Mental Health and Related Services Act 1998

Section 66

Approved procedure number 12

Electroconvulsive Therapy (ECT)

Target Audience	Approved Treatment Facilities under the Mental Health and Related Services Act; Approved Treatment Agencies under the Mental Health and Related Services Act
Jurisdiction	Northern Territory
Document Owner	Chair Mental Health and Related Services Act Approved Procedures and Quality Assurance Committee
Approval Authority	Chief Executive
Author	Approved Procedures and Quality Assurance Committee

Purpose

To outline the requirements for compliance with section 66 of the Mental Health and Related Services Act 1998 (the Act), and provide guidance to the legislative requirements relating to the performance of Electroconvulsive Therapy (ECT).

Note:

Proceedings for professional misconduct, unsatisfactory professional performance or unprofessional conduct may be taken against a medical practitioner under the Health Practitioner Regulation National Law because of a contravention of section 66 of the *Mental Health and Related Services Act 1998*. Under section 243 of Health Practitioner Regulation National Law, disciplinary proceedings may be taken under the Law irrespective of whether proceedings for the offence have been taken.

Introduction

ECT is a procedure performed under general anaesthesia and muscle relaxation in which modified seizures, induced by the selective passage of an electrical current through the brain are used for therapeutic purposes. ECT is most commonly prescribed for the treatment of severe depression, but may also be used for other types of serious mental illness such as mania, schizophrenia, catatonia and other neuropsychiatric conditions. It is most often prescribed as part of a treatment regime in combination with other therapies.

The nature of ECT and the history associated with its use means that some patients may experience distress or fear when it is proposed as an appropriate treatment. However, there have been significant

advances in the technology and knowledge about ECT and studies support its use as a safe and effective psychiatric treatment. Guidelines to clinical practice published by organisations such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian and New Zealand College of Anaesthetists (ANZCA) have contributed to the high standards now associated with the treatment.

(a) Government regulation plays a major role in setting standards for the performance of ECT and the Act contains detailed legislative provisions regulating consent to treatment, the elements of informed consent and the circumstances under which ECT may be performed without informed consent.

Practice Note:

The decision to recommend the use of ECT must always be based on a thorough physical and psychological evaluation of the individual person, which takes into account:

- the illness;
- the person's history; and
- the degree of the person's distress and suffering.

The person must receive, in the week prior to the commencement of a course of ECT a full physical examination, including:

- an Echocardiogram (ECG);
- pathological testing including a Full Blood Count (FBC), Liver Function Tests (LFT), Renal Function Tests, and other tests as indicated;
- a chest X-ray (if indicated); and/or
- a computed tomography (CT) scan (if indicated).

The person must also receive a full anaesthetic review prior to commencement of ECT in order to ensure anaesthetic safety.

Specific medical conditions should also be reviewed with regard to any hazard that ECT may present.

Current medications must be reviewed to determine compatibility with ECT.

Informed consent

Section 7(2) of the Act states that informed consent is given when:

(a) the person's consent is freely and voluntarily given without any inducement being offered;
(b) the person is capable of understanding the effects of giving consent; and
(c) the person communicates his or her consent on the approved form.

Section 7(3) of the Act states that a person can give informed consent only when he or she has been given:

(a) a clear explanation of the assessment and possible diagnosis, the nature of the proposed treatment, including sufficient information about the type of treatment, its purpose and likely duration to permit the person to make a balanced judgment regarding undertaking it; and
(b) an adequate description, without concealment, exaggeration or distortion, of the benefits, discomforts and risks associated with the treatment; and
(c) an adequate description of any appropriate alternative form of treatment that is reasonably available; and

(d) a clear answer to all relevant questions asked by the person (and the answer has been understood by the person); and

(e) advice that the treatment may be refused or consent may be withdrawn at any time while the treatment is being undertaken; and

(f) advice that independent legal or medical advice may be obtained in relation to the treatment before giving consent (and reasonable assistance is provided to obtain that advice, if requested); and

(g) advice of all rights of review and appeal under this Act (available from the Department of Health internet site); and

(h) advice of any relevant financial advantage that may be gained by a medical practitioner proposing the treatment and by the approved treatment facility or approved treatment agency where the treatment is to be undertaken; and

(i) advice of any relevant research relationship between a medical practitioner proposing the treatment and the approved treatment facility or approved treatment agency where the treatment is to be undertaken; and

(j) explanations, descriptions and advice in a manner or form that the person is used to communicating in (and due regard is to be given to age, culture, disability, impairment and any other factors that may influence the person understanding the explanation).

Section 7(4) states that the person must be given adequate time to consider the information provided under section 7(3) (listed above) before being asked to give his or her informed consent.

If a person is unable to communicate adequately in English but is able to communicate adequately in another language, they are to be assisted by a competent interpreter- see section 7(5).

Section 7(6) allows for the person, whose informed consent is being sought to request that another person be present while the informed consent is obtained.

Procedure

Requirements under the Act

Consent to treatment

Section 66(1) states that it is an offence to perform ECT unless:

(a) the person has given informed consent to the treatment; or

(b) informed consent for the treatment is obtained from an adult guardian or decision maker for the person, or from the Civil and Administrative Tribunal in accordance with Part 4 of the *Advance Personal Planning Act 2013*.

Practice Note: Advance Personal Plans and enduring power of attorney

When considering, consent for ECT, a reasonable attempt must be made to determine whether the person has an Advance Personal Plan or enduring power of attorney in place. If so, there may be provisions that impact upon medical or other clinical management and care for the person.

Checks must therefore be made with the person' family, the public trustee and within hospital records. If such a document is in place, it must be examined to determine if:

(a) there is a decision maker appointed (which there will be with a power of attorney); and

(b) if they are appointed to make decisions in relation to medical treatment.

If there is no decision maker appointed in an Advance Personal Plan, the direction the patient has given in that document in relation to medical treatment must be considered and their wishes followed as applicable.

If the matter is to go before the Tribunal, the documentation provided to the Tribunal is to include any relevant details of the Advance Personal Plan and power of attorney.

Practice Note: Recording consent

Where a patient is willing to give informed consent, **Form 26 - Electroconvulsive Therapy (ECT) Informed Consent** must be signed by the patient and a witness. The signed form is to be placed on the patient's clinical record.

In signing **Form 26 - Electroconvulsive Therapy (ECT) Informed Consent**, a patient gives consent to receive up to 12 treatments of ECT. This information must also be included in the patient's Individual Care Plan. If additional treatments are required consent is required for each individual treatment.

A person who has given informed consent, can withdraw it at any time. If consent has been withdrawn, the initial consent form is cancelled. All consent forms that have become invalid because the person has withdrawn consent must be clearly marked as cancelled. Where the person withdraws consent he or she must receive a clear explanation (recorded in the person's clinical record) of the likely consequences of not receiving the treatment.

Fresh consent is then required before further treatment can be carried out or reinstated. Should consent be once again obtained another **Form 26 Electroconvulsive Therapy (ECT) Informed Consent** will need to be completed.

Where a patient is not able to or not willing to give consent to ECT, other treatment options should be pursued. If no other treatment option is applicable, advice and/or consent must be sought from the Tribunal.

Where an adult guardian or nominated decision maker consents to the treatment, **Form 27 Electroconvulsive Therapy (ECT) Authorisation or Notification** must be completed.

ECT Without Consent

Authorisation for ECT by the Tribunal

Under the provisions of section 66(2), the Tribunal may authorise ECT to be performed on a person if it:

(a) is satisfied that the person is unable to give informed consent to the treatment; and

(b) receives a report from two authorised psychiatric practitioners (APPs) that they are satisfied, after considering;

- the person's clinical condition,
- history of treatment, and
- other appropriate alternative treatments,

that ECT is a reasonable and proper treatment to be administered and that without the treatment the person is likely to suffer serious mental or physical deterioration; and

(c) is satisfied that:

(i) all reasonable efforts have been made to consult the person's primary carer; or

(ii) there is a valid reason for not complying with subparagraph (i).

Practice Note: Cultural considerations:

It is important to understand the cultural context in which patients consent to, or refuse, ECT. There may be specific beliefs in certain cultures surrounding electricity and touching of the head that can prevent patients from accepting ECT as a form of treatment.

Another barrier occurs in refugees and immigrant populations who may have experienced incarceration for political reasons in psychiatric institutions and who have been subjected to ECT involuntarily without psychiatric indication. Survivors of torture, who have been subjected to electrical shocks, may also resist the notion of ECT.

The reluctance to proceed with ECT on a voluntary basis is unfortunate but must be respected in these circumstances, even though these individuals may benefit significantly from ECT in treating mood and psychotic disorders that have developed as a complication of trauma or migration (National Institute for Clinical Excellence, UK 2003).

Practice Note: Application to the Tribunal for authorisation

If ECT is considered necessary, but non-urgent, two APPs must apply to the Tribunal via **Form 27 Electroconvulsive Therapy (ECT) Authorisation or Notification**.

The Act requires that the two APPs must be of the view that ECT has clinical merit, that all alternative treatments have been considered and that ECT is appropriate in the circumstances, that without ECT the patient is likely to suffer serious mental and physical deterioration.

The assessing APPs must also satisfy the Tribunal that reasonable efforts have been made to consult the person's primary carer in relation to the treatment, or that there is a valid reason for not consulting the person's primary carer.

The Tribunal sits on Wednesday in Darwin and Friday in Alice Springs.

If the Tribunal gives approval, the course of ECT treatments may proceed according to the procedural guidelines of the premises that is licensed to undertake ECT. When the Tribunal authorises the administration of ECT on the person's behalf, it will issue its authorisation in writing by signing off on **Form 27 Electroconvulsive Therapy (ECT) Authorisation or Notification**.

If the Tribunal does not approve the course of ECT, the APP should then explore and recommend other treatment options.

Treatment in the case of an emergency on an involuntary patient

Section 66(3) allows for ECT to be performed on a person who is an involuntary patient, where two APPs are satisfied that it is immediately necessary:

(a) to save the person's life; or
(b) to prevent the person suffering serious mental or physical deterioration; or
(c) to relieve severe distress.

Sections 66(4) and (5) requires that where ECT is performed under subsection (3), the APPs must provide a report to the Tribunal of the therapy performed as soon as practicable after it is performed. The report is to contain:

(a) the reasons why the authorisation of the Tribunal was not obtained;
(b) the number of treatments performed;
(c) the person's response to the treatment; and
(d) details of any significant side effects of the treatment on the person.

Practice Note: Notification to the Tribunal following emergency ECT

If two APPs are of the view that ECT is immediately necessary under the provisions of section 66(3), it can be provided to the person without the Tribunal's advance approval. Emergency ECT is only performed on rare occasions, where patients have such severe mental illness that delay may cause significant psychiatric and/or physical consequences and exacerbate acute distress.

Where emergency ECT is performed, the two APPs must make the report to the Tribunal via **Form 27 Electroconvulsive Therapy (ECT) Authorisation or Notification** as soon as practicable and no later than 24 hours after treatment has been provided. The tribunal is to be separately notified following each occasion of emergency ECT treatment.

It should be explicitly noted that the notification on emergency grounds does not permit ongoing ECT (more than one) and that an application to Tribunal should be made (where informed consent cannot be obtained due to sedation/intubation) before the next ECT is administered by requesting an urgent Tribunal listing.

Form 27 has been designed to allow clinicians to apply to the Tribunal for authorisation for further ECT at the same time as notification of emergency treatment.

A sedated/intubated person is highly vulnerable as their response to ECT is unable to be adequately assessed if they remain sedated/intubated.

APPs are to ensure that the level of protection of patient rights intended by section 66 of the MHRSA including:

- the need for every episode of emergency ECT performed under section 66(3) to be individually reported to the Tribunal as soon as practicable, and
- the need for consultation with the patient's primary carer

has been observed and related actions and decisions are to be adequately documented in the patient's clinical records including the bases for clinical decision making and plans for treatment and management.

Performing ECT

Under the requirements of section 66(6), at least two medical practitioners are to be present when ECT is performed, one of which is to be experienced and trained in accordance with approved procedures in performing ECT and one is to be experienced in administering anaesthesia.

Practice Note:

Prior to ECT, unit staff must ensure the following:

- unless it is under emergency conditions, the consent form is signed by the person, adult guardian, nominated decision maker or authorisation has been provided by the Tribunal;
- previous ECT history is recorded;
- baseline vital signs are recorded; and
- all required documentation is completed.

Only staff that have been trained in the administration of ECT as recommended by the RANZCP and ANZCA are to administer ECT.

Licensing of premises

ECT must only be performed in an approved treatment facility or premises licensed under section 67. Refer to procedure **12A – Electroconvulsive Therapy (ECT) Licensing of Premises** for further information.

Operational requirements not prescribed by the Act

Post ECT Care

Recovery

Following the administration of ECT, the patient should be recovered in an appropriately equipped recovery room. A Registered Nurse trained in recovery techniques should be present at all times. The Registered Nurse should monitor the patient's airway as well as their pulse rate, blood pressure, any tardive seizures, oxygen saturation and their level of consciousness and orientation should also be assessed. All observations must be documented in an appropriate ECT chart or clinical record. As an inpatient the person should stay in the recovery room until alert and orientated, and observations are within the person's pre-ECT parameters.

Management of adverse effects

Headache, myalgia, nausea and drowsiness are self-limiting and require symptomatic and supportive treatment. The person should be advised not to exercise vigorously following ECT.

Post-ECT delirium

If post-ECT delirium is mild, close nursing supervision and support may be the only measures required.

If it is severe, there should be consultation with the anaesthetist and medication given, this may include psychotropic medication.

If it is persistent, physical investigations should be considered, and status epilepticus needs to be excluded by an electroencephalogram (EEG).

The intravenous access should be left in situ until recovery is achieved.

Means of reducing the risk of delirium should be considered, including altered electrode placement, ultra-brief pulse width, a reduction in ECT frequency and minimising the use of psychotropic medications.

ECT Treatment Record

Each person receiving ECT must have all the following information recorded in their Treatment Record:

- name, (Hospital) record number, sex and date of birth;
- diagnosis for which ECT is prescribed;
- nature of the consent given;
- status under the Act;
- presence of an advance health directive;
- medical and surgical history;
- blood pressure, physical examination and investigation results;
- the initial stimulus dose and electrode placement; and
- the required frequency of prescribed ECT, with each treatment to be signed and dated by the treating doctor.

For each treatment received, the following details must be recorded:

- names of the doctors giving the anaesthetic and the ECT;
- placement of electrodes;
- doses of anaesthetic and relaxant medications given stimulus dose (including, where relevant, pulse width, frequency, duration and current);
- duration of the seizure;
- description of the motor response/movement and EEG seizure;
- recommendation of dosing for the next treatment/s;
- the signature of the ECT operator and the anaesthetist; and
- any untoward events.

Other Documentation

In addition to the statutory requirements for documentation, good clinical practice requires that the clinical record show documentation of the requirements of professional standards of practice, guidelines and relevant local policy and procedures, including:

- a treatment plan;
- the rationale for the proposed ECT;
- details of the process of gaining consent;
- details of any second opinions, where applicable;
- details of the practitioner who performed the ECT; and
- the person's response to the treatment and risk assessment.

Where a substitute decision maker has given consent to the non-psychiatric treatment, a copy of the relevant document or order giving authority for the person to consent to the treatment (for example, a guardianship order or some other evidence of the person's power to give consent) should be in the clinical record.

Document Quality Assurance

	Method	Responsibility
Implementation	Document will be accessible via the MHARS Act internet and intranet pages and the PGC.	Senior Compliance and Clinical Policy Co-ordinator MHAOD Branch
Review	Document will be reviewed within a period of 4 years.	Approved Procedures Quality Assurance Committee
Evaluation	Document will be informally evaluated at time of review.	Approved Procedures Quality Assurance Committee

Key Associated Documents

All related material produced by the Northern Territory Department of Health is available from:
https://health.nt.gov.au/professionals/mental-health-information-for-health-professional

Mental Health and Related Services (MHARS) Act 1998 – available from:
https://legislation.nt.gov.au/en/LegislationPortal/Acts/By-Title#

Definitions and Search Terms

Preferred Term	Description
ANZCA	Australian and New Zealand College of Anaesthetists
APP	Authorised Psychiatric Practitioner
ECT	Electroconvulsive Therapy is the application of an alternating current at a frequency of 50 - 60 cycles per second, ranging from 70 to 150 volts, for a period of 0.1 to 1.0 seconds. If the voltage is above 70 volts it produces a seizure that is similar to a grand mal epileptic seizure and lasts 30 - 60 seconds (Coles, 1982). ECT is a recognised standard medical treatment, used for the treatment of various disorders pursuant to s66 of the Act.
Informed Consent	Consent that meets the provisions of section 7 of the Mental Health and Related Services Act 1998, as described in the content of this procedure.
MHARS Act	*Mental Health and Related Services Act 1998*
Nominated decision maker	Someone nominated by a person to make decisions on their behalf under an Advance Personal Plan or enduring Power of Attorney.
Occupier	Occupier of premises includes a person who occupies or has control of the premises, whether or not the person is the owner of the premises.
Patient	A person who is being assessed or receiving treatment under the Mental Health and Related Services Act 1998
RANZCP	Royal Australian and New Zealand College of Psychiatrists

Alternative Search Terms

Attachment A - ECT flowchart