Electroconvulsive Therapy

Chief Psychiatrist Standard

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Government of South Australia
SA Health

Contents

Electroconvulsive Therapy Chief Psychiatrist Standard

1. Introduction

The purpose of the *Electroconvulsive Therapy Chief Psychiatrist Standard* (the Standard) is to outline the requirements for the administration of Electroconvulsive Therapy (ECT) in South Australia, within the framework of the companion document SA Health *Electroconvulsive Therapy Policy Guideline*.

This Standard has been prepared under the objects and principles of the *Mental Health Act 2009*.

The principle objects of the *Mental Health Act 2009* are:

- to ensure that persons with severe mental illness receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with the goal of bringing about their recovery as far as is possible; and

- for persons with mental illness to retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services.

This Standard does not address the use of restrictive practice to administer ECT, and the effect of an Advance Care Directive refusing ECT. Refer to the Office of the Chief Psychiatrist for current advice.

2. Roles and Responsibilities

This Standard applies to all those involved in the administration and operation of the *Mental Health Act 2009* across public and private settings. Responsibility for implementing the Standard applies to clinicians, clinical leaders, and leaders who make policy, strategic and operational decisions.

Refer to the SA Health *Electroconvulsive Therapy Policy Guideline* for further information on roles and responsibilities.

Services, managers and clinicians will be guided by the following principles in the provision of ECT:

- ECT services should be designed to bring about the best therapeutic outcomes for patients and, as far as possible, their recovery and participation in community life;
- ECT services should be guided by evidence-based best-clinical practice;
- ECT should be provided on a voluntary basis whenever possible;
- There should be regular medical examination of every patient's mental and physical health;
- The needs of patients, their families and carers including cultural and linguistic requirements should be considered to provide treatment that is accessible and responsive to these specific needs;
- Patients, and their families and carers, should be provided with information about their illness, treatment options and rights, unless there are specific reasons that mean it is not practicable and safe to do so; and
- All aspects of the provision of ECT should be documented.

Review of the operation of this Standard is the responsibility of the Chief Psychiatrist.

3. Electroconvulsive Therapy – Chief Psychiatrist Standard

The Standard is mandatory for public hospitals incorporated under the *Health Care Act 2008* and private hospitals licensed under the *Health Care Act 2008* that administer ECT. Each standard herein contains the required elements of practice, within the framework of the companion document: SA Health *Electroconvulsive Therapy Policy Guideline*.

3.1 Standard 1 – Indications for ECT

3.1.1 The indications for the use of ECT must be clearly documented in the patient's record. This documentation must include the diagnosis, target symptoms, and the reason for choice of ECT.

3.1.2 A second opinion from a psychiatrist experienced in the practice of ECT must be sought:

- When there is any uncertainty about the recommendation of ECT; and
- When ECT is being considered for treatment of indications other than those listed at 3.1.1 – 3.1.7 of the *Electroconvulsive Therapy Policy Guideline (2019)*.

3.2 Standard 2 – Adverse Effects of ECT

3.2.1 The clinician must conduct a comprehensive assessment of the risks and the expected benefits of ECT for every patient. This risk assessment must be documented and include the actions taken to manage and minimise these risks.

2.2 All patients receiving ECT must undergo a clinical assessment of cognitive function and memory capacity prior to ECT, during a course of ECT, and at the completion of the course.

2.3 Assessments must include a patient assessment of quality of life (QoL) that monitors the patient's perspective of the outcomes of ECT treatment for them.

2.4 These assessments should include recognised and standardised clinical assessment tools where appropriate.

2.5 These assessments and monitored outcomes of the patient's clinical progress must be documented in the patient's record.

2.6 Unusual levels of confusion or memory problems identified during the ECT course must prompt a review of ECT prescription and technique and be discussed with the patient, their carer(s) or substitute decision-maker(s).

3.3 Standard 3 – Consent and Legal Framework

3.3.1 The administration of ECT must comply with the provisions of the *Mental Health Act 2009*.

3.3.2 Consent for ECT must be in writing on the relevant form (MRMHA-L- Consent for ECT or MRMHA-M-Emergency ECT without Consent), and be both informed and effective.

3.3.3 A competent adult has the right to complete an Advance Care Directive in regards to their consent to ECT in accordance with the *Advance Care Directives Act 2013*.

3.3.4 An Advance Care Directive may include written instructions about the patient's wishes to receive or not to receive ECT treatment in the event that their decision-making capacity to consent to ECT is impaired in the future.

3.3.5 Where a person is incapable of making a decision and has an Advance Care Directive, consent must be provided by all substitute decision-makers (if there is more than one) appointed in an Advance Care Directive or, by the South Australian Civil and Administrative Tribunal.

3.4 Standard 4 – ECT Facilities

3.4.1 Each ECT facility will also comply with:

- *Health Care Act 2008*
- *Mental Health Act 2009* noting the role of the Prescribed Psychiatric Treatment Panel to conduct a review of the progress of a person where they have had 3 or more courses of ECT in a 12 month period or 2 or more emergency ECT episodes within a 12 month period
- *Advance Care Directives Act 2013*
- National Standards for Mental Health Services 2010
- National Safety and Quality Health Service Standards (Second edition) 2017
- National Safety and Quality Health Service User Guide for Health Services Providing Care for People with Mental Health Issues 2018
- National Practice Standards for the Mental Health Workforce 2013
- Relevant standards of professional bodies
- SA Health, Local Health Network and/or private health care provider requirements.

3.5 Standard 5 – Preparing the Patient for ECT

3.5.1 A pre-ECT work-up must be completed and documented to include a thorough history, physical examination, clinically relevant investigations and specialist consultations.

3.5.2 An anaesthetic assessment of the patient is mandatory.

3.5.3 All medications must be reviewed and adjusted as appropriate prior to commencing a course of ECT.

3.5.4 A check list of pre-ECT procedures and observations must be completed before each treatment.

3.5.5 If restraint is required, contact the Office of the Chief Psychiatrist for advice.

3.6 Standard 6 – Administration of ECT

3.6.1 Clinical decisions must be in accordance with evidence-based guidelines regarding the placement of ECT electrodes, stimulus parameters and electrical dosage for each patient, and adjusted on measured treatment efficacy and cognitive outcomes.

3.6.2 ECT treatment may only be administered to an anaesthetised patient.

3.6.3 The ECT machine must have EEG monitoring capacity, be maintained in good working order and serviced according to the manufacturer's service guidelines which is at least every 12 months.

3.6.4 Sine-wave ECT is not to be used.

3.6.5 EEG monitoring should be routinely performed and EEG reports easily accessible to review the treatment course and guide clinical decisions about dosing.

3.6.6 A time-out process ensuring that the "correct patient, correct procedure, correct site" must be undertaken during the ECT procedure.

3.6.7 A minimum of three people must be present at the treatment:

- A medical officer appropriately trained and credentialed in ECT
- A medical officer appropriately trained and skilled in anaesthesia; and
- A nurse trained and credentialed in anaesthetic and resuscitation techniques.

3.7 Standard 7 – Anaesthesia for ECT

3.7.1 A medical officer appropriately trained and skilled in anaesthesia (consultant anaesthetists or anaesthetic registrar) must be responsible for anaesthetic assessment prior to ECT and for administration of the anaesthesia during the delivery of ECT and for monitoring recovery.

3.7.2 The anaesthetic applied must be documented in the patient record in accordance with guidelines of the Australian and New Zealand College of Anaesthetists.

3.8 Standard 8 – ECT in Children and Adolescents

3.8.1 All young patients must have a comprehensive medical assessment and a psychiatric assessment.

3.8.2 A specialist in child and adolescent psychiatry must conduct a direct assessment to recommend ECT, or be consulted in an emergency situation when direct assessment is not possible.

3.8.3 Consent for treatment for children under the age of 16 years must be given by a parent or legal guardian. The ECT procedure must be clearly explained to the patient and family.

3.8.4 A person aged 16 years of age and over can consent to treatment. Gaining informed and effective consent requires specific attention and careful consideration of the patient's age and capability and based on these, appropriate communication.

3.9 Standard 9 – Continuation and Maintenance ECT

3.9.1 Continuation and maintenance ECT should only be considered in patients:

- who have shown improvements as a result of an initial course of ECT; and
- where there is a history of relapse despite adequate pharmacotherapy;
- where the patient has shown an intolerance of alternative treatments; or
- where the patient has stated a preference for ECT treatment.

3.9.2 ECT schedule, electrode placement, stimulus parameters and course duration must be tailored to each patient.

3.9.3 ECT treatment and the informed effective consent must be fully documented in the patient records.

3.9.4 The patient must be reviewed by the treating psychiatrist or a psychiatry registrar at regular intervals as clinically indicated, and no less frequently than 3 monthly. This review must be documented and include assessment and monitoring of the ECT treatment.

3.9.5 The patient must have an anaesthetic review at least every twelve (12) months.

3.9.6 Patients having outpatient ECT must be able to comply with following conditions:

- adherence with the ECT schedule
- not driving on the day of ECT treatment
- fasting prior to ECT treatment
- continuing to take appropriate medications; and
- after receiving ECT treatment, have a responsible person who can take the person home and stay with the patient for the recommended post-anaesthetic recovery time period.

3.10 Standard 10 – Training, Credentialing and Clinical Privileging

3.10.1 To be granted ECT clinical privileges at a particular site, the psychiatrist or advanced psychiatric trainee must be credentialed at that site and must demonstrate that they have achieved competence in the administration of ECT, and records must be maintained at each site.

3.10.2 To be eligible to train psychiatry registrars, supervise Entrustable Professional Activity (EPA) and credential other psychiatrists in ECT, the specialist psychiatrist must be ECT

credentialed, have achieved competence in the administration of ECT and hold privileging status at the particular site.

3.10.3 The ECT nurse coordinator must be credentialed in the administration of ECT in accordance with the SA Health ECT Policy Guideline.

3.10.4 ECT services in training hospitals should have mechanisms in place for the appropriate and required supervision of trainees.

3.11 Standard 11 – Nursing Coordination Requirements for ECT

3.11.1 The ECT nurse coordinator, in conjunction with the medical leader of the ECT service, will oversee the supervision, organisation and planning of all aspects of ECT delivery, evaluation and reporting requirements.

3.11.2 The ECT nurse coordinator ensures and may conduct the monitoring of patient outcomes and potential adverse effects of ECT - prior to ECT, during a course of ECT and at the completion of the course.

3.11.3 Dedicated hours must be provided by the hospital's administration for an identified ECT nurse coordinator, appropriate to the workload of the unit.

3.12 Standard 12 – ECT Facility Requirements

3.12.1 The Chief Psychiatrist Office will coordinate the formal inspection of all public and private ECT facilities in South Australia once every three years, and assess the facility according to ECT Facility Requirements Criteria in the SA Health ECT Policy Guideline *(3.12 – Guideline 12 – ECT Facility Requirements).*

3.12.2 The administration of ECT must include a continuous quality improvement framework and must meet National Safety and Quality Standards.

4. National Safety and Quality Health Service Standards

National Standard 1 Clinical Governance	National Standard 2 Partnering with Consumers	National Standard 3 Preventing & Controlling Healthcare-Associated Infection	National Standard 4 Medication Safety	National Standard 5 Comprehensive Care	National Standard 6 Communicating for Safety	National Standard 7 Blood Management	National Standard 8 Recognising & Responding to Acute Deterioration
☒	☒	☒	☒	☒	☒	☐	☒

This Standard is relevant to National Standards 1, 2, 3, 4, 5, 6 and 8, described in detail below.

Standard 1 – Clinical Governance
The clinical governance and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care and improve health outcomes for patients.

Standard 2 – Partnering with Consumers
The systems and strategies to create a person-centred health system by including patients in shared decision making, to ensure that patients are partners in their own care, and that consumers are involved in the development and design of quality health care.

Standard 3 – Preventing and Controlling Healthcare-Associated Infection
The systems are in place to support and promote prevention and control of healthcare-associated infections, and improve antimicrobial stewardship.

Standard 4 – Medication Safety
The systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed patients, and monitor use of the medicines.

Standard 5 – Comprehensive Care
The integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.

Standard 6 – Communicating for Safety
The systems and strategies for effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.

Standard 8 – Recognising and Responding to Acute Deterioration
The systems and processes to respond effectively to patients when their physical, mental health or cognitive condition deteriorates.

5. References, Resources and Related Documents

SA Health Electroconvulsive Therapy Policy Guideline

Mental Health Act 2009

MRMHA-L- Consent for ECT

MRMHA-M-Emergency ECT without Consent

6. Definitions

Definitions of specialist clinical and technical elements for the administration of ECT are included throughout the SA Health *Electroconvulsive Therapy Policy Guideline.*

7. Document Ownership and History

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