Information Sheet

Legal authority for the use of restrictive practice (force) to administer ECT treatment

This Information Sheet considers the provision of Electro-Convulsive Therapy (ECT) under section 42 of the *Mental Health Act 2009* (MHA) and the power to use restrictive practice (force) to administer ECT

Given the significance of the legal requirements under the MHA, and for the purpose of completeness, all steps are included, not only the specific requirements related to consent.

This information sheet replaces an earlier Memorandum issued to Chief Executive Officers in October 2019. Always check the OCP website for the latest version of this information sheet.

The focus of this information sheet is to explain legal authority for the use of restrictive practices for ECT. In practice the use of such restraint should be rare, and all steps should be taken to minimise and eliminate where possible the use of such practices.

One of the Guiding Principles of the *Mental Health Act 2009* is that ***restrictive practices should be used only as a last resort for safety reasons and not as a punishment or for the convenience of others.***

The Chief Psychiatrist Restraint Standards, aimed at eliminating and minimising restraint should also be followed.

Power to use restrictive practices (force) to administer ECT

The use of restrictive practices (force) to administer ECT cannot be authorised under the MHA but can be authorised by an order of the South Australian Civil and Administrative Tribunal (SACAT) pursuant to subsection 32(1)(c) of the Guardianship and Administration Act 1993 (GAA).

ECT can be administered **without the use of restrictive practices** when:

- The patient has a mental illness; **AND**
- ECT, or a course of ECT, has been authorised for treatment by a psychiatrist who has examined the patient: **AND**
- EITHER**:**
  - written consent has been given:
    - by the patient, if the patient is 16 years and over and has capacity (using Form MRMHA-L);
    - if the patient is 16 years and over but is incapable of making decisions on his or her own behalf:
      - and has an advanced care directive (ACD) which appoints a substitute decision maker – by each of their substitute decision maker(s) (using Form MRMHA-L) or SACAT (by way of an order under s. 42(1) of the MHA); or
      - in any other case, by a medical agent or guardian (using Form MRMHA-L or SACAT) or SACAT (by way of an order under subsection 42(1) of the MHA);
    - if the patient is under 16 years of age – by a parent or guardian; **AND**

  the patient complies with that consent; **OR**

- without consent if a psychiatrist considers that the patient has a mental illness of such a nature that administration of that particular episode of ECT is urgently needed for the patient's well-being and in the circumstances it is not practicable to obtain that consent (Form MRMHA-M) and the patient does not physically oppose the administration of the ECT.

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> The patient has a mental illness; **AND**

> ECT, or a course of ECT, has been authorised for treatment by a psychiatrist who has examined the patient: **AND**

> **EITHER**:

- written consent has been given by:
  - the patient (if the patient has capacity) (using Form MRMHA-L) Please note – this is mentioned for completeness. It would be highly unusual for a person to consent for treatment on one hand, and then require restraint for the administration of that treatment on the other, as the latter almost always would suggest a withdrawal of consent;
  - if the patient has an advanced care directive (ACD) which appoints a substitute decision maker – each of their substitute decision maker(s) (using Form MRMHA-L) or by SACAT order under s. 42(1) of the MHA
  - in any other care, by a medical agent or guardian (using Form MRMHA-L or SACAT) or a SACAT order under subsection 42(1) of the MHA; and
  - the patient complies with that consent; **OR**
- without consent if a psychiatrist considers that the patient has a mental illness of such a nature that administration of that particular episode of ECT is urgently needed for the patient's well-being and in the circumstances it is not practicable to obtain that consent (Form MRMHA-M); **AND**
- A guardian appointed under section 29 of the GAA, or a substitute decision maker appointed under an ACD, has made a section 32(1) special powers application under the GAA, **AND**
- SACAT has made a special powers order under section 32(1) of the GAA authorising the persons involved in the care of the patient to use such force as may be reasonably necessary for the purpose of ensuring proper medical treatment.

Note:

> The MHA provides extra protections for patients relating to prescribed psychiatric treatment, including ECT.

> Section 42 of the MHA, which describes the powers and functions relating to ECT, specifically states under subsection 42(4)(b) that consent to ECT does not include consent to the use of restrictive practice (force).

> Consent to ECT may be withdrawn at any time by the person by whom consent has been given.

> The power to use restrictive practice under MHA subsections 24(4), 28(3), 31(3) and 34A when a patient is subject to an Inpatient Treatment Order does not extend to administering prescribed psychiatric treatment.

> The power to use restrictive practice under MHA section 56 care and control does not extend to administering prescribed psychiatric treatment.

> Guardians and substitute decision-makers retain a role in decisions about the use of section 32(1)(c) special powers because it is only they who can apply to the Tribunal for an order under section 32(1)(c).

> Once an order for special powers is made, the treating team can use force as reasonably necessary to ensure proper medical treatment. Even so,

best practice and the MHA require the guardian or substitute decision maker to participate or be kept informed as is appropriate and practicable.

- With respect to guardianship and administration orders, it is understood SACAT will tailor an order to provide specificity to the patient's circumstances with appropriate flexibility, rather than make a broad order, as this reflects the need to make 'the least restrictive order consistent with the rights and personal autonomy of the person and consistent with his or her proper care and protection'.

The Office of the Chief Psychiatrist recognises the operational impact of the change to practice since the original memorandum was issued last year. The OCP would welcome information on the practicalities on both these matters, ahead of future formal consultation. Please address feedback via HealthOCP@sa.gov.au.

For additional information contact the Legislation and Policy Team on 8226 1091.

For more information about ECT principles and practices see the ECT Policy Guideline and ECT Chief Psychiatrist Standard now available on the OCP website.

https://www.chiefpsychiatrist.sa.gov.au

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For more information

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