Practice requirements for electroconvulsive therapy services

Summary This Policy outlines the requirements for safe, effective and recovery-oriented delivery of ECT across NSW Health. It reflects evidence-based best practice and supports standardised procedures. The ECT Handbook must be read with this Policy.

Document type Policy Directive

Document number PD2026_010

Publication date 12 March 2026

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Replaces PD2011_003

Review date 12 March 2031

Policy manual Patient Matters Manual for Public Health Organisations

File number H25/38339

Status Active

Functional group Clinical/Patient Services - Medical Treatment, Mental Health

Applies to Local Health Districts, Specialty Network Governed Statutory Health Corporations, Public Hospitals

Distributed to Ministry of Health, Public Health System, Government Medical Officers, NSW Ambulance Service, Private Hospitals and Day Procedure Centres

Audience Adult psychiatrists;Mental health nurses;Medical Officers;Anaesthetists;Child and adolescent psychiatrists

Secretary, NSW Health

NSW Health

Policy Directive

Practice requirements for electroconvulsive therapy services

Policy Statement

NSW Health is committed to ensuring Electroconvulsive Therapy (ECT) is delivered as a safe, effective, and evidence-based treatment for depression, mood disorders, and other mental illnesses.

Research advances in treatment technique mean ECT is now a highly effective and generally well-tolerated treatment with a low risk of major complications. The administration of ECT should adopt a person-centred and trauma-informed approach to enable recovery-oriented treatment delivery.

Summary of Policy Requirements

This Policy Directive outlines the requirements for the delivery of ECT across NSW Health, supporting safe, effective, and recovery-oriented care. It reflects evidence-based best practice and consensus opinion from experts involved in its development, supporting standardised procedures and minimising clinical variation of ECT treatment across NSW.

All staff must comply with the clinical, consent, legal and governance requirements in this Policy Directive.

This Policy Directive must be read in conjunction with the *Electroconvulsive Therapy Handbook: Implementing the practice requirements for ECT services (ECT handbook)*. The ECT handbook provides a comprehensive guide to ECT, covering its clinical use, risks, consent and legal considerations, facility standards, treatment preparation, anaesthesia, and service coordination.

All NSW Health staff involved in the administration of ECT must use the *ECT handbook* to guide treatment of people with mental illness. Health services are required to meet the reporting, forms and documentation obligations detailed in this Policy Directive and the *ECT handbook*.

Revision History

Version	Approved By	Amendment Notes
PD2026_010 March-2026	Deputy Secretary, Health System Strategy and Patient Experience	Rescinds PD2011_003. Includes the development of the practice compendium *Electroconvulsive Therapy Handbook: Implementing the practice requirements for ECT services*.
PD2011_003 January-2011	Deputy Director-General Strategic Development	Rescinds PD2010_068. Incorporates the Minimum requirements in the delivery of ECT in NSW.
PD2010_068 November-2010	Deputy Director-General Strategic Development	New Policy Directive.

Contents

1. Background

Electroconvulsive therapy (ECT) is a safe and effective treatment for people with mood disorders and several other forms of mental illness. Following research advances in treatment technique, ECT is now a highly effective and generally well-tolerated treatment with a low risk of major complications.

1.1. About this document

This Policy Directive defines the practice requirements for ECT services to ensure safe, effective, efficient and respectful provision of ECT treatment in NSW. The Policy Directive reflects evidence-based best practice and consensus opinion from experts involved in its development, supporting standardised procedures and minimising clinical variation of ECT treatment across NSW.

In this Policy Directive, the term “patient” and “person” or “people” are used interchangeably.

1.1.1. The *Electroconvulsive Therapy handbook*

The *Electroconvulsive Therapy Handbook: Implementing the practice requirements for ECT services (ECT handbook)* provides additional guidance and must be read in conjunction with this Policy Directive. The *ECT handbook* provides a comprehensive overview of ECT as part of the modern toolkit of therapies for mental illness.

1.2. Key definitions

Acute treatment period	Period during which ECT is administered 2 or 3 times per week with the goal of improving symptoms and achieving response or remission
Brief pulse ECT (BP-ECT)	The use of an ECT stimulus with a pulse width between 0.5 and 1.0 milliseconds.
Continuation ECT (C-ECT)	C-ECT is the administration of further ECT after the acute treatment period has ended, with the goal pf preventing a relapse of the same illness episode. C-ECT is typically administered at a frequency of between once per week and once per month and is tapered over time. C-ECT may continue for up to 6 months.
Credentialling	The formal process used to verify the qualifications, experience, professional standing, and other relevant professional attributes of medical officer. The purpose is to assess competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments (for example, the process of assessing a person’s skills in administering ECT).

ECT prescriber	The primary psychiatrist responsible for the care of the person receiving ECT who prescribes the treatment. The psychiatrist may work in a public hospital, community mental health team, in a private hospital or in private consulting rooms.
ECT practitioner	The medical officer who is credentialled to administer ECT.
ECT treating team	The group of practitioners that deliver the treatment within a general hospital theatre complex or stand-alone ECT suite.
Maintenance ECT (m-ECT)	M-ECT is ECT administered after the successful use of C-ECT with the aim of preventing recurrence of illness.
Must	Indicates a mandatory action that is required to be complied with.
Should	Indicates a recommended action that is the correct or most reasonable course to be followed unless there are sound reasons for taking a different course of action.

1.3. Legal and legislative framework

The administration and provision of consent for ECT must comply with the *Mental Health Act 2007* (NSW) (The Act). The Act outlines the rights of people receiving mental health care, including rights to access appropriate care, provisions for informed consent, requirements applying to involuntary patients and other patients, and the involvement of carers in decision making. The Act also describes the involvement of the NSW Mental Health Review Tribunal.

Provisions pertaining to the administration of ECT are prescribed in Chapter 4, Part 2, Division 3 of the *Mental Health Act 2007* (NSW).

Forms and documents required for ECT under the *Mental Health Act 2007* (NSW) and the *Mental Health Regulation 2025* (NSW), can be found on the State Health Forms Catalogue and the NSW Health website *Mental Health Act 2007 forms*. See Section 3.16 Documentation for forms and documents that must be used for ECT.

2. Electroconvulsive therapy services in Local Health Districts and Specialty Health Networks

Local health districts and specialty health networks must establish electroconvulsive therapy (ECT) services that provide acute ECT, continuation ECT (C-ECT) and maintenance ECT (M-ECT). ECT services must be delivered in compliance with the mandatory practice requirements (see Section 3).

3. Mandatory practice requirements

3.1. Person-centred and trauma-informed care

The person receiving electroconvulsive therapy (ECT) must be at the centre of care provided by ECT services and must receive trauma-informed care. NSW Health's approach to trauma-informed care and practice in mental health services is provided by the Agency for Clinical Innovation. The *Electroconvulsive Therapy Handbook: Implementing the practice requirements for ECT services (ECT handbook)* contains specific recommendations and strategies to optimise person-centred practice.

3.2. Indications

The ECT prescriber must document the indication for the use of ECT in the person's medical record, including the diagnosis and the reason for choosing ECT as a treatment.

These indications are considered as standard indications for ECT:

- major depressive episode
- manic episode
- mixed episode
- schizophrenia (both acute episodes and treatment-resistant)
- schizoaffective disorder
- catatonia
- neuroleptic malignant syndrome
- severe post-partum mood and psychotic episodes.

When ECT is prescribed for these indications, the *Mental Health Act 2007* (NSW) requires certification by 2 medical officers, one of whom must be a psychiatrist, see Section 3.3.

If ECT is to be prescribed for any indication other than those listed above, a second opinion by another psychiatrist supporting the use of ECT is required.

3.3. Psychiatrist second opinions

A second psychiatrist's opinion is required before an acute course of ECT in the following circumstances:

- there is uncertainty about the recommendation of ECT
- ECT is being recommended for indications other than those in Section 3.2
- the person receiving ECT, their carer or family requests a second opinion.

Second opinions must be documented in the medical record.

A second psychiatrist's opinion must also be obtained:

- if more than 12 ECT will be given during an acute treatment period

- if more than 20 ECT will be given during an acute treatment period (from site Clinical lead or their delegate)
- if more than 28 ECT will be given during an acute treatment period (further opinion should be obtained either from the site ECT clinical lead, or an ECT clinical lead from an alternative site, or another expert in ECT)
- before transitioning the person from continuation ECT (C-ECT) to maintenance ECT (M-ECT) at the 6-month time-point after completion of the acute treatment period.
- if more than 18 treatments of C-ECT are to be given before the transition to M-ECT at 6 months.
- annually or after every 18 treatments (whichever occurs sooner) for people receiving M-ECT.

3.4. People under the age of 18 years

All people under the age of 18 years who are prescribed ECT must have a comprehensive medical and psychiatric assessment.

A child and adolescent psychiatrist must either conduct the assessment or be consulted when direct assessment is not possible, and the child and adolescent psychiatrist must be involved in the decision to prescribe ECT. The *Mental Health Act 2007* (NSW) requires that for children aged under 16 years a certificate recommending ECT be given by a psychiatrist with expertise in the treatment of children or adolescents.

3.5. Consent for ECT

The informed consent procedures and provisions in the *Mental Health Act 2007* (NSW) must be applied to the administration of ECT. Clinicians must refer to Section 6 *Consent and legal issues* in the *ECT handbook* for information on consent requirements.

ECT may only be administered if informed consent is provided by a person with capacity to do so, or where the Mental Health Review Tribunal has provided an ECT determination at an ECT inquiry. An ECT inquiry must be conducted when ECT is proposed for an involuntary patient, a person who is under the age of 16 years, or a voluntary patient when it is uncertain whether they have capacity to consent.

Procedural guidance for consent pathways is at Appendix 1 for people 16 years of age and over and at Appendix 2 for people under 16 years. This includes requirements for involving the Mental Health Review Tribunal when determining informed consent. Additional information is on the Mental Health Review Tribunal website.

A new consent must be obtained for all acute courses of treatment. ECT consent must be renewed every 6 months during C-ECT and M-ECT.

Clinicians must refer to the NSW Health Manual *Consent to Medical and Healthcare Treatment Manual* to ensure the consent requirements for ECT are met.

3.6. Assessment of cognitive function and symptoms

Every person who receives ECT must undergo assessment of cognitive function, symptom profile and severity. This must occur prior to ECT, during the ECT treatment period and at the completion of the acute treatment period.

Appendix 7 in the *ECT handbook* outlines the required schedule for symptom assessments and the recommended tools.

Appendix 8 in the *ECT handbook* outlines the required schedule for cognitive assessments and the recommended tools.

In circumstances where the person is severely ill or has cognitive impairment before starting ECT, the cognitive assessment must still be attempted and recorded in the person's medical record. If the person refuses assessment or does not complete it, this should be recorded.

3.7. Pre-ECT work-up and consultations

The ECT prescriber must ensure that a pre-ECT work-up is performed and documented, including a thorough history, physical examination, clinically relevant investigations, and specialist consultations if required.

An anaesthetic consultation before ECT is mandatory.

Medical and psychotropic medications must be reviewed and adjusted as appropriate before starting ECT. Information about medication management is provided in the *ECT handbook*.

3.8. Anaesthesia for ECT

A specialist anaesthetist must oversee the provision of anaesthesia in the ECT service.

The procedural anaesthetist may be an anaesthetic consultant, a supervised anaesthetic registrar, or a general practitioner (GP) anaesthetist accredited by the Joint Consultative Committee on Anaesthesia (JCCA). Trainees must be supervised at a level consistent with their experience.

The presence of an anaesthetic assistant is mandatory. The anaesthetic assistant must be present for induction of, and emergence from, anaesthesia and remains under the instruction of the anaesthetist until no longer required. The anaesthetic assistant must meet the requirements in Australian and New Zealand College of Anaesthetists (ANZCA) documents *PS08(A) Assistant for anaesthetist*.

A formal pre-anaesthetic assessment must be conducted before starting a course of ECT.

Equipment, staffing and treating environment must comply with the following Australian and New Zealand College of Anaesthetists (ANZCA) documents (or their most current iterations):

- PG07(A) Guideline on pre-anaesthesia consultation and patient preparation
- PS04 Statement on the Post-Anaesthesia Care Unit
- PS08(A) Position statement on the assistant for the anaesthetist
- PG18(A) Guideline on monitoring during anaesthesia
- PS26(A) Position statement on informed consent for anaesthesia or sedation

- PS55(A) Position statement on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations.

The anaesthetist must document the anaesthetic technique in the medical record in accordance with ANZCA documents *PG06(A) Anaesthesia record*.

3.9. Facilities and equipment

ECT can only be performed in a hospital approved for this purpose. Facilities must also comply with the relevant standards specified by professional bodies and NSW Health. ECT may be administered in a 'stand-alone' ECT suite within a psychiatric hospital or in a theatre complex within a general hospital. People receiving ECT may be outpatients of the hospital.

ECT equipment and servicing must comply with the requirements specified in the *ECT handbook*.

3.10. Treatment approach

3.10.1. Specified staff to be present

The ECT treating team members who must be present at each ECT treatment are:

- a medical officer credentialled to administer ECT (the ECT practitioner)
- a medical officer credentialled in anaesthesia (the procedural anaesthetist)
- an anaesthetic assistant

A mental health nurse with experience supporting the administration of ECT may also attend, depending on the operational requirements of the service or the specific care needs of the person receiving ECT.

3.10.2. Treatment approach

The ECT schedule, electrode placement, stimulus parameters, frequency of treatment and course duration must be:

- tailored to the person receiving ECT
- based on considerations of efficacy and cognitive outcomes
- in accordance with accepted guidelines, being the Royal Australian and New Zealand College of Psychiatrists *professional practice guidelines for the administration of electroconvulsive therapy*, and
- in accordance with the *ECT handbook*.

The treatment approach must be discussed with the person receiving ECT and where possible with their carer(s) and families, and their preferences must be carefully considered when determining the ECT prescription.

People receiving acute ECT must be reviewed by the ECT prescriber or delegated trainee psychiatrist at least twice per week and no more than 3 treatments are to be prescribed in advance.

Each ECT service must use an ECT dosing protocol specific to the treatment approach. This must be regularly reviewed by the site and local health district (LHD) or specialty health network (SHN) ECT committees (see *ECT handbook* Appendix 6: *Titration and treatment schedules*).

The ECT treating team must routinely perform electroencephalogram (EEG) monitoring, and fa paper or electronic record of ictal EEG traces must be stored chronologically in the medical record ensuring they are easily accessible at the time of prescription and administration of ECT.

The ECT procedure must meet the requirements of NSW Health Policy Directive *Clinical Procedure Safety* (PD2025_006).

When more than one clinical team is involved in ECT, the requirements of NSW Health Policy Directive *Clinical Handover* (PD2019_020) must be met.

Sine wave ECT must not be used.

3.11. Continuation treatment

The ECT prescriber may consider C-ECT where there is:

- a significant risk of relapse (or signs of early relapse when acute ECT is reduced)
- a lack of effectiveness of alternative maintenance medication
- an intolerance of alternative treatments, or
- a clear indication for ECT alongside a preference for this treatment stated by the person.

The ECT prescriber must carefully monitor people receiving C-ECT for signs of relapse or adverse effects, to inform decisions regarding frequency of treatment and stimulus parameters.

Informed consent must be renewed after 6 months for people receiving C-ECT and documented in the person's medical record using *Form 5 Information and Consent – Electro Convulsive Therapy (NH606710)*.

3.12. Maintenance treatment

The ECT prescriber may consider M-ECT where there is:

- a significant risk of recurrence
- a lack of effectiveness of alternative maintenance medication
- an intolerance of alternative treatments, or
- a clear indication for ECT alongside a preference for this treatment stated by the person.

The psychiatrist proposing to continue M-ECT must discuss their reasoning with the person, their carers and family, and document their reasoning in the person's medical record at least every 6 months.

Psychiatrist second opinion requirements specified in Section 3.3 must be complied with.

ECT services must establish robust systems of clinical governance to provide appropriate oversight and ensure that appropriate clinical review and consideration of the ongoing need for M-ECT occurs.

Informed consent must be updated every 6 months for people receiving M-ECT and documented in the person's medical record using *Form 5 Information and Consent – Electro Convulsive Therapy (NH606710)*.

3.13. Assessment and review during continuation and maintenance treatment

The ECT prescriber or delegated trainee psychiatrist must review:

- all people receiving C-ECT at least after every 3 treatments
- all people receiving M-ECT at least after every 4 treatments.

At each review, the clinician must assess psychiatric symptoms, any side effects of treatment (including cognitive side effects) and any changes in the quality of the EEGs.

An objective assessment to monitor symptoms and cognition must occur at least every 3 months during C-ECT and every 6 months during M-ECT. Objective assessment includes quantifying symptoms (see Appendix 7 in the *ECT handbook*) and cognition, using recommended assessment tools (see Appendix 8 *ECT handbook*).

If the assessment detects clinically significant deterioration, there must be a detailed review of the overall status of the person by the ECT prescriber. The ECT prescriber must consider a change in technique and review of the ongoing need for ECT.

All people receiving C-ECT or M-ECT must have a physical examination completed and documented in the person's medical record at least once every 6 months.

A formal pre-anaesthetic assessment must also be conducted for people receiving C-ECT or M-ECT every 6 months, with the purpose of detecting any specific changes in anaesthetic risk and informing the need for changes to anaesthetic approach.

3.14. Outpatients receiving ECT

When ECT is administered on an outpatient basis, the person must be informed that they must be accompanied by a family member, friend, carer or community worker, and that there must be someone who can be with the person for the 24 hours following treatment.

3.15. Credentialling and clinical privileging

The process of credentialling ECT practitioners is described in detail in the *ECT handbook*.

ECT practitioners must be credentialed and receive clinical privileges from the LHD or SHN Medical and Dental Appointments Advisory Committee.

Each site ECT clinical lead is responsible for credentialing ECT practitioners and must advise the site clinical director or medical superintendent of which medical staff have been credentialed.

Each site ECT clinical lead must conduct an annual review of each ECT practitioner's treatment technique to ensure they continue to meet the standard to perform ECT independently.

Other medical officers may administer ECT under the direct supervision of an ECT practitioner, who must be present during the procedure.

ECT practitioners must maintain knowledge of clinical practice and be familiar with current clinical guidelines for ECT (see the Royal Australian and New Zealand College of Psychiatrists *professional practice guidelines for the administration of electroconvulsive therapy*).

ECT clinical leads must attend an appropriate ECT training course or obtain equivalent professional education on ECT every 5 years.

3.16. Documentation

Forms and documents that must be used for ECT include:

- certification of ECT by 2 medical officers (one of whom must be a psychiatrist) [see *Certificates for Electro Convulsive Therapy (ECT)* provided by the Mental Health Review Tribunal]
- *Form 5 Information and Consent – Electro Convulsive Therapy (NH606710)* - available on the *Finsbury Green Sourceit Catalogue* and the NSW Health website *Mental Health Act 2007 forms*.
- an ECT register with information about the administration of ECT at each facility (see template on the NSW Health website *Mental Health Act 2007 forms*). The ECT register can be kept in hard copy or electronically.
- notification to carer forms (available on the *Finsbury Green Sourceit Catalogue* and the NSW Health website *Mental Health Act 2007 forms*.)
- a pre-procedural checklist before each ECT treatment. The checklist must comply with the NSW Health Policy Directive *Clinical Procedure Safety* (PD2025_006).

Documentation relevant to the administration of and consent for ECT must meet the requirements of NSW Health Guideline *Mental Health Clinical Documentation Guidelines* (GL2014_002).

3.17. Coordination of ECT services

Local health districts and specialty health networks must appoint a dedicated ECT coordinator for each ECT service and allocate sufficient dedicated hours appropriate to the workload of service. Requirements and duties of the ECT coordinator are provided in the *ECT handbook*.

3.18. Clinical governance systems

LHDs and SHNs must establish specific systems of clinical governance to provide appropriate oversight of ECT services (see Section 15 *Clinical governance systems* in the *ECT handbook*).

In particular, local health districts and specialty health networks must:

- appoint an ECT clinical lead (who must be a psychiatrist) with responsibility for the overall operation and governance of the ECT service
- allocate to the ECT clinical lead sufficient dedicated hours appropriate to the workload of the service (see Section 15.2 *Role of ECT site leads and LHD or SHN ECT clinical leads* in the *ECT handbook*)
- establish a system of clinical monitoring and clinical outcomes auditing of the ECT service, recording data in relation to treatment given, symptom and cognitive outcomes, and any associated medical morbidity
- establish a system of clinical compliance and service auditing which includes reviewing compliance with this Policy Directive in each site

3.19. ECT committees

Local health districts and specialty health networks must establish:

- an ECT committee for the LHD or SHN, and
- an ECT committee for each facility or site administering ECT, reporting to the LHD or SHN committee.

If ECT is only administered at one site, then a single ECT committee will suffice.

Information about the purpose of the ECT committees and recommended meeting frequencies is provided in the *ECT handbook*.

3.20. Engagement of people with lived experience and carers

LHDs and SHNs must consult with people with a lived experience of ECT and mental health, and their carers about:

- the facilities that provide ECT and the processes of the ECT service (for example timing and scheduling of ECT services, and transport for outpatients)
- the information resources for people receiving ECT or who may receive ECT.

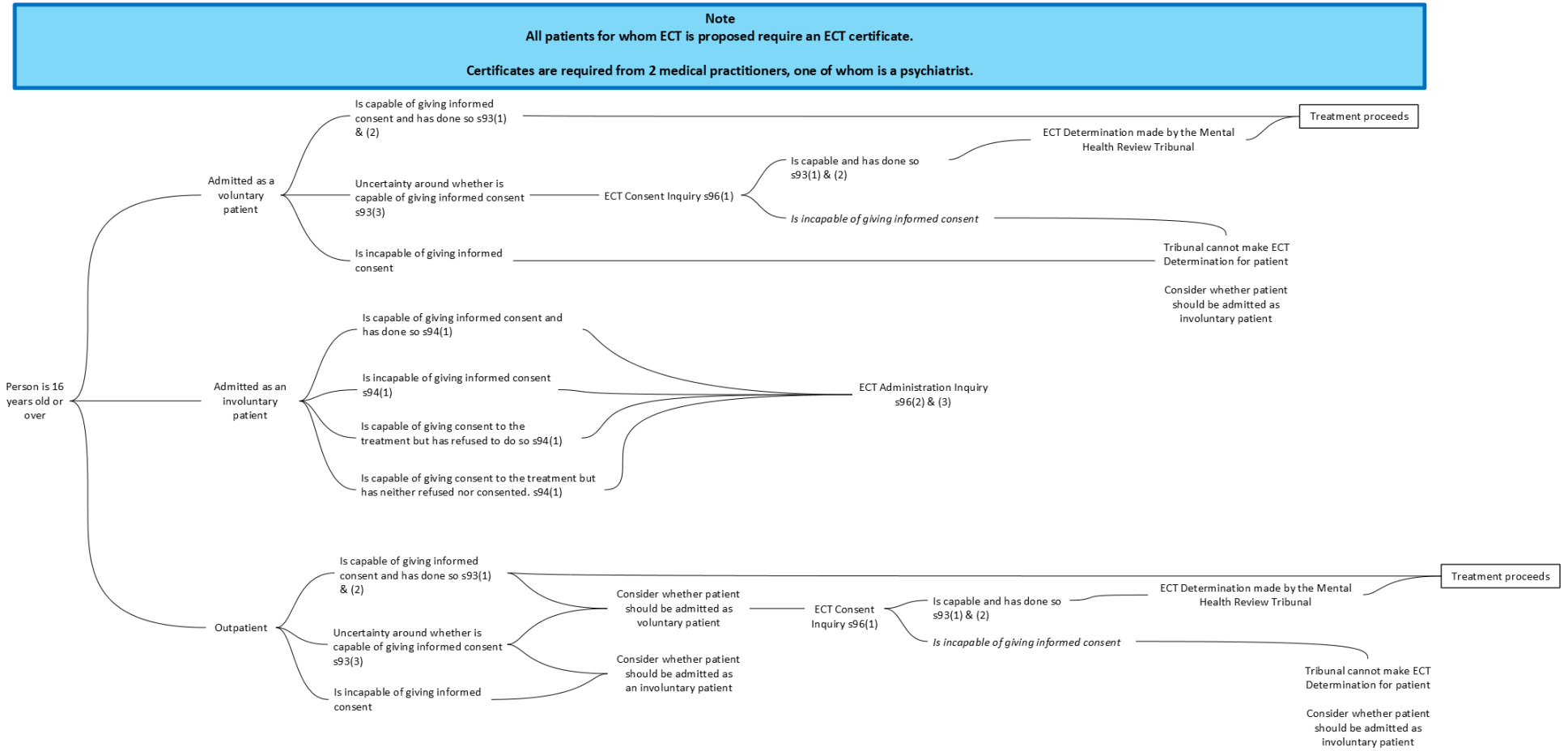
This consultation may be through the ECT committee where there is sufficient representation of people with a lived experience of mental health and carers to constitute effective engagement.

The *ECT handbook* contains recommendations and strategies for ECT services to support people with lived experience, their carers and families, including information for people about ECT.

4. Appendices

- Appendix 1 Consent pathways for people 16 years of age and over
- Appendix 2 Consent pathways for people under 16 years of age

4.1. Appendix 1 Consent pathways for people 16 years of age and over



4.2. Appendix 2 Consent pathways for people under 16 years of age

Note
All patients for whom ECT is proposed require an ECT certificate.

Certificates are required from 2 medical practitioners, one of whom is a psychiatrist with expertise in the treatment of children.