinician must give the person a full explanation about the alternatives and consequences of receiving and not receiving treatment (s 234 MHA) and consider any less restrictive ways of providing treatment, including under an advance directive (s 13 MHA). Failure to abide by the restrictions on ECT is a criminal offence punishable with a penalty of 2 years in prison and a fine of 200 penalty units or at the time of writing $27,500.

4.1.2. PADs

In Queensland, a person can make an advance directive giving directions for their future healthcare and can also authorize a healthcare attorney to make decisions on their behalf (s 5(4) POA), except for special health matters (which includes ECT) (s 6 POA, s 68 GAA). Advance directives can only be made by a person if they are made freely and voluntarily when they have decision-making capacity and will only come into effect when a person loses capacity (s 36, s 42 POA). PADs need to be in writing in an approved form and must be signed by an eligible witness (eg. justice of the peace, notary public or lawyer, and not persons who have an interest in the directive) (s 31 POA) and a doctor must certify at the time of signing that the maker of the advance directive appeared to have capacity to make it (s 44(6) POA). An advance directive can only be revoked by a new advance directive made

Table 1
A Few Selected Australian Legislative Provisions Regulating ECT and PADs.

Type of Provisions	QLD	ACT	WA	VIC	SA	NSW	NT
Are There Any Restrictions on ECT?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Can ECT be given to Adults with Consent of Patient?	Yes (s 236 MHA)	Yes, for up to 9 treatments or less if specified by the patient (s148 MHA)	Yes (s197 MHA)	Yes, for up to 12 treatments within 6 months (s 91 & 92 MHA) Patient must not withdraw consent during treatment or once regained capacity (s98(1) MHA).	Yes, for up to 12 treatments within 3 months (s42(1) MHA)	Yes (s89(a) MHA)	Yes
Can ECT be given to Adults who consent in a PAD?	Yes, and PAD can limit number of treatments consented to (s233 (3) MHA)	Yes, provided person doesn't refuse or resist (s 149(2) MHA)	Yes, only up to 9 treatments (notes to s197 MHA).	Yes, with Tribunal Approval (s94A(1) MHA)	Yes (s42(1) MHA)	Not stated. No PAD legislation, maybe under common law?	Not stated
Can ECT be given to Adults with consent of a Proxy Appointed by the Patient?	No, Attorney cannot consent to ECT (s6 POA)	No, Attorney cannot consent to ECT (s35 and s37 POA)	Yes, for voluntary patients, involuntary patients must have Tribunal approval (s197 & s198 MHA)	Yes, but permission must also be sought from Tribunal for both voluntary and involuntary patients (s94A MHA)	Yes, but Attorney must try to give effect to PAD (s42(1) MHA	Not stated	Yes (s66(1) (b) MHA)
Can ECT be provided in an Emergency?	Yes, provided application is made to Tribunal (s237 MHA)	Yes, where a person does not refuse or resist (s149(3) MHA)	Yes, with approval of Chief Psychiatrist (s199 MHA)	No, but Tribunal will expedite hearing (Mental Health Bill 2014 (Vic), 2014)	Yes, but must notify Chief Psychiatrist (s42 (6)(b) MHA)	Not stated	Yes, but must report to Tribunal (s 66(3) MHA)l
Can ECT be given to non-consenting patients with the approval of the Tribunal?	Yes, but Tribunal must consider views of person in PAD (among other things) (s509 MHA)	Yes, but Tribunal must NOT make order if the person has refused treatment in PAD (s157(1)(c) MHA)	Yes, but Tribunal must take into account patient's wishes, including those in a PAD (s8 and s414 MHA)	Yes, but Tribunal must have regard to views of patient in advance statement (s93 MHA)	Yes (s42(1) MHA)	Yes, where it is a reasonable and proper treatment necessary or desirable for the safety and welfare of the patient (s96(3) MHA)	Yes (s66 1 (b) MHA)
Can Force be Used to Give ECT consented to in a PAD?	Not clear	No (s149(2) MHA).	Not stated	Not stated	No(s42(4)(b) MHA	Not stated	Not stated

There are no restrictions on ECT and no PAD legislation for Mental Health Patients in Tasmania.

when that person has decision-making capacity (s 48 POA, s 227 MHA).

Queensland is unique in that a person can create a self-binding directive by stating that they consent even if they later object (s 35 POA). However, a person cannot consent to seclusion or restraint to enforce their PAD even if they object (Queensland Health, 2020b). That is, Mary's PAD would not have been able to authorize forcing her to fast (presumably by putting her in seclusion).

The Queensland MHA sets up a records system to capture all advance directives which have been made (s 225 MHA) and requires staff to inform a person about the option to make an advance directive or appoint a health attorney on discharge, with the assistance of independent rights advisors (Queensland Health, 2020b).

PADs are non-binding for involuntary mental health patients, but the clinician should discuss treatment with the patient and 'have regard' to the patient's views in an advance directive (s 53 MHA). Further, the doctor must explain to the patient why their PAD was not followed and record it on their file (s 54, MHA). However, there is still an obligation on the clinician to implement the PAD as much as they can. The Queensland Chief Psychiatrist's Policy provides that:

> A health practitioner must, to the greatest extent possible, follow an AHD if it is consistent with appropriate and safe clinical practice. If some elements of an AHD cannot be followed, this does not remove the obligation of a practitioner to consider other elements of the directive (Queensland Health, 2020a, p.10).

4.2. Australian Capital Territory ('ACT')

In the ACT, ECT and PADs are regulated by the Mental Health Act, 2015 (ACT) **('MHA')** and the Powers of Attorney Act, 2006 **('POA')**. Like Queensland, the ACT has a capacity-based MHA in which a person can only be civilly committed if they lack decision-making capacity or they have capacity and are likely to cause harm to themselves or others or experience mental deterioration (s58, s66 MHA).

4.2.1. ECT

The ACT legislation provides strong protection for persons who want to refuse ECT. ECT can only be performed for a maximum of nine treatments if a person has given their informed consent, including in an advance directive, provided the person does not refuse or resist (s149(2) MHA). The Tribunal needs to consider the views of the person with respect to ECT in an advance agreement or advance consent direction (s 156 MHA) and cannot make an order for ECT if a person has refused ECT in an advance consent direction (s 157(1)(c) MHA). ECT can be administered if a person has an electroconvulsive therapy order or an emergency electroconvulsive order and a psychiatric treatment order or a forensic psychiatric treatment order (s 149(3) MHA). Doctors need to record whether ECT was given under a Tribunal order or was given with consent and keep it for 20 years, or be liable for a fine of $3200 for an individual or $16,200 for a corporation (s 165, s 166 MHA). As noted above, administration of ECT to children under 12 is banned (I7(c) MHA).

4.2.2. PADs

The ACT legislative framework for PADs is generally well regarded in the literature (eg. Edan & Maylea, 2021) and has been favored by the Australian Productivity Commission as its preferred model (Productivity Commission, 2020). It is based on extensive consultation with the involvement of persons with mental health problems, their primary carers and their disability advocacy organizations in light of the CRPD (Second Reading Speech for Mental Health Bill 2015) and reflects active research into a more robust practice model (Weller, 2012).

In the ACT a person has a choice as to whether to make an 'advance agreement' or an 'advance consent direction.' An advance agreement involves giving general information of their wishes and preferences and the provision of practical help such as, instructions for notifying particular people, paying bills and providing care to others (s27(2) MHA). An advance consent direction allows a person, in consultation with their treating team, to refuse particular medications or procedures and name persons who can receive certain information or not (s 27(1) MHA).

The formal requirements for making an advance consent direction are greater than for an advance agreement. Advance agreements must be signed by the maker, a representative from the maker's treating team, any nominated person and any people who are likely to provide practical help (s 26(3), (4) MHA). An advance consent direction must be in writing and signed by two witnesses, one which is a representative of the treating team and one which is not (s27(3)). If it is an advance consent direction in relation to ECT, the formal requirements are even stricter. It must be signed by four witnesses, two of which must be in the patient's treating team and two of whom must be in the presence of each other (s 27(4) MHA). Advance agreements and advance consent direction can be ended by a person with decision-making capacity by telling a member of the person's treating team orally or in writing that they want to end it, or by entering into another advance agreement or advance consent direction (s 29(1), (3) MHA).

Doctors need to take reasonable steps to find out if there is an advance agreement or advance direction in place (s 28(1), MHA). A representative from the patient's treating team is required to inform and assist patients to enter into an advance agreement or advance consent direction (s 25 MHA) and to ensure that they are kept on a person's record, are updated when they are changed and that the relevant people have notice of them (s 26(5), s 27(6) MHA).

Guardians and attorneys must exercise their powers in accordance with what is stated in an advance agreement (s 30(2), s 31 MHA) and if there is an advance consent direction the consent of a guardian is not required (s 30(3) MHA). Similarly, an attorney cannot consent to ECT (s 35, s 37 POA).

Clinicians must not apprehend, detain, restrain or use force to give effect to an advance agreement or direction (s 28(2)(b), s 28(3)(d) MHA). If a person is resisting, the clinician can apply to the Tribunal for consent to give treatment in accordance with their PAD (s 28(4) MHA). Therefore, Mary would have still had to wait for orders from the Tribunal to be given ECT. If an advance agreement or advance consent direction are in force the doctor must follow it with respect to the giving or not giving of medication or a procedure named in the agreement (s 28 (3) MHA). If a clinician thinks that giving of treatment is unsafe or inappropriate, they may only give an alternative treatment if the person is willing, the person has a guardian who has consented, or if the Tribunal orders after the clinician makes a Tribunal application (s 29(5) MHA). The reasons for treatment must be recorded in the patient's record (s 29(6) MHA).

4.3. Western Australia

In Western Australia, regulation of ECT and PADs is spread across the Mental Health Act, 2014 (WA) **('MHA')** and the Guardianship and Administration Act, 1990 (WA) **('GAA')** and regulations **('GAA Regs')**. Unlike Queensland and ACT, the MHA does not limit civil commitment to those lacking capacity to consent.

4.3.1. ECT

In Western Australia, ECT can be given to a voluntary patient with their informed consent (s 197 MHA), although notes in the legislation say that informed consent can be given by a PAD (s 110ZJ(2) GAA) or by a guardian or person responsible for the adult (s 110ZJ(3) GAA). For voluntary patients a PAD is binding subject to concerns about its validity and changes in circumstances and so on. ECT can be performed on an involuntary patient with the approval of the Tribunal, although the medical practitioner must have regard to the guidelines (s 547(f) MHA). The Tribunal must take into account the patient's wishes which include those set out in a PAD (s 414, s 8 MHA). ECT can also be performed in an

emergency with the approval of the Chief Psychiatrist (s 199 MHA). Each mental health service where ECT is performed must keep statistics about it, especially about serious adverse events (s 201 MHA). As noted above, ECT is banned in Western Australia for children under 14 (s 194 MHA). It is a criminal offence to perform ECT in breach of the MHA which is punishable by a $15,000 fine and up to two years imprisonment (s 193 MHA).

4.3.2. PADs

Persons over 18 years old with full legal capacity can make a PAD which will apply at any time the maker is 'unable to make reasonable judgments in respect of that treatment' (s 110P, s 110S(1) GAA). The Western Australian legislative regime is unusual in that it provides that a treatment decision does not operate if circumstances exist at the time the person made the directive which would have caused a reasonable person to change their mind about the decision (s 110S(4) GAA). An advance directive is not valid if it is not voluntary, is made as a result of inducement or coercion, and the person does not understand the nature and consequences of the decision at the time it is made (s 110R GAA). An advance directive must be made in approved form set by the regulations and witnessed by two persons, one of whom is authorized to take declarations (s 110Q GAA). The maker is encouraged to get legal or medical advice and to indicate who gave that advice in the advance directive (s 110Q GAA; GAA Regs, Schedule 2 Standard form). Presumably, this would prevent a PAD from being invalidated if there are concerns that the person lacked decision-making capacity when they made it. The Tribunal has broad powers to declare an advance directive valid or invalid, when it applies, or to revoke or give directions about it (s 110 W, s110X GAA).

4.4. Victoria

In Victoria, ECT and PADs are regulated across a few different pieces of legislation in a complicated framework. These first is the Mental Health Act, 2014 (Vic) **('MHA')** which allows persons with mental health problems to make non-binding advance directives. The second is the Medical Treatment Planning and Decision Act, 2016 (Vic) **('MTPDA')** which allows people to make a non-binding 'values statement' and a binding 'instructional directive' (s 6 MTPDA). However, while it is not completely clear from the poorly drafted wording of the Act, it appears that it does not apply to compulsory mental health patients (s 48 MTPDA), but may still apply to voluntary mental health patients and advance directives about general medical treatment. The third piece of legislation is the Guardianship and Administration Act, 2019 (Vic) **('GAA')**.

However, it should be noted that the Royal Commission into Victoria's Mental Health System (2021), has recommended that Victoria draft a new mental health act by mid-2022. In accordance with that recommendation, the Victorian government has recently released the Mental Health and Wellbeing Bill, 2022 **('MHWB')**, in which the provisions for PADs and ECT are almost the same as those in the 2014 MHA. However, the government has decided that the provisions in relation to making involuntary detention and treatment a last resort will undergo further review and not be presented to parliament until mid-2023, (Department of Health (Victoria), 2022). To this end it has established an independent review panel led by Justice Shane Marshall and key stakeholders, including lived experience consumers, to look more closely at the law in relation to compulsory treatment and restrictive interventions, including how those laws may more closely align with personal treatment decision-making laws – such as the MTPDA and GAA (Mental Health and Wellbeing Bill 2022 (Vic), 2022). Therefore the law in Victoria in relation to compulsory treatment and PADs is likely to change further as a result of that independent review.

4.4.1. ECT

As noted above, the restrictions on ECT in Victoria were tightened up in 2014, moving from the discretion of the psychiatrist to requiring Tribunal approval, as were many of the orders for involuntary detention and treatment. ECT can be performed where an adult has given consent in writing, or where a person lacks decision-making capacity and the Tribunal has granted an application (s 92 MHA). In making an order for ECT the Tribunal must 'have regard' to the views of the person in any advance statement (s 93 MHA). ECT must not be performed without Tribunal approval if a person with decision-making capacity withdraws their consent or regains decision-making capacity and withdraws their consent (s 98(1) MHA). The Victorian legislation prescribes that the maximum course of ECT treatments is 12 within 6 months (s 91(1) MHA). A further oversight mechanism is that the use of ECT must be reported to the Chief Psychiatrist (s 98(3) MHA).

4.4.2. PADs

Victoria was the first jurisdiction to introduce legislation allowing persons with mental health problems to document their preferences and chose the Scottish model of non-binding advance statements as the most suitable approach (James, Maude, & McGrath, 2020). However, the Victorian model has been criticized as it differs between mental health and physical health under the MTPDA and because advance statements do not give patients enough power to ensure that their will and preferences are followed (Maylea et al., 2018; Royal Commission into Victoria's Mental Health System, 2021). While a person with mental health problems can make an instructional directive about their psychiatric treatment under the MTPDA, it will have no effect if a person is an involuntary patient under the MHA (s 48 MTPDA). However, 'the authorized psychiatrist may still have regard to the MTPDA instructional directive as evidence of the patient's views and preferences about treatment' (Department of Health (Victoria), 2016).

Persons with mental health problems are intended to use an advance statement to set out their preferences in relation to treatment in the event that they become a compulsory patient (s 19, MHA) and may need to have both an instructional directive (for medical and voluntary mental health treatment) and an advance statement (for compulsory mental health treatment) (Department of Health (Victoria), 2016).

An advance statement can be made at any time provided that the person has decision-making capacity and respects the formal requirements (s 19 MHA). While there is no prescribed form, an advance statement must be in writing, signed and dated by the maker and witnessed by an authorized witness who attests that the maker knows what an advance statement is and its consequences (s 20 MHA). An advance statement can be revoked when a person has decision-making capacity and replaced by a new advance statement in accordance with the same formal requirements, but cannot be amended (s 20, s 21 MHA). As remarked by Weller (2012), the formal requirements necessary for an advance statement are quite stringent in Victoria, given that it can be quite easily overridden.

In a rather confusing and convoluted provision, where a person has an instructional (ie. binding) directive giving informed consent to ECT under the MTPDA, and lacks decision-making capacity (but is a voluntary patient under the MHA), the Tribunal can give effect to the instructional directive after considering the views of the person and a range of other matters such as whether there is any less restrictive alternative, the views of carers, the likely consequences if ECT is not performed and any second psychiatric opinion (s 94A(2) MHA). That is, if Mary made a binding advance directive under the MTPDA consenting to ECT, her psychiatrists would still need to apply to the Tribunal to implement it. The main benefit of this 'alternative pathway' to ECT under s 94A(2) MHA seems to be that it would allow voluntary patients to access ECT in a private hospital and without having to be sectioned under the MHA and transferred to a public hospital first (Department of Health and Human Services, 2018). A medical treatment decision-maker appointed by an instructional directive can give consent to ECT, but they must also seek permission from the Tribunal (s 94A(1), MHA). Hence, the 'alternative pathway' under section 94A of the MHA maintains

Tribunal supervision of all use of ECT by everyone other than persons who have decision-making capacity to give informed consent at the time of treatment.

Advance statements under the MHA are non-binding although psychiatrists and the Tribunal must 'have regard' to them. An advance statement can be overridden by a psychiatrist if they think it is not clinically appropriate or that it does not fit the type of treatment ordinarily provided by the health service, although the psychiatrist must give the patient reasons (s 73 MHA).

4.5. South Australia

In South Australia, ECT and PADs are regulated under the Mental Health Act, 2009 (SA) **('MHA')**, Advance Care Directives Act, 2013 (SA) **('ACDA')** and Advance Care Directives Regulations, 2014 **('ACD regs')**. South Australia has a risk of harm-based civil commitment criteria which applies where a person lacks decision-making capacity and there is no less restrictive alternative.

4.5.1. ECT

In South Australia, ECT can be administered where a person over 16 has provided written consent, with the consent of a substituted decision-maker appointed by an advance directive, a medical agent or guardian, or by the Tribunal (s 42(1) MHA). Consent is limited to 12 episodes of ECT for a period of 3 months and each subsequent course must be consented to separately (s 42(2) MHA). Interestingly, South Australia is the only jurisdiction to provide that consent extends to the administration of anesthetics required for the purposes of ECT (s 42(4)(a) MHA). Consent does not extend to the use of force for administering the ECT treatment (s 42(4)(b) MHA) and may be withdrawn at any time (s 42(4)(c) MHA). There are emergency provisions which allow a psychiatrist to give ECT if it is not practicable to obtain consent and to notify the Chief Psychiatrist (s 42(6)(b), 42(7) MHA). Contravention of the ECT provisions is an offence which carries a maximum $50,000 fine.

4.5.2. PADs

People can make an advance directive under the ACDA with respect to future decisions about their future mental health care, residential accommodation and arrangements of their personal affairs and appoint one or more substitute decision-makers (s 10(a) ACDA). However, advance directives are only binding for refusals of voluntary treatment and are not binding for those refusals of mandatory medical treatment (s 12(1) ACDA; s 19(1) & (2) ACDA) (such as involuntary mental health treatment under the MHA). A clinician must comply with a binding provision of an advance care directive, and as far as reasonably practicable comply with a non-binding provision of an advance care directive, and seek to avoid any outcome of intervention the person would wish to be avoided (s 3)(1) ACDA). A clinician may refuse to comply with a provision if they believe on reasonable grounds that the person did not intend the advance directive to apply in particular circumstances or the provision does not reflect the current wishes of the person who gave it (s 36(2) ACDA). A PAD is also not applicable if a health practitioner believes that the person has attempted suicide and the healthcare is directly related to that attempt (cl 12A, ACD regs).

A PAD in South Australia must be made in English (although an interpreter can be used) in accordance with a specified form and be appropriately witnessed according to the regulations (s 11(2), s 14 ACDA). The witnesses will certify that they gave person the required information, that they understood it and the person did not appear to be acting under duress or coercion (s 15(1) ACDA). However, the failure to fill in part of the form will not invalidate it (unless the form says so) (s 11 (5) ACDA). A person giving an ACD must also certify that they have been given an advance care directive information statement and that they understood it (cl 5, ACD regs). A PAD where a person appears to lack decision-making capacity can only be revoked by the Tribunal (s 31 ACDA). However, one of the most interesting and unique aspects of the South Australian legislation is the creation of an alternative resolution regime where the Public Advocate can act as a mediator (Pt 7, Div 2, ACDA).

4.6. New South Wales and Tasmania

As noted above, Tasmania has no specific regulation of ECT. However, ECT is restricted in New South Wales under the Mental Health Act, 2007 (NSW).

4.6.1. ECT

In New South Wales, ECT may be administered to a voluntary patient over 16 years with their free, voluntary and written informed consent after being provided extensive information set out in the MHA about ECT (s 89, s 91 MHA) and where they have not been medicated to an extent that they cannot consent (s 92 MHA). Involuntary patients or persons under 16 years can be given ECT with the consent of the Tribunal (s 89, s 91 MHA). However, curiously, the medical superintendent of a particular facility can override the Tribunal and refuse to give a patient ECT (s 90 MHA). Tribunal enquiries into ECT must be held promptly (s 95 MHA) where a person has the right to appear (s 96 (5A) MHA). Each facility which administers ECT is required to set up and record it in a register (s 97 MHA). Failure to follow the ECT legislative procedures in NSW is a criminal offence with a maximum fine, at the time of writing, of $5500.

4.6.2. PADs

There is no legislative framework for PADs in New South Wales or Tasmania. Advance directives have been recognized by the common law in New South Wales with respect to the advance refusal of medical treatment (in that case dialysis) in Hunter and New England Area Health Service v A [2009] NSWSC 761), based on English authorities such as Airedale NHS Trust v Bland [1993] AC 789 and Re MB (An Adult: Medical Treatment) [1997] 2 FCR 541). However, in B v Mental Health Tribunal [2020] TASSC 10, the Tasmanian Supreme Court distinguished between common law advance directives in *Hunter* (applicable to general medical patients) from situations where there was a statutory right to administer medical treatment contrary to the patient's wishes. In that case, the Supreme Court held that while the Tribunal needed to consider the patient's wishes to refuse all anti-psychotic medication which were recorded in her advance directive, the Tribunal was able to give little weight to those wishes and make a contrary decision by relying on the compulsory powers in the Mental Health Act 2013 (Tas). *B* is binding in Tasmania, and being a decision of a state Supreme Court, would be a very persuasive authority (although not binding) in New South Wales. Hence, in the absence of a legislative framework for PADs, persons with mental health problems in Tasmania, and most probably in New South Wales, would be unable to make a binding common law advance directive which could override the authority of their mental health legislation.

4.7. Northern Territory

In the Northern Territory, ECT and PADs are regulated under the Mental Health and Related Services Act, 1998 (NT) **('MHA')** and the Advance Personal Planning Act, 2013 (NT) **('APPA')**.

4.7.1. ECT

In the Northern Territory, ECT must be given with a person's informed consent or with the consent of a guardian, decision-maker appointed under a PAD, or Mental Health Tribunal (s 66 (1) MHA) or in an emergency (s 66(3) MHA). ECT must be performed in an appropriately licensed premises (s 66 MHA). The legislation does not specify if a PAD could be considered sufficient for providing informed consent for ECT.

4.7.2. PADs

In the Northern Territory, advance directives are mentioned in a minimal way in the MHA in that a clinician must take reasonable steps to ascertain whether a patient has made any advance decisions or appointed a decision-maker to act on their behalf (s 168B MHA). However, the MHA is unclear beyond that on whether a doctor must actually implement the advance directive, and in what circumstances they can depart from it, and the provision has not been judicially considered. The APPA may apply to voluntary mental health patients, but the APPA provides that it does not affect the operation of any other law which allows one person to take a health care action on behalf of another (s 54, APPA) which would include compulsory mental health treatment.

5. Specific issues in legislating ECT and PADs

It can be seen from the above analysis that there is considerable variation in the regulation of ECT and PADs in all states and territories in Australia, with no state or territory permitting the making of binding PADs for compulsory mental health patients, except in the ACT which allows people to refuse ECT in an advance consent decision. It also appears that states which have an emphasis on capacity-based rather than risk of harm-based civil commitment criteria and have had more recent reviews and comprehensive reviews of their mental health legislation, have more a sophisticated regulation of PADs.

However, a number of specific issues with how ECT and PADs are legislated have emerged.

5.1. Complexity and lack of clarity

There is no doubt that the law relating to PADs and how they interact with mental health legislation in most Australian jurisdictions is extremely complex. Provisions spanning multiple pieces of legislation, regulations, and practice guidelines, are likely to be beyond the reach and understanding of busy clinicians, not to mention users of mental health services. Many provisions about PADs seem rather piecemeal and do not form a logical well thought out and comprehensive legislative scheme. Further, lack of clarity around how general medical advance directive legislation applies in the mental health context exacerbates the confusion. It is hardly surprising that PADs are not well understood or utilized in mental health in Australia.

We recommend that regulation of the use of PADs in the mental health context be located in one place, ideally the Mental Health Act, especially if the mental health law is conceptualized more broadly than being focused on involuntary detention and treatment, but to include voluntary treatment and wellbeing, as recommended by the Victorian Royal Commission. The ACT legislation is probably the most comprehensive and clearest legislative framework in Australia, which partly explains why it is so well regarded. The development of a Mental Health Code of Practice in each state and territory explaining how to make, revoke, implement and use PADs, with practical examples would also be useful. Further, the implementation of legislation is usually more effective if it is backed up by practical training for staff and education for consumers/users.

5.2. Different treatment for physical and mental health

There is a clear divide between the legislative treatment of advance directives for physical health problems and their use in the mental health context in Australia. The main difficulty is that mental health law permits the use of involuntary detention and psychiatric treatment which gives clinicians the ability to override PADs. As long as coercion in psychiatry is permitted, it is difficult to see how the division between advance directives in physical health and mental health can be overcome. It may be that equivalence between physical and mental health is not achievable due to legitimate public interests that arise in the mental health context, such as life-threatening situations and risk of harm to third parties, which may mean that some ability for clinicians or Tribunals to override a PAD in limited circumstances is unavoidable (Owen et al., 2019).

However, it may be possible that PADs could be regarded as being partially legally binding along a spectrum of enforceability (Lenagh-Glue et al., 2022). One area where PADs could be legally binding is with respect to consent to, or refusal of, certain procedures like psychosurgery or ECT, as is already the case in the ACT and England and Wales. If contemporaneous consent or refusal of ECT is sufficient to be binding, it is hard to see why consent or refusal in a valid PAD made when a person had decision-making capacity should not be sufficient.

Further, PADs could be given greater weight where they have satisfied more stringent formal requirements when they are made, relating to the provision of information, decision-making capacity assessments, and the involvement of the treating team (discussed further below). For instance, some jurisdictions like South Australia, New South Wales and Queensland already have strict rules about certain oral and written information which must be provided by clinicians to patients in respect of ECT. A requirement that a person has received and understood that information before making a PAD about ECT could be one requirement (of many) to make it binding. In the ACT, making a binding advance directive with respect to ECT requires four witnesses, at least two from the treating team, as opposed to only two witnesses for a non-binding directive.

In addition, all jurisdictions require some certification that the maker of a PAD has decision-making capacity and that the person has understood what a PAD is and what its legal consequences are likely to be. However, most of the time that certification is made by a witness, rather than an independent person who has expertise in decision-making capacity testing. Given that many clinicians have concerns about whether a person had decision-making capacity at the time they make a PAD, it is arguable that a formal psychological assessment by an independent professional at the time it is made ought to give a PAD more legal force. Further, the provision of supported decision-making at the time a PAD is made would also help ensure that the maker of a PAD has understood their decision and may potentially expand the group of people who can make a valid PAD. While formal psychological capacity assessment does impose another hurdle where uptake of PADs is already low, this could be counteracted by making formal assessments more accessible and as part of the discharge process (as noted below). It is also likely that the certainty of being able to make a PAD which is legally binding under statute may be more motivating to persons with mental health problems, than current provisions where advance statements are non-binding and can be easily overridden causing people to think 'why bother?'

Finally, a better understanding of what it means to 'have regard' to or 'consider' a non-binding PAD when a clinician is considering overriding it is required. There is a strong argument that a PAD ought to be binding except where it is impossible to implement, nonsensical or would result in a serious adverse outcome. In this regard, the South Australian legislation is interesting in that it emphasizes trying to follow the person's intent and to achieve (or avoid) an outcome the patient wants. Patients ought to be able to appeal clinical decisions not to follow a PAD to the Tribunal.

5.3. Involvement of treating teams

Some legislative frameworks, such as the ACT, privilege the involvement of the treating team in the creation of PADs. Whereas others, like Queensland, require a PAD to be in a particular form which needs to be signed by the patient's doctor. Such frameworks mean that PADs require collaboration between the patient and their medical team and would allay clinical fears that patients might refuse all psychiatric treatment, or that the patient may make a PAD without proper consideration, information and advice. On the other hand, it is foreseeable that some patients who do not like or have a more contentious relationship

with their clinicians may feel that having to get medical 'sign off' for their PADs is too restrictive and not in accordance with their human rights. They may prefer a different model, such as in Victoria, where medical approval is unnecessary, or Western Australia where the receiving of medical or legal advice is 'encouraged' and would probably give a PAD more weight, but is not mandated. The involvement of independent mental health advocates, as in Queensland, may assist in addressing concerns about power imbalances between patients and clinicians in the making of a PAD in collaboration with the maker's treating team.

Further, clinical involvement in the making of PADs means that the patient's doctors are more likely to be aware of the existence of and to actually implement a PAD and that doctors and patients will need to discuss the patient's treatment preferences going forward thereby (hopefully) improving communication and building a therapeutic alliance. Research also shows that the uptake of PADs tends to increase with greater clinical support. To this end, the ACT legislation makes a representative of the clinical team responsible for helping the patient make a PAD, keeping it on their record and making sure the rest of the clinical team and other nominated persons and helpers are updated. The Queensland legislation makes the creation and updating of a PAD part of the discharge process and requires that PADs are recorded on a central computer registry which comes up on a patient's electronic record to ensure that the patient's clinicians are aware of the patient's PAD. Regular making and updating of PADs during discharge also decreases the risk that a PAD might be significantly outdated and uncertain because of later changes in circumstances and technology. Even the Northern Territory legislation requires clinicians to enquire if a patient has a PAD.

5.4. Use of force and restrictive practices to implement PADs

The only jurisdiction which allows a patient to specify that they want their consent in their PAD to stay valid even after their later objection is Queensland. But, even so Mary would not have been able to make a self-binding PAD authorizing her true wishes that her PAD be implemented quickly (without waiting for Tribunal approval) even though she was resisting it by refusing to fast after she lost decision-making capacity.

The inability of staff to enforce a PAD where a person who may have lost decision-making capacity and is resisting is more in line with the CRPD ethos that a person's contemporaneous wishes should always be obeyed regardless of their decision-making capacity (discussed above). However, it does significantly limit the effectiveness of PADs in helping patients who want ECT to access faster treatment with a view to trying to reduce their time in hospital. In such cases the temporary restriction on their liberty may in fact give them greater long-term liberty, by getting quicker relief from their symptoms, being discharged from hospital faster and avoiding restrictive practices while waiting for the Tribunal to convene and make a decision. Therefore, a legislative provision which gives patients the choice to explicitly specify in their PAD that they consent to specific forms of restraint or seclusion being used in order to implement their PAD, would empower patients like Mary who want their PAD to be enforced. Such a provision should, of course, limit the use of restrictive practices as being only for the purposes of enforcing the patient's wishes in the PAD and only being the minimum necessary restriction for the shortest amount of time. The MHA could specify as a matter of legislative drafting that the usual legislative protections around the use of restrictive interventions to enforce the PAD in the relevant mental health law would also still apply. The person would then be free, of course, to revoke such permission for enforcement, or to change their PAD once they regained decision-making capacity.

While *there* may be concerns around patients being pressured by clinicians to consent to the enforcement of their PADs when it is made, this may be alleviated by the involvement of independent advocates or independent legal advice. It is also a risk in relation to all advance directives. Hence, legislative provisions that make it an offence to use duress or unduly influence makers of advance directives, or that advance directives can be invalidated if there is evidence that they are not freely made.

5.5. Making clear that references to ECT include anesthesia

South Australia is the only jurisdiction which provides that consent to ECT also includes the giving of anesthesia. While terms in legislation and contracts are often interpreted widely to include matters which are 'incidental' or 'ancillary' to them, a legislative provision which expressly states that consent to ECT includes consent to everything necessary to be able to safely give ECT, including anesthesia, would resolve all legal uncertainty.

5.6. Use of a prescribed form for creating a PAD

Some jurisdictions include a template or proforma for PADs and this can be useful to assist makers with expressing their will and preferences in a structured way and prompt them to respond to certain issues they may not have thought of. It is probably easier, less intimidating and less legalistic to fill in a form rather than to try to draft an advance directive from scratch. Lenagh-Glue et al. (2022), after engaging in consultation with clinicians and 'people seeking wellness,' have produced a useful template. In addition, as discussed above, such a template could clarify what the maker wants to happen if they lose capacity and change their mind.

5.7. Involvement of the Tribunal

In most jurisdictions, the Mental Health Tribunal plays an important role in overseeing treatment (especially ECT) where a person does not consent, or does not have the capacity to consent at the time. It can also play a role where there is doubt or disputes about a PAD.

Most Tribunals have expedited lists for ECT cases which can slow down patients like Mary who want to be able to access treatment without delay. On the other hand, if the Tribunal is convened too quickly, participants in the hearing may not have enough time to prepare by briefing counsel or getting expert reports. In those cases, the Tribunal could ask patients who are not ready if they need an adjournment and fix a later hearing date.

Another approach with advance directives in general health in South Australia has been for the public advocate to give parties information and conduct pre-hearing mediation. A recent review of the Advance Care Directives Act, 2013 (SA) showed that the Office of the Public Advocate, having employed a suitably qualified and experienced person, was able to resolve 97% of forty-four disputes which were regarded as being 'suitable for mediation' without needing a hearing (Lacey, 2019).

5.8. Relationship between PADs and the appointment of proxies

Many advance directives permit a person to not only make statements about their future wishes, but also to appoint particular people to make decisions on their behalf. Legislation needs to make the relationship between the person's own statement of will and preferences and the role of other substitute decision-makers clear.

5.9. Legal protection for clinicians in following a PAD

As noted above, failure to abide by ECT restrictions in mental health law is a criminal offence and clinicians may be concerned that they are exposing themselves to liability in trying to follow the patient's wishes in a PAD to the greatest extent possible. It is noted that only the Victorian, South Australian and Queensland general advance directive legislation provides doctors with any form of protection from legal liability. In Victoria and South Australia, that occurs where the clinician followed an instructional directive in good faith and without negligence (s 53

MTPD; s 42 ACD). In South Australia, a clinician is permitted to assume that an advance directive is valid unless they know otherwise (s 40, ACD). In Queensland, clinicians are not liable for not implementing an advance directive they do not know about (s 102 POA) (although they should ask the patient) or they comply with an advance directive they do not know is invalid (s 100 POA). They are also protected if they do not comply with an advance directive they believe is uncertain, or is inconsistent with good medical practice (s 103 POA). The provision of legal protection for clinicians in legislation will support clinicians in implementing advance directives and allay concerns about their legal exposure.

6. Conclusion

This paper has provided an overview of the regulation of ECT and PADs (and the overlap between the two) in Australia, has highlighted some issues with that legislation, and has made some suggestions for reform. It has distinguished legally recognized advance directives from informal clinical practice tools, provided a brief history of how PADs have emerged from the anti-psychiatry and consumer/user movements and considered their place in the international human rights context. It has also explained the stricter regulation of ECT in every state and territory of Australia bar Tasmania since the 1970s and 1980s which reflects consumer/user and community concerns about ECT as an invasive treatment. Within that context, PADs can play an important role in allowing patients to refuse or consent to ECT in advance while they still have decision-making capacity. However, Australian legislation in relation to PADs is often unclear and confusing and quite different for persons with physical and mental health problems. No state or territory permits compulsory patients to make binding PADs, although in the ACT the Tribunal cannot make an order for ECT where a person has refused it in an advance consent decision. Future reforms could involve simplifying the relevant legislation, creating partially binding PADs especially for consenting to and refusing ECT, improving the provision of information, support and clinical involvement in the making of PADs, giving patients like Mary the choice to make a self-binding directive, clarifying that consent to ECT includes consent to everything necessary to be able to safely give ECT, including anesthesia, improving Tribunal processes, and increasing legal protection for clinicians following PADs. Given the issues with mental health legislation this paper has identified, it is not surprising that PADs are underutilized in mental health in Australia. Yet, they remain a positive legal tool to increase patient participation and reduce coercion in psychiatry.

Recommendations
Creation of partially binding PAD – for consenting to and refusing ECT
Improvement in the provision of information, support and clinical involvement in the making of PADs
Providing choice to patients to make a self-binding directive
Clarifying that ECT consent includes consent to everything necessary to be able to safely give ECT including anesthesia
Improvement of Tribunal processes
Increasing legal protection for clinicians following PADs

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