### 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
- QLD: Mental Health Act 2006 ss234–6, 607–9; The Administration of Electroconvulsive Therapy 2017
- SA: Mental Health Act 2006 ss242, 80; ECT Chief Psychiatrist Standard 2014; ECT Policy Guidelines 2014
- TAS: Mental Health Act 2013
- VIC: Mental Health Act 2014 ss91–99; ECT Treatment Chief Psychiatrist’s Guidelines 2019
- WA: Mental Health Act 2014 ss190–199, 403–10; Chief Psychiatrist’s Guidelines for the use of ECT 2006
- NZ: Mental Health Act (Compulsory Assessment and Treatment) Act 1992, ss259–60; Guidelines to MH Act 2012 12.4

#### 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).

#### 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 medical practitioners. Psychologist (preferably with a second opinion from another consultant psychiatrist).
- Medical practitioner or mental health clinician. If uncertain, or none of the 2 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 ECT 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 necessary or desirable course of 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. 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; clinical judgment; likely results if ECT is not performed; any second psychiatrist opinion.
- Reasons for recommending ECT, and a treatment plan including number of treatments.
- N/A
- 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 Appeals Tribunal (ACAT).
- Mental Health Review Tribunal (MHRT).
- Mental Health Review Tribunal (MHRT).
- Psychiatrist, then the South Australian Civil and Administrative Tribunal.
- N/A
- Medical Practitioner (MHRT).
- 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 issues including: who the patient understands the inquiry, what effect any medication has on the patient's ability to communicate, and views of the patient and carer.
- 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; it is a minor effectiveness of ECT for persons that age.
- 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/gender of significant risks of ECT and alternatives; whether ECT is likely to promote health.

#### Who can authorise emergency ECT?
- CP and doctor must jointly apply to ACAT.
- No emergency ECT regime.
- Two authorised medical practitioners.
- Psychiatrist and senior medical administrator.
- Psychiatrist
- N/A
- Psychiatrist must apply to MHRT.
- Medical practitioner, with CP approval (CP guidelines apply).
- N/A
- No emergency ECT regime.

#### Criteria for emergency ECT
- Similar to ACAT criteria above (but no PTO or FPTO is in force). If 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 on all other treatments reasonably available have failed.
- 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.
- N/A
- N/A
- N/A
- N/A
- 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.