CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist's Standard for Clinical Care

Chief Psychiatrist's Standards for the Administration of Electroconvulsive Therapy (ECT) in WA

Issued under section 547 of the
Western Australian *Mental Health Act 2014*

January 2025

Scope of this standard

This standard applies to all services approved by the Chief Psychiatrist to administer electroconvulsive therapy in Western Australia under the *Mental Health Act 2014* (*MHA 2014*).

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Version Control

Purpose	Statutory Requirement under the *MHA 2014*		
Relevant To	All services approved by the Chief Psychiatrist to administer Electroconvulsive Therapy in Western Australia		
Approval Authority	Dr Nathan Gibson, Chief Psychiatrist		
Effective Date	January 2025	**Review Date:**	As required
Enquiries Contact	Reception, Office of the Chief Psychiatrist Tel: 08 6553 0000		
Source Documents	*Mental Health Act 2014* Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy (2015) Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia (2024)		

Version	Date From	Date To	OCP Ref
2.0	January 2025	Current	OCP50679

Acknowledgements

We acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of our State and its waters. We pay our respects to Elders who were, who are, and who will be, and extend this to all Aboriginal and Torres Strait Islander peoples seeing this message.

We acknowledge the individual and collective expertise of those with a living or lived experience of mental health, alcohol, and other drug issues. We recognise their vital contribution at all levels, and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

We are committed to embracing diversity and eliminating all forms of discrimination in the provision of health and mental health services.

Table of contents

ECT in Western Australia

In WA, the *Mental Health Act 2014* (MHA 2014) provides the legal framework for all ECT treatment, and all ECT service provision in the state.

Electroconvulsive Therapy (ECT) is a therapeutic medical procedure used to treat severe psychiatric disorders. Its primary purpose is to rapidly relieve symptoms, especially in situations where other treatments have not worked, or are not fast acting enough.

It is a form of neurostimulation which involves the delivery of a small electrical current to the brain to induce a brief seizure for therapeutic purposes, while the patient is under anaesthetic. It is well established as a safe and effective evidence-based treatment for a range of conditions.

Statutory requirements

ECT services are highly regulated in Western Australia. In order for a mental health service to perform ECT, it must be approved by the Chief Psychiatrist (CP), with the order published in the Gazette (s. 544). The CP may also specify any conditions to the approval. The register of approved ECT services can be found on the Chief Psychiatrist's website.

To be approved, ECT services must be designed to meet:

- Statutory requirements under the MHA 2014 including:
    - Standards for the Administration of ECT in WA (these standards)
    - Chief Psychiatrist's Standards for Clinical Care
    - Chief Psychiatrist's Authorised Hospital Standards (where required)
- All relevant requirements of the National Safety and Quality Health Service (NSQHS) Standards Second Edition 2021.
- All relevant organisational policy frameworks.

These standards apply to all ECT services in Western Australia.

ECT must be provided in accordance with these standards and with reference to the Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2024 (ECT Guidelines).

ECT cannot be administered to a child who has not reached 14 years of age (MHA 2014 s. 194).

Performing ECT on another person except in accordance with MHA 2014 s. 194 to 199 is an offence and carries a potential penalty of $15,000 and imprisonment for 2 years.

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.

Rights

The Australian Charter of Healthcare Rights describes the rights that every person has when accessing health care.

Central to a person's rights is the ability to make decisions over their bodily integrity, which includes decisions about any treatment being provided to them.

Irrespective of a patient's legal status or capacity to provide valid informed consent, the wishes of the person must be considered when making treatment decisions (MHA 2014 s. 8 and 179).

Support person's rights are recognised in the *Carers Recognition Act (2004)* and the MHA 2014 Part 17.

The MHA 2014 provides a statutory framework for the rights of family members and support persons to be provided with information that is considered personal and confidential about treatment and be involved in care.

Refer to the ECT Guidelines Guideline 3.2 and 3.3 for further information.

Terminology

Consumer/patient

We have used the term “consumer” to refer to a person who has used or may use mental health services, and the term “patient” to refer to a person receiving treatment and when quoting from the MHA 2014, as this is the term used in the Act.

Support person

We have used the overarching term ‘support person’ to refer to a family member, carer, or personal support person for a mental health consumer.

Aboriginal

Within Western Australia, the term ‘Aboriginal’ is used in preference to ‘Aboriginal and Torres Strait Islander’, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to Torres Strait Islander colleagues and community.

Children

The MHA 2014 refers to anyone under the age of 18 as a child, so the term ‘child’ or ‘children’ has been used in preference to terms such as young person, when referring to anyone under 18.

Standard 1: ECT Service Delivery

ECT may only be administered in Western Australia in services that have been approved by the Chief Psychiatrist under s. 544 of the MHA 2014.

Services should be designed to be safe, effective, accessible, and inclusive for people of all cultures, languages, disabilities, ages, religions, sexualities, and gender identities. This should be achieved through partnership with individuals throughout their healthcare journey, and through meaningful codesign of services to make sure that they cater for the communities they serve.

Policy and procedures

1.1	The ECT service has policies and procedures which:
	a) Demonstrate how the service delivers ECT.
	b) Describe how the service monitors the safety and quality of the service, and ensures the wellbeing of the patient in all settings where ECT is administered.

Facility and equipment

Refer to ECT Guidelines Guideline 4.1.

1.2	ECT may only be administered in a dedicated ECT suite or in 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.
1.3	The ECT service ensures that all equipment required for the administration of ECT:
	a) Is of the required standard and maintained according to accepted standards.
	b) Is registered with the Therapeutic Goods Administration's Australian Register of Therapeutic Goods, except where appropriate ethics approval has been received for research purposes.
	c) Is equipped to provide EEG monitoring of the seizure and meet the requirements of the ECT Guidelines Guideline 4.1.4.
1.4	The ECT service ensures that emergency equipment is available, maintained and situated close to treatment and recovery rooms.

Staffing

Refer to ECT Guidelines Guideline 4.2.

1.5	The ECT service has a psychiatrist and a registered nurse with suitable ECT training and experience employed in designated roles as ECT Director and ECT Nurse Coordinator.
1.6	The ECT service has identified roles which have clear position descriptions, responsibilities, reporting lines and accountabilities.
1.7	The ECT service has processes in place to ensure that all staff involved in the administration of ECT receive suitable orientation to the service and have up to date training in ECT treatment including emergency procedures.
1.8	There is a robust credentialling process in place that provides assurance that:
	a) Any psychiatrist or medical practitioner providing ECT has sufficient training and skill to do so safely.
	b) Any medical practitioner providing anaesthesia has the appropriate skills and experience to administer anaesthesia for ECT.
1.9	Trainees in psychiatry satisfy the requirements of training in ECT set down by the RANZCP before being allowed to administer ECT with remote supervision.

Standard 2: Consent and the legal framework

ECT cannot be administered to a child who has not reached 14 years of age (MHA 2014 s.194).

ECT can only be administered either with informed consent from the voluntary patient, or in compliance with the MHA 2014 under Part 21 Division 6. The MHA 2014 s. 194 to 199 gives specific rules for consent to ECT depending on the age of the patient, and whether they are voluntary or involuntary.

Performing ECT on another person except in accordance with s. 194 to 199 is an offence and carries a potential penalty of $15,000 and imprisonment for 2 years.

The MHA 2014 requires that the patient or substitute decision-maker must be:

a) Provided with a full explanation of the proposed treatment and given information about it in a way or format that suits their needs and preferences.

b) Given sufficient time to consider the treatment decision.

c) Given the opportunity and sufficient time to obtain advice or assistance from anyone they wish to assist with their decision making, e.g., advocates, members of the treating team, Aboriginal mental health workers, Elders, other cultural support people.

The psychiatrist prescribing the ECT is responsible for ensuring that the patient has been provided with sufficient information (refer to ECT Guidelines Guideline 3.4.2).

Consent

Refer to ECT Guidelines Guideline 3.

2.1	The ECT service has a policy which describes the expected standard for obtaining consent for ECT. It includes:
	a) Process for adults who are voluntary patients.
	b) Process for children aged 14-17.
	c) Process where a guardian is providing consent on behalf of a person who lacks decision making capacity.
	d) Process for people subject to the MHA 2014.
	e) Process for people subject to the Criminal Law Mentally Impaired (CLMI) Act 2023.
	f) Steps to follow if there is a change of MHA 2014 status from involuntary to voluntary between treatments: *for adult patients informed consent must be obtained and documented in the patient's medical record prior to any further treatments being given.*

	g) Steps to follow if there is a change of MHA 2014 status from voluntary to involuntary between treatments: *approval from the Mental Health Tribunal (MHT) is required prior to further treatment, unless the emergency ECT provisions within the MHA 2014 apply.*
	h) Process for situations where the use of emergency ECT (MHA 2014 s. 199) is considered.
	i) How decision making is supported, and information is provided in a variety of formats and languages.
	j) How support people are included in the consent process.
2.2	The service can demonstrate that the process for obtaining informed consent ensures that:
	a) The number of treatments is specified. *Consent for ECT cannot be provided for unlimited duration. A course of ECT, including maintenance ECT, is provided as a number of treatments.*
	b) Electrode placement is specified.
	c) A new consent is obtained if, during a course of treatment, there are substantial changes to the treatment (e.g. electrode placement or wavelength).
	d) Further consent is obtained with any specified new course of treatment.
	e) Separate consent is obtained for the anaesthetic.
	f) The patient is advised of the right to withdraw consent at any time.
	g) Information regarding the consent process is documented in the patient's medical record.
2.3	The ECT service has mechanisms in place to ensure that all staff understand the MHA 2014 requirements for consent for ECT.
2.4	The ECT service ensures that psychiatrists and other medical practitioners prescribing ECT understand their obligations in regard to the Mental Health Tribunal; and provide adequate information to the Mental Health Tribunal to allow them to make a decision under Part 21 Division 6 of the MHA 2014.

Standard 3: Treatment provision

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

Refer to ECT Guidelines Guideline 5, 6, 7, 8, 9 and 10.

3.1	The ECT service has a policy for the provision of ECT treatment, which describes:
	a) How assessment is carried out and recorded.
	b) How cognitive side effects are assessed and monitored using standardised tools.
	c) How response to treatment is assessed and monitored.
	d) How handover occurs at all stages of the process where there is a change of team e.g. from ward to ECT suite and vice versa.
	e) How communication, handover and feedback take place between prescribing psychiatrist and ECT interventionist.
	f) How communication, handover and feedback take place between prescribing psychiatrist and anaesthetist.
	g) The process for seeking a second opinion if requested.
	h) Escalation processes.
3.2	A pre-ECT assessment is routinely completed and documented, and includes:
	a) A thorough medical history and examination.
	b) An ECG, serum electrolytes and all other relevant investigations.
	c) Any indicated specialist opinions.
	d) A dental assessment.
	e) A medication review.
	f) A nursing assessment.
	g) An anaesthetic assessment.
3.3	The ECT service has a procedure for a team time out which occurs for every ECT treatment before the anaesthetic and meets the minimum requirements set out in the ECT Guidelines Guideline 8.4.4.

Standard 4: Safety, quality and reporting

The ECT service must ensure that proper records are kept in line with MHA 2014 s. 200, 201, 204, 410, 582 and associated standards. Under s. 201 of the MHA 2014 the person in charge of a mental health service where ECT is performed, needs to provide monthly statistics on the use of ECT to the Chief Psychiatrist.

Refer to ECT Guidelines Guideline 4.3 and 4.4.

4.1	The ECT service has a clear governance structure with identified personnel accountable for safety and quality functions, and a format (e.g. ECT committee) to formally oversee it.
4.2	The ECT service has processes in place to:
	a) Monitor and review its clinical performance across all aspects of the patient journey.
	b) Benchmark its performance against comparable services.
	c) Identify and address areas for improvement.
4.3	The ECT service has processes in place to recognise, report and investigate clinical incidents, and to report notifiable incidents to the Chief Psychiatrist in accordance with the policies for mandatory reporting of notifiable incidents to the Chief Psychiatrist for Public Mental Health Services and Private Hospitals.
4.4	The ECT service maintains a comprehensive record of ECT treatments for reporting, benchmarking, and quality improvement purposes which includes:
	a) Demographics of people accessing the service (including but not limited to age, sex/gender, residential postcode, Aboriginal status).
	b) Diagnosis.
	c) Clinical outcomes.
	d) Cognitive side effects.
4.5	The ECT services has systems in place to monitor variation in ECT practice against expected outcomes, and to address unwarranted clinical variation.
4.6	The person in charge of the ECT service provides monthly statistics on the use of ECT to the Chief Psychiatrist in accordance with s.201 MHA 2014.
4.7	The ECT service documents in the medical record any instance where the Chief Psychiatrist or delegate approves the use of emergency ECT, and reports to the Chief Psychiatrist the number of emergency ECT approvals authorised and completed in the reported month.
4.8	The ECT service has systems to ensure that proper records are kept in line with MHA 2014 s. 200, 201, 204, 410,582 and associated standards.

Consumer feedback

4.9	The service actively and routinely seeks feedback and evaluation from consumers and support people and uses it to improve service delivery.
4.10	The service has a clear pathway for consumer complaints, and proactively ensures that consumers and support people are aware of the complaint pathways provided by the MHA 2014 either to the service directly or to the Health and Disability Service Complaints Office (HaDSCO).