The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Regulation of electroconvulsive treatment (ECT) in Australian and New Zealand Mental Health Acts

	ACT: Mental Health Act 2015 ss145, 149, 153–4, 156–7, 160–2	**NSW: Mental Health Act 2007** ss88–96, *ECT Minimum Standard of Practice NSW 2011*	**NT: Mental Health and Related Services Act 1998** s66	**QLD: Mental Health Act 2016** ss234–6, 507–9; *The Administration of Electroconvulsive Therapy 2018*	**SA: Mental Health Act 2009** ss42, 90; *ECT Chief Psychiatrist Standard 2014; ECT Policy Guideline 2014*	**TAS: Mental Health Act 2013**	**VIC: Mental Health Act 2014** ss91–99; *ECT Treatment: Chief Psychiatrist's Guideline 2019*	**WA: Mental Health Act 2014** ss192–199; 409–15; *Chief Psychiatrist's Guidelines for the use of ECT 2006*	**NZ: Mental Health Act (Compulsory Assessment and Treatment) Act 1992,** ss59–60, *Guidelines to MH Act 2012 10.4*
Definition of ECT	A procedure for the induction of an epileptiform convulsion in a person. ECT can be administered a maximum of 9 times per authorisation (3 in emergencies).	None listed. Ordinarily, ECT can be administered a maximum of 12 times in a 6 month period.	None listed.	Application of electric current to specific areas of the head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent for the treatment of a mental illness.	None listed in the Act. A patient may consent to a maximum of 12 episodes over three months; this total includes an episode used to determine correct doses in the future.	No reference to ECT in the Act or regulations.	Application of electric current to specific areas of a person's head to produce a generalised seizure. A *course* of ECT cannot exceed 12 treatments and must be performed within 6 months.	Treatment involving the application of electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent. 12 is the maximum that may be prescribed at a single time.	None listed. A course of ECT is roughly 12 episodes.
If informed consent is not given, who may apply to perform ECT?	Chief psychiatrist (CP) or a doctor.	Two medical practitioners (unless the medical superintendent of the facility refuses to allow it).	Two authorised psychiatric practitioners.	Psychiatrist (preferably with a second opinion from another consultant psychiatrist).	Medical practitioner or mental health clinician. If uncertain, or none of the 7 main indications apply, seek a second opinion from a psychiatrist.	N/A	Authorised psychiatrist.	Medical practitioner.	Responsible clinician.
Criteria the applicant must consider	If reasonable grounds exist to believe that ACAT could make an *electroconvulsive therapy order*, and the person lacks decision-making capacity (DMC) to consent to ECT. Also: a *psychiatric treatment order* (PTO) or a *forensic psychiatric treatment order* (FPTO) must also be in force.	Clinical condition, history of treatment, and any appropriate alternatives. Is ECT a reasonable and proper treatment and necessary or desirable for the safety or welfare of the patient?	Clinical condition, history of treatment and other appropriate alternatives. Is it a reasonable and proper treatment to be administered and are they likely to suffer serious mental or physical deterioration without it?	The most clinically appropriate treatment alternative for the person having regard to clinical condition and treatment history? Also: patient/family preferences, degree of suffering, need for rapid response, and risk/benefit compared to other treatments.	Mental illness must exist. Indications must be clearly documented in the patient's record. A comprehensive risk/benefit assessment must be carried out. Clinical assessment of cognitive and memory function must be carried out before/during/after.	N/A	Whether there is no less restrictive way to treat, having regard to: views and preferences (and the reasons they're held) of patient about ECT and any beneficial alternatives available; views of carer/parent etc; likely results if ECT is not performed; any second psychiatrist opinion.	Reasons for recommending ECT, and a treatment plan including number of treatments.	None listed in the Act. The guidelines refer to *RANZCP 2007 Clinical Memorandum #12: ECT*. This contains pre-ECT evaluation considerations, such as the necessity of a full medical history and physical examination (including a fundoscopy).
Who hears the application?	ACT Civil and Administrative Appeal Tribunal (ACAT).	Mental Health Review Tribunal (MHRT).	Mental Health Review Tribunal (MHRT).	Mental Health Review Tribunal (MHRT).	Psychiatrist, then the South Australian Civil and Administrative Tribunal.	N/A	Mental Health Tribunal (MHT).	Mental Health Tribunal (MHT).	Second psychiatrist (independent of requesting clinical team) appointed by Review Tribunal.
Criteria that must be considered when hearing the application	Whether the person consents, or has the DMC to consent; their views and wishes (including any advance statement); the views of carers, people at the hearing, any attorney, guardian or nominated person; any alternative treatment, care or support reasonably available; any relevant medical history.	Above criteria, and other info including: whether the patient understands the inquiry, what effect if any medication has on the patient's ability to communicate, and views of the patient and carer/parent.	Whether the person is unable to give informed consent, and whether all reasonable efforts have been made to consult the primary carer.	Whether: ECT is in the patient's best interests; evidence supports the effectiveness of ECT for the particular mental illness; effectiveness of any prior ECT; if a minor - effectiveness of ECT for persons that age.	None listed.	N/A	Above criteria, and capacity to give informed consent.	Above criteria; CP guidelines and approved premises; patient's wishes; views of family/carer's wishes; nature/degree of significant risks of ECT and alternatives; whether ECT is likely to promote health.	Is the treatment in the best interests of the patient? Also: the second psychiatrist must consider the provisions on informed consent in the *RANZCP 2010 Code of Ethics: Principle 5.*
Who can authorise emergency ECT?	CP and doctor must jointly apply to ACAT.	No emergency ECT regime.	Two authorised psychiatric practitioners.	Jointly: Psychiatrist and senior medical administrator.	Psychiatrist.	N/A	Psychiatrist must apply to MHT.	Medical practitioner, with CP approval (CP guidelines apply).	No emergency ECT regime.
Criteria for emergency ECT	Similar to ACAT criteria above (but no PTO or FPTO is in force). The person has a mental illness **and** ECT is necessary to save the person's life, or to prevent the likely onset of a risk to the person's life within 3 days **and** the treatment is the most appropriate reasonably available or all other treatments reasonably available have failed.	N/A	Immediately necessary to save life, prevent serious mental or physical deterioration, or to relieve severe distress. Report ECT to MHRT as soon as practicable afterwards.	Need to save the patient's life or prevent the patient from suffering irreparable harm. A second opinion should be sought from another consultant psychiatrist.	Urgently needed for the patient's wellbeing, and in the circumstances it is not practicable to obtain that consent. Notify the CP within one business day afterwards.	N/A	Needed to save the life of the patient or prevent serious damage to health or prevent the patient suffering or continuing to suffer significant pain or distress.	Needed to save life or because there is an imminent risk of the patient behaving in a way that is likely to result in serious physical injury to the patient or another person. Approved premises required.	N/A

Disclaimer: These tables were developed by the RANZCP as at 30 June 2017 in order to allow key provisions in the Mental Health Acts to be compared. They were updated on 19 June 2019 to reference updated ECT guidelines only. They are intended for reference purposes only and are not intended to be a substitute for legal or clinical advice.

COMMENT: The regulation of ECT varies widely in most respects across the different Acts. Common features generally include the number of treatments in a course (9–12), the role of tribunals in hearing applications for involuntary ECT, and a separate framework for authorising ECT in emergencies. The main exception is Tasmania, where ECT is not subject to any special regulation. Most Acts have special provisions addressing capacity to consent to ECT, or the matters which the patient must be informed about, or both (see accompanying table 'Special provisions governing informed consent to electroconvulsive treatment (ECT) in Australian and New Zealand Mental Health Acts').