



CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy

October 2015

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Foreword

The *Mental Health Act 2014* (MHA 2014) requires that all services that perform electroconvulsive therapy (ECT) in Western Australia (WA) be approved by the Chief Psychiatrist (CP) (s.544).

In preparation for this the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy 2011* were updated to ensure that they meet the requirements of the MHA 2014.

I am grateful for the review of these standards in 2014 by the WA Electroconvulsive Therapy and Neurostimulation Special Interest Group (WA ENSIG) and the Licensing and Accreditation Regulatory Unit (LARU).

LARU is responsible for:

- the licensing and monitoring of private hospitals in WA
- regulating accreditation in WA in both public and private hospitals
- ensuring that licensed facilities are safe and provide an appropriate environment of care consistent with the required legislation and minimum standards.

Mental health services (MHS) throughout WA must ensure that they comply with both the CP and LARU standards.

It is intended that these standards will be regularly reviewed and revised to maintain contemporary best practice for the delivery of ECT into the future.

The expectation is that services that perform ECT meet all of the standards to achieve the approval of the Chief Psychiatrist as required under Mental Health Act 2014 s.544:

Division 5 – Mental health services approved for electroconvulsive therapy

S.544. Chief Psychiatrist to approve mental health services

(1) The Chief Psychiatrist may, by order published in the Gazette, approve a mental health service as a mental health service at which electroconvulsive therapy can be performed.

(2) The order may specify any conditions subject to which electroconvulsive therapy can be performed.

(3) The Chief Psychiatrist may, by order published in the Gazette, amend or revoke an order published under subsection (1).

The standards are intended to apply to mental health services throughout Western Australia and must be read in conjunction with the *Chief Psychiatrist's Guide for the use of Electroconvulsive Therapy in Western Australia* (ECT Guide 2006) which provides details and discussion regarding the provision of ECT.

Guiding Principles for the Standards

- The promotion of safe and therapeutic, high quality treatment to patients;
- a focus on provision of information to patients and carers;
- a focus on involving the patient and where appropriate the carer in the patient's own treatment (patients should be involved in all decisions regarding their treatment and care, and as far as possible, given the opportunity to choose their treatment and setting);
- patients have the right to have their nominated carer involved in all aspects of their care when they choose to exercise that right;
- ECT treatment and support should be coordinated in a manner that ensures continuity of care for the patient between service providers and settings;
- a focus on the issue of informed consent and when ECT may be administered without the provision of consent;
- the promotion of therapeutic evaluation of ECT;
- awareness of best practice and continual quality improvement processes;
- ensure clinical practice is driven by evidence base where this exists; and
- compliance with all relevant legislation including the MHA 2014, consent to treatment and amendments and all related legislation which has been amended or subsequently replaced as relevant legislation.



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CHIEF PSYCHIATRIST

October 2015

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Definitions

ECT Interventionalist

must either be an RANZCP accredited psychiatrist trained in contemporary ECT practice, including the use of EEG monitoring, at a recognised ECT training program or a medical practitioner under supervision and will be the person administering the ECT treatment.

ECT Prescriber

Must be a psychiatrist who has a demonstrated understanding of ECT which includes:

- benefits,
- indications,
- contraindications,
- alternatives,
- the treatment methodology and process,
- any side-effects or possible adverse events, and
- what to expect, before, during and after the administration of the treatment.

ECT Nurse Coordinator

Will oversee the supervision, organisation and planning of all aspects of ECT delivery, evaluation and reporting requirements in collaboration with the medical leader of the ECT service. This must be a senior nurse who is currently a Registered Nurse (Division 1) with the Australian Health Practitioner Regulation Agency (AHPRA). In addition the person will be able to demonstrate recent, extensive clinical experience and competence specific to this role and work within their scope of practice.

ECT Nurse

Must have the necessary training and / or demonstrated experience to enable them to perform the various nursing roles required in the ECT suite, must be a Registered Nurse (Division 1) with AHPRA, have current CPR competency and work within their scope of practice.

Course

A course of ECT, including maintenance ECT, is provided as a number of treatments and electrode placement is to be specified. It is to be expected that changes to dosages are inherent in any initial consenting process (new consent is not required for dosage change unless that dosage represents unexpected significant variation from usual titration processes).

Standard 1: Rights and Responsibilities

The rights and responsibilities of patients being treated with ECT are lawfully observed and upheld by the MHS. These rights and responsibilities should be documented, applied and promoted throughout all phases of the treatment. The rights and responsibilities for patients and their carers must be recognised and respected.

- 1.1 ECT is administered in accordance with the MHA 2014.
- 1.2 The provision of ECT is subject to the informed consent of the voluntary patient and wherever possible, of the involuntary, mentally impaired accused (MIA) or child patient in accordance with the MHA 2014 Part 14 Division 1.
- 1.3 The MHS provides patients and their carers with written and verbal information/explanation that is culturally and linguistically appropriate, including an explanation of their rights and responsibilities regarding ECT in a way that is understandable to them. This should be verbally repeated at regular intervals throughout the treatment.
- 1.4 Voluntary patients should be made aware that they may withdraw consent at any time.
- 1.5 The MHS upholds the right of the patient to be a partner in all aspects of the administration of ECT.
- 1.6 The MHS upholds the right of the patient to have a personal support person involved in their care in accordance with the MHA 2014.
- 1.7 The MHS upholds the right of the patient to access advocacy services.
- 1.8 The MHS upholds the right of the patient to express complaints and grievances regarding the ECT and to have these grievances addressed by the MHS.
- 1.9 The MHS upholds the right of carers to be involved in the management of the patient's ECT treatment with the patient's informed consent.
- 1.10 Staff of the MHS should be aware of the rights and responsibilities of patients and carers, in relation to the provision and administration of ECT.

Standard 2: Safety

ECT is a safe, therapeutic medical procedure for the treatment of severe psychiatric disorders (RANZCP 2013). The MHS has a strong focus on safety in the provision of ECT.

- 2.1 The MHS promotes the optimal safety and wellbeing of the patient in all settings where ECT is administered.
- 2.2 There are policies and procedures which promote the safety of all patients administered ECT.
- 2.3 The psychiatrist prescribing ECT must be aware of and take into consideration the contraindications to the administration of ECT.
- 2.4 The anaesthetist must be informed by the psychiatrist and/or treating team as to any medical conditions or any other physical issue that may significantly affect risk or safety.
- 2.5 The MHS ensures that all equipment required for the administration of ECT, is of the required standard and maintained according to accepted standards.
- 2.6 The MHS ensures that appropriate safety strategies (which may include “team time outs”) are in place with regard to confirming the -
 - identification of the patient; and
 - the impending treatment including:
 - consent to treatment is current
 - electrode placement
 - ECT dosage settings
 - procedures to ensure that ECT is not administered pre-anaesthetic.
- 2.7 The MHS is responsible for ensuring that emergency equipment is maintained and situated close to treatment and recovery rooms.
- 2.8 All staff involved in the administration of ECT will be trained in the treatment processes including emergency procedures.
- 2.9 If ECT is not safe to administer the treatment must be ceased immediately.
- 2.10 The MHS conducts regular reviews of safety in all service settings where ECT is administered, including an environmental appraisal consistent with standard occupational health and safety practices, to minimise risks to patients and staff.

Standard 3: Informing Patients and Carers

Patients and carers are provided with appropriate information about the administration of ECT and have the opportunity to discuss their concerns and ask questions.

- 3.1 The MHS will provide written and verbal information about ECT to patients and, where nominated, their carers in plain English or where appropriate a language and format that enables the patient and carer to fully understand the reasons for the treatment, alternatives, the treatment methodology and process, any side-effects or possible adverse events and what to expect, before, during and after the administration of the treatment.
- 3.2 Patients who have the capacity to consent to ECT also need to separately consent to anaesthesia.
- 3.3 A voluntary patient should be informed and aware that consent is required for a course of ECT.
- 3.4 Voluntary patients should be informed that in consenting to a course of ECT they are able to withdraw consent at any time during treatment.
- 3.5 The MHS will provide the opportunity for a discussion between medical staff and the patient and the carer, advocate or support person, to explain the treatment and answer any questions.
- 3.6 The MHS will make every effort to provide to the patient, carer or personal support person any requested specific information regarding the treatment requested.
- 3.7 Provision of information should be in a variety of formats and could include pamphlets, guides, journal articles or digital media.
- 3.8 The MHS should, where requested by the patient or carer, enable the patient or carer to be provided with information external to the mental health facility.
- 3.9 A psychiatrist proposing continuation or maintenance ECT should explain to the patient the rationale for such proposed treatments, and discuss the evidence to justify its use in the patient's particular circumstances including alternatives to the treatment, and the possible risks and benefits of proceeding with each alternative.
- 3.10 The MHS will ensure that there is no coercive practice on obtaining consent by any staff member of that service.

Standard 4: Consent and administration of ECT without consent

ECT must only be administered either with informed consent from the voluntary patient or in compliance with the MHA 2014 under Part 21 Division 6. ECT cannot be administered to a child who has not reached 14 years of age (MHA 2014 s.194).

- 4.1 Where the patient has capacity to give informed consent (MHA 2014 Part 5, Divisions 1 & 2) that consent is actively sought from all patients prior to any ECT being given or any changes in care delivery are planned.
- 4.2 Patients should be given sufficient time and the ability to seek the view of others when deciding whether to consent to ECT (MHA 2014 s.20).
- 4.3 A valid informed consent must be obtained from voluntary patients and the patient advised of the right to withdraw consent at any time.
- 4.4 All consent forms used must comply with the services Consent to Treatment or equivalent policy.
- 4.5 In relation to patients who have capacity to provide consent, the appropriately endorsed process for consent to anaesthesia must be completed. In relation to involuntary patients, Mentally Impaired Accused (MIA) patients and all children who have reached 14 years of age but are under 18 years of age, Mental Health Tribunal (MHT) approval is required.
- 4.6 Consent for ECT cannot be provided for unlimited duration. A course of ECT, including maintenance ECT, is provided as a number of treatments and electrode placement is to be specified. It is to be expected that changes to dosages are inherent in any initial consenting process (new consent is not required for dosage change unless that dosage represents unexpected significant variation from usual titration processes).
- 4.7 Further consent is required with any specified new course of treatment.
- 4.8 The MHS is to ensure that consent is verbally confirmed prior to every treatment.
- 4.9 In the case of involuntary patients, MIAs and all children who have reached 14 years of age but are under 18 years of age the MHS must have a process in place that is compliant with MHA 2014 Part 14 Division 1 and ss.409-415 prior to ECT treatment. Engagement of the patient in shared decision making is encouraged.
- 4.10 The MHS must have a process in place that complies with MHA 2014 s.199 when intending to perform emergency ECT on adult involuntary and MIA patients.
- 4.11 If there is a change of status from involuntary to voluntary for adult patients informed consent must be obtained and documented in the patient's medical record prior to any further treatments being given.
- 4.12 Policies and procedures relating to consent for ECT must be available in ECT suites, wards, and relevant staff orientation manuals.
- 4.13 Information regarding consent must be documented in the patient's medical record.

Standard 5: Assessment

Prior to the administration of ECT a thorough assessment of the patient must be completed.

- 5.1 ECT must only be administered for a mental illness where there is a sufficient level of evidence of effectiveness and reasonable clinical indication.
- 5.2 Assessment must include any physical and psychological risks to the giving of ECT.
- 5.3 The patient's symptoms must be documented before a course of treatment commences, in order to be able to assess progress particularly in relation to specific target symptoms.
- 5.4 Appropriate caution must be exercised in determining any complicating factors or relative contraindications and managing those factors where relevant (ECT Guide 2006 2.2).
- 5.5 There must always be a pre-ECT evaluation which should include physical, psychological, neurological and other relevant investigations, and a full and complete examination of the patient must be completed and documented (ECT Guide 2006 2.4).
- 5.6 A medication review must be completed before the prescribing of ECT (ECT Guide 2006 4.3 and 4.4).
- 5.7 A nursing assessment must be completed prior to the administration of ECT (ECT Guide 2006 8.3 & 8.4).
- 5.8 An anaesthetists' assessment must be completed prior to the administration of ECT (ECT Guide 2006 9.2).
- 5.9 The need for continuation or maintenance ECT must be made in line with the therapeutic guidelines (ECT Guide 2006 chapter 7).
- 5.10 ECT clinical assessments for progress are to be performed and documented, and should be carried out before the course of ECT commences (as a baseline), following each treatment (with the exception that an individual stable on maintenance ECT may require less frequent review), and on any occasion suggesting complications of treatment and at the end of the course of treatment.
- 5.11 It is recommended that contemporary measurement tools are used to assist clinical assessment and analysis of treatment and side effects.

Standard 6: Treatment

ECT will be provided in a safe and therapeutic manner by competent and trained clinicians.

- 6.1 ECT must be administered either in an ECT suite or part of an operating/anaesthetic theatre equipped with correct equipment for the provision of ECT, the recovery of the patient and any emergency treatment that may be required.
- 6.2 Patients must be prepared for treatment (ECT Guide 2006 4.2 & 4.5.3).
- 6.3 ECT machines must be registered with the Therapeutic Goods Administration Medical Devices except where appropriate ethics approval has been received for research purposes.
- 6.4 The function of ECT machines is to be reviewed against current research evidence and updated when no longer able to meet best practice requirements.
- 6.5 The ECT machine must be equipped to provide EEG monitoring of the seizure and meet the requirements of ECT Guide 2006 4.5.2.
- 6.6 Treatment must include strategies in regard to placement of electrodes and stimulus dose (ECT Guide 2006 4.6 & 4.7).
- 6.7 Treatment must include monitoring of the seizure (ECT Guide 2006 4.8).
- 6.8 Treatment must include nursing management of the patient (ECT Guide 2006 8.5, 8.6 & 8.7).
- 6.9 Treatment must include anaesthetic management of the patient (ECT Guide 2006 9.3 & 9.5).
- 6.10 The use of multiple ECT (the delivery of more than one adequate seizure per treatment session) is not acceptable.
- 6.11 All clinicians involved in the administration of ECT must be trained, skilled and competent within the duties required of their discipline.
- 6.12 The MHS must maintain documentation of the training and competency of staff involved in the delivery of ECT.
- 6.13 The MHS must ensure that the clinicians who provide the treatment meet the defined criteria for credentialing and defining the scope of clinical practice.

Standard 7: Evaluation

The efficacy of the treatment must be evaluated and consideration given to adverse or side effects, results of the treatment and further requirement of the treatment.

- 7.1 The number of ECT treatments required by a patient in a course of treatment should be guided by the patient's progress and clinical improvement which should be documented in the patient's medical record.
- 7.2 There must be a comprehensive evaluation of the treatment (ECT Guide 2006 4.9).
- 7.3 Consideration in the evaluation must be given to the possibility of adverse or side-effects of the treatment (ECT Guide 2006 5.0) and where appropriate reported to the Chief Psychiatrist.
- 7.4 Patients should not automatically be considered to be non-responders until evaluated at the end of a course of treatment.
- 7.5 With regard to maintenance ECT the overall treatment plan should be reviewed at the end of a course of treatment.
- 7.6 There should be an evaluation of the nursing component of the treatment (ECT Guide 2006 7.0).
- 7.7 There should be an evaluation of the anaesthetic component of the treatment (ECT Guide 2006 9.0).
- 7.8 Following a comprehensive evaluation the plan of treatment should be updated or altered as required.
- 7.9 The MHS providing ECT has the responsibility of evaluating the quality and safety of their service (e.g. adverse events).

Standard 8: Documentation and Reporting

It is imperative that comprehensive documentation and reporting is maintained by any service providing ECT. Documentation not only provides a written record of the process but is essential in planning and evaluating treatment and managing complaints.

- 8.1 The person in charge of the approved ECT service must ensure that proper records are kept in line with MHA 2014 ss. 200, 201, 204, 410 & 582 and associated standards.
- 8.2 All facilities performing ECT should keep an ECT register for auditing purposes.
- 8.3 The consultant psychiatrist has overall responsibility for the quality and comprehensiveness of ECT documentation (ECT Guide 2006 section 6.1.4 for minimum documentation requirements).
- 8.4 Practitioners should record in the patient's medical record, in a clear and chronological manner, all relevant matters regarding the treatment.
- 8.5 Where possible standardised documentation should be used to promote consistency between services.
- 8.6 As part of quality improvement the MHS should conduct regular reviews or audits against these standards.
- 8.7 Where ECT delivery is an agreed action for another service there should be a clear agreement and corresponding documentation between the two services, which will maintain comprehensive and contemporaneous documentation.
- 8.8 MHS must ensure compliance with the requirement for the CP to approve all episodes of emergency ECT being performed (MHA 2014 s.199).
- 8.9 The Department of Health should receive coded data using the most recent version of the ICD 10 (AM) for each treatment from public MHS in accordance with Operation Directive 137/08 'Hospital Morbidity Data Reporting Cycle' and from private mental health services in accordance with their licencing agreement under the Hospitals and Health Services Act 1927 and Department of Health Hospital Morbidity Data System (HDMS) collection requirements (HDMS Reference Manual July 2014 – Appendix 10).

Standard 9: Ethical and professional responsibilities

All staff involved in the provision of ECT should have knowledge of the procedure, skills in providing the service and applied ethical standards which ensure that ECT is only used for the therapeutic treatment of persons who require this specific treatment.

- 9.1 Staff have a duty to report any unethical conduct in regard to the prescription and administration of ECT.
- 9.2 The MHS is to ensure that staff involved in the provision of ECT are credentialed or appropriately trained and experienced in discipline specific aspects of ECT.
- 9.3 The ECT prescriber (psychiatrist) must have a demonstrated understanding of ECT which includes:
 - benefits,
 - indications,
 - contraindications,
 - alternatives,
 - the treatment methodology and process,
 - any side-effects or possible adverse events, and
 - what to expect, before, during and after the administration of the treatment.
- 9.4 The ECT interventionalist must either be an RANZCP accredited psychiatrist trained in contemporary ECT practice, including the use of EEG monitoring, at a recognised ECT training program or a medical practitioner under supervision.
- 9.5 A psychiatrist who wishes to administer unsupervised ECT should first be able to demonstrate previous administration of a minimum of ten ECT treatments under direct supervision; administration of at least one patient through a course of ECT and certification of competence by an accredited ECT practitioner who has provided several directly supervised sessions including theoretical and practical discussions or attendance at a recognised ECT training programme.
- 9.6 The minimum requirements for a psychiatrist's ongoing accreditation or privileges to administer ECT without supervision should be performing or personally supervising a minimum of ten ECT treatments per annum and the ongoing ability to demonstrate contemporary best practice in ECT.
- 9.7 A medical practitioner who wishes to practice ECT with remote supervision should first be able to demonstrate previous administration of a minimum ten ECT treatments under direct supervision; administration of at least one patient through a course of ECT and certification of competence by an accredited ECT practitioner who has provided several directly supervised sessions including theoretical and practical discussions or attendance at a recognised ECT training programme.
- 9.8 The minimum requirements for a medical practitioner's ongoing accreditation to administer ECT with remote supervision should be performing a minimum of ten ECT treatments per annum and the ongoing ability to demonstrate contemporary best practice in ECT.
- 9.9 Trainees in psychiatry must satisfy the requirements of training in ECT set down by the RANZCP before being allowed to administer ECT with remote supervision.

- 9.10 The ECT Nurse Coordinator, in collaboration with the medical leader of the ECT service, will coordinate the organisation and planning of all aspects of ECT delivery, evaluation and reporting requirements. This must be a senior nurse who is currently a Registered Nurse (Division 1) with the Australian Health Practitioner Regulation Agency (AHPRA). In addition the person will be able to demonstrate recent, extensive clinical experience and competence specific to this role and work within their scope of practice. It is a requirement that they have completed a recognised ECT training course or intend to in the near future and must be current in cardiopulmonary resuscitation (CPR).
- 9.11 The ECT Nurse must have the necessary training and / or demonstrated experience to enable them to perform the various nursing roles required in the ECT suite, must be a Registered Nurse (Division 1) with AHPRA, have current CPR competency and work within their scope of practice. It is highly desirable that:
- a team of dedicated nurses work in the ECT suite on a regular basis to facilitate consistency and competency in ECT nursing processes
 - they have attended or received training in contemporary evidenced based ECT techniques, including:
 - electrode placement,
 - physiological modifications of induced seizures,
 - physiological monitoring during, in recovery and post ECT care.
- 9.12 Medical practitioners must have appropriate anaesthetic credentialing to administer anaesthesia for the purpose of ECT.

References

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- Chief Psychiatrist Practice standards for the administration of Electroconvulsive Therapy Office Of the Chief Psychiatrist 2011
- WA Health Consent to Treatment Policy 2011
- The ECT Guide: The Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in WA 2006
- Electroconvulsive therapy manual (Licensing, legal requirements and clinical guidelines) Victorian Government dept. of Mental Health 2009
- Electroconvulsive Therapy: ECT minimum Standard of Practice in NSW, Document number PD2011 003, 2011
- Chief Psychiatrist Standard: Compliance is Mandatory- Electroconvulsive Therapy Chief Psychiatrist Standard-Objective File Number: 2013-13690-Mental Health Strategy, Government of South Australia, 2014.
- Scottish ECT Accreditation Network (SEAN), SEAN Standards, Version V1.0 January 2010
- The Royal Australian and New Zealand College of Psychiatrists Clinical Memorandum #12 ELECTROCONVULSIVE THERAPY Guidelines on the administration of ECT. Revised 2007 ((GC1/07,R23)
- The Royal Australian & New Zealand College of Psychiatrists, Position Statement 74, Electroconvulsive Therapy (ECT), March 2014. Document Code: PS 74 PPP Electroconvulsive Therapy (ECT)
- Department of Health, W.A. Operational Directive 0137/08-File No: RSD 03414 Hospital Morbidity Data Reporting Cycle, 2008
- Department of Health Hospital Morbidity Data Systems (HDMS) Reference Manual July 2014 Appendix 10
- Hospital and Health Services Act 1927, Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987