HPFT

Consent to Examination, Care and Treatment Policy

Including Electro-Convulsive Therapy (ECT)

HPFT Operational Policy

Version	7
Executive Lead	Executive Director Quality & Medical Leadership
Lead Author	Consultant Psychiatrist – ECT Lead
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Ratified By	West SBU Quality and Risk Meeting. Chair's Action by other Clinical Directors
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Target Audience	Anyone: ❖ developing or revising a formal document describing aspects of what Trust employees do and how it should be done (i.e. Policy Authors') ❖ all other staff as they need to be aware of how the new Policy Management System works.

Document on a Page			
Title of document	Consent to Examination, Care and Treatment Policy		
Document Type	Operational Policy		
Ratifying Committee	Quality and Risk Management Committee		
Version	**Issue Date**	**Review Date**	**Lead Author**
(Insert Version No)	7	27/11/2022	
Staff need to know about this policy because (complete in 50 words)	Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare. Seeking consent is also a matter of common courtesy between health professionals and patients.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	This policy sets out the standards and procedures in Hertfordshire Partnership NHS Foundation Trust, which aims to ensure that health professionals are able to comply with the guidance. This policy must be read in conjunction with the Medical Treatment for Mental Disorder under the MHA Policy		
Summary of significant changes from previous version are:	Amendment to Consent Form 1 **- Patient A**greement to **T**reatment (Appendix 4) Amendments to Anaesthetic risks and advice Addition of Confirmation of Capacity Status Form (Appendix 7)		

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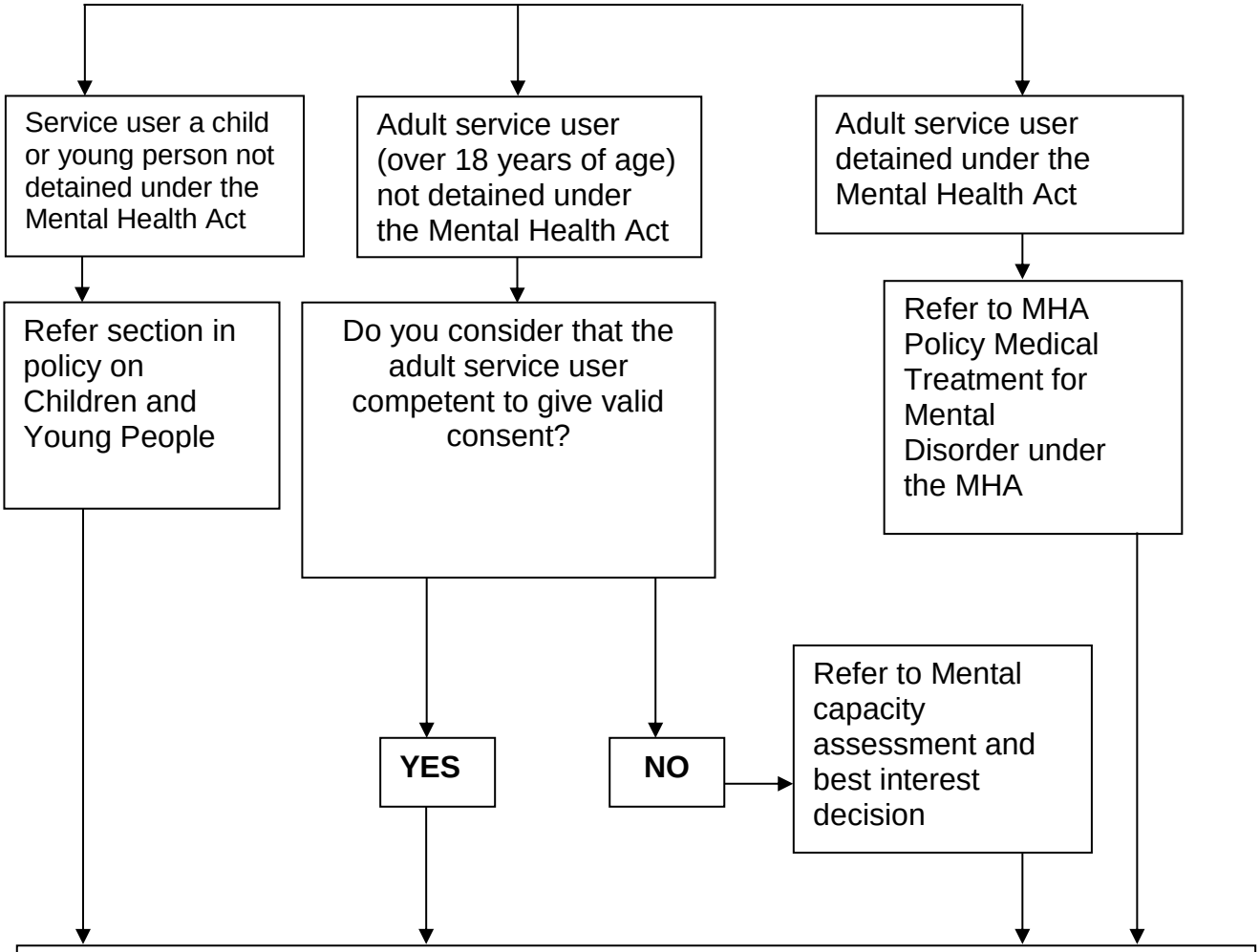
PART 1 – Preliminary Issues:

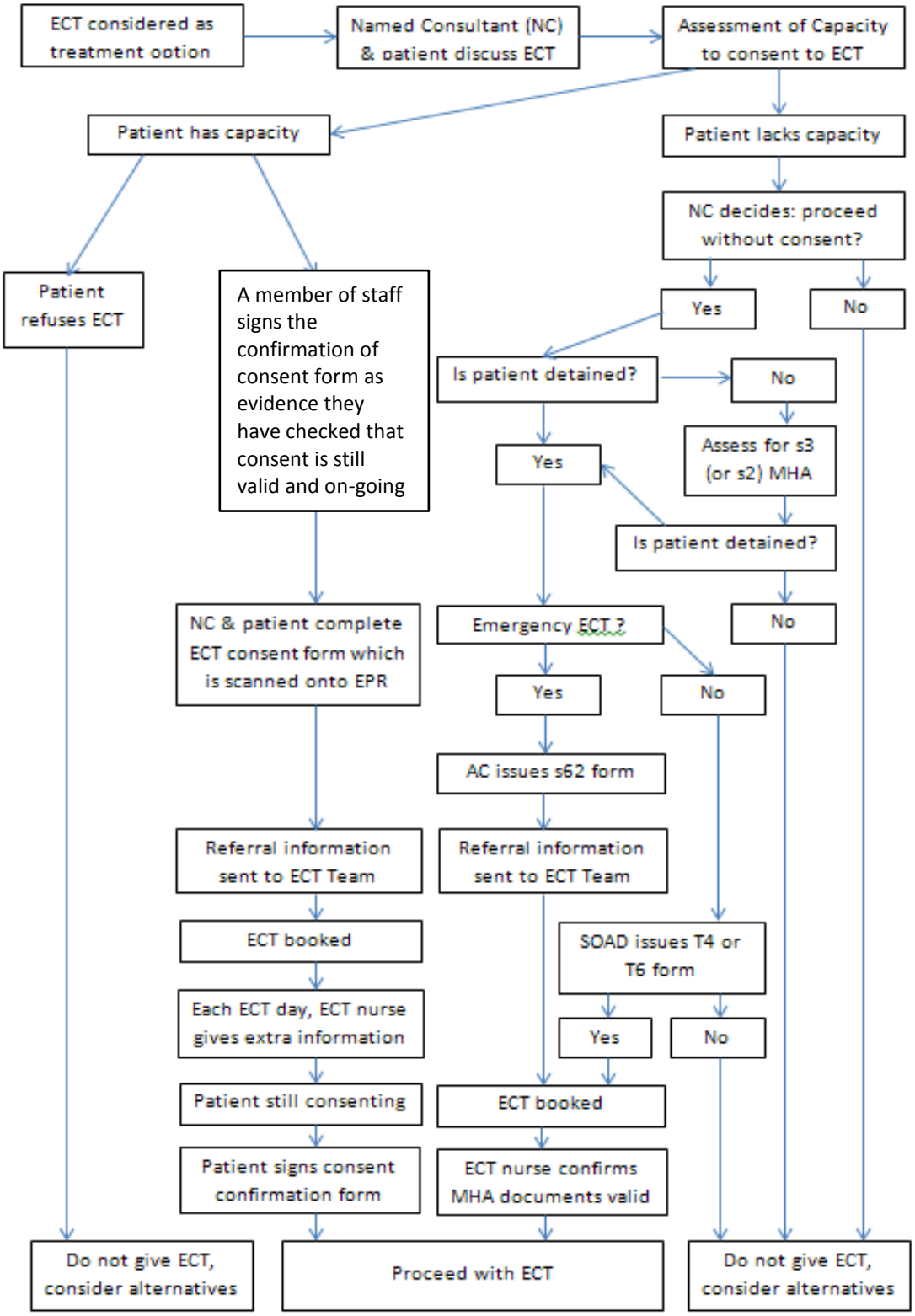
1. Flow Chart – Consent Overview

SU child detained - Refer to CYP & MHA policies



Obtain valid consent that meets the requirements of this policy

- Know your responsibilities
- Ensure valid consent is obtained
- Information provided to the service user
- Is written consent required
- Record all information
- Consent for all ECT Treatment
- Record any withdrawal of consent


ECT considered as treatment option
Named Consultant (NC) & patient discuss ECT
Assessment of Capacity to consent to ECT
Patient has capacity
Patient lacks capacity
NC decides: proceed without consent?
Patient refuses ECT
A member of staff signs the confirmation of consent form as evidence they have checked that consent is still valid and on-going
Yes
No
Is patient detained?
No
Yes
Assess for s3 (or s2) MHA
Is patient detained?
NC & patient complete ECT consent form which is scanned onto EPR
Emergency ECT ?
No
Yes
No
AC issues s62 form
Referral information sent to ECT Team
Referral information sent to ECT Team
ECT booked
SOAD issues T4 or T6 form
Each ECT day, ECT nurse gives extra information
Yes
No
Patient still consenting
ECT booked
Patient signs consent confirmation form
ECT nurse confirms MHA documents valid
Do not give ECT, consider alternatives
Proceed with ECT
Do not give ECT, consider alternatives

Part 2 – What needs to be done and who by

2. Summary

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare. Seeking consent is also a matter of common courtesy between health professionals and patients.

The Department of Health has issued a range of guidance documents on consent and these should be consulted for details of the law and good practice requirements on consent. (*Reference Guide to Consent for examination or Treatment*, (2009), Second Edition. www.dh.gov.uk)

This policy sets out the standards and procedures in Hertfordshire Partnership NHS Foundation Trust, which aims to ensure that health professionals are able to comply with the guidance.

This policy must be read in conjunction with the **Medical Treatment for Mental Disorder under the MHA Policy**

3. Purpose

The aim of this policy is to enable staff to comply with the law and DoH guidance on obtaining valid consent to treatment and care, so that the process is properly focussed on the rights of the individual patient:

- To ensure that staff are aware of their responsibility to patients in respect of obtaining consent before providing any care or treatment.
- To ensure staff are aware of the process for obtaining valid consent.
- To ensure staff are aware of their legal duties under the Mental Capacity Act 2005 in respect of care or treatment afforded to people who lack the capacity to make the relevant decision(s) for themselves.
- To ensure clear guidance and reference to the law and good practice documents are available to all staff.
- To ensure the interests of patients, staff, researchers and the Trust are safeguarded.

4. Definitions of terms used in this policy

Consent - is a service user's agreement for a health professional to provide care. Service Users may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally or in writing.

Electroconvulsive Therapy (ECT) - ECT is an evidence-based form of treatment for certain psychiatric disorders, whereby 2 electrodes are used to pass a brief electrical current, supplied by a specialist machine, through the brain with the intention of inducing an epileptic type seizure. Current practice requires ECT to be given under a general anaesthetic and using a muscle relaxant drug.

Patients receiving ECT Treatment will have the treatment under anaesthetic. ECT is administered on 2 sites based on the anaesthetic assessment and grading.

HPFT Kingfisher Court ECT Services is an accredited Service meeting ECTAS Standards. These Standards describe the process of administration of ECT and are consistent with NICE guidance.

5. Duties and Responsibilities

The **Executive Director for Quality and Medical Leadership** will have executive responsibility and accountability for the implementation of this policy.

The **Clinical Directors** are responsible for ensuring this policy is adhered to within their Strategic Business Unit when clinical staff undertake the consent process. They are responsible for ensuring that consent is obtained by those staff appropriate to take consent and that actions identified as a result of clinical audits are implemented.

The **Consultant Psychiatrist or named Consultant in change of a service user's care** is responsible for identifying whether Electroconvulsive Therapy would be an appropriate treatment for the individual. If this is the case then they are responsible for ensuring the individual is provided with information on the procedure, its risks and benefits, assessing their capacity to consent and taking them through the written consent process.

The **Electroconvulsive Therapy Lead Nurse / Nursing Staff** will make sure prior to the commencement of ECT that appropriate consent has been taken and confirm on the day of the procedure that the service user has no further questions about their treatment and still wish to proceed. In a patient lacking capacity to consent, the nurse will check that the appropriate Mental Health Act documents have been completed.

Any staff involved in consent are responsible for ensuring the contents of this policy are adhered to and have a legal duty to have regard to the provisions of the Mental Capacity Act 2005 and the Code of Practice when they have to take decisions on behalf of a person who lacks the mental capacity to take that decision for him/herself.

6. What is Consent?

Consent is a patient's agreement for a health professional to provide care.

Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing.

For the consent to be valid, the patient must:

- Be competent to take the particular decision
- Have received sufficient information about treatment options, likely benefits and risks, including of not having treatment
- Not be acting under duress / influence of others.

The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice.

In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them.

Some patients, especially those with long-term conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

7. Process for Obtaining Consent

7.1 Valid Consent

For consent to be valid, it must be given voluntarily by an appropriately informed person (the patient or for a patient under the age of 18, in some circumstances, someone with parental responsibility – please see the separate part of this policy that applies) who has the capacity to consent to the intervention in question.

Consent can be given orally, in writing or may be implied. Written consent merely serves as evidence of consent. A signature on a form will not make the consent valid if the elements of capacity and appropriate information have not been satisfied.

7.2 Does the patient have capacity?

For a person to have capacity, he/she must be able to comprehend and retain information material to the decision, especially as to the consequences of having or not having the intervention in question, and must be able to use and weigh this information in the decision–making process. Patients also need to be able to communicate their decision.

A Capacity to Consent to Treatment form must be completed (This is contained in Appendix 3 of the MHA Medical Treatment for Mental Disorder)

The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. It does not matter if the impairment or disturbance is permanent or temporary.

A person lacks capacity if:

- they have an impairment or disturbance (for example a disability, condition or trauma or the effect of drugs or alcohol) that affects the way their mind or brain works, and that impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

The assessment of capacity and the test for capacity are now set out in the Mental Capacity Act 2005.

The Code of Practice to support the Act is available and staff working with people who lack capacity are required to have regard to the Code (MCA Code of Practice 2005).

If the service user is detained under the MHA and lacks capacity to consent to ECT they cannot be given ECT without a SOAD certificate stating that the following conditions apply:

- the treatment is appropriate;
- there is no valid advance decision refusing ECT;
- there is no suitably authorised attorney or deputy who objects to the treatment on the patient's behalf;
- the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

In an emergency situation, the patient's Approved Clinician can issue a Section 62 authorisation for a detained patient to receive ECT before the assessment by the SOAD takes place.

(The appropriate forms are contained in Appendix 5 of the MHA Medical Treatment for Mental Disorder)

7.3 Is the consent given voluntarily?

To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the patient either to accept or refuse treatment. Such pressure can come from partners or family members as well as health or care professionals. Staff should be alert to this possibility and where appropriate should arrange to see the patient on their own to establish that the decision is truly that of the patient.

The Mental Capacity Act also requires that all practical and appropriate steps are taken to enable a person to make the decision themselves. These steps include the following:

- Providing relevant information. For example, if there is a choice, has information been given on the alternatives?
- Communicating in an appropriate way. For example, could the information be explained or presented in a way that is easier for the person to understand?
- Making the person feel at ease. For example, are there particular times of the day when a person's understanding is better?
- Supporting the person. For example, can anyone else help or support the person to understand information and to make a choice?

7.4 Has the patient received sufficient information?

The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and the risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure.

Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen, where to go, how long the treatment will be/last, how they will feel afterwards and so on.

Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who want little or no information and ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (in writing, orally or non-verbally) that they do not wish to be given this level of information, this should be documented.

All information given, whether orally, in writing or in another format needs to be documented on the appropriate Trust Consent Form and, in the event that a Consent Form is not used, within the patient health record.

7.5 Provision for patients whose first language is not English

This Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children to interpret for family members who do not speak English, although in the absence of a professional interpreter, it may be acceptable to use an adult family member or friend.

a) Where there are specific language and sensory communication requirements, e.g.people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English, effective communication must continue to be maintained.

b) This may require, with the agreement of the service user, the involvement of carers and/or advocates to facilitate informed discussion. It is not appropriate to use children to interpret healthcare information for family members.

Contact Patient Advice Liaison Service for more information

7.6 When should consent be sought?

Giving and obtaining consent is a process and not a one off event. Service users can change their minds and withdraw consent at any time.

Where there are specific cultural/religious practices which may affect compliance with treatment the service user should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead.

After an appointment with a health professional service users may think of further questions which they would like answered and a telephone contact should be provided to the service user at the time of the appointment.

Health professionals should always check that the service user still consents to the care especially where there is ongoing or maintenance treatment. In no circumstances should a person be given sedation before being asked for their consent to proceed with the treatment.

7.7 Seeking consent for anaesthesia

Consent should usually be sought by the practitioner undertaking the procedure. However, it is standard anaesthetic practice for the consent to anaesthesia to be sought by the surgeon undertaking the operation. In the case of ECT, the Trust ECT consent form includes consent for the anaesthetic and this is obtained by the psychiatrist as a part of the ECT consent process.

Patients are assessed by the anaesthetist before they begin a course of ECT and if there are any particular issues regarding anaesthetic risk, these will be explored with the patient. The anaesthetist will discuss enhanced risks with the psychiatrist and , if necessary, the psychiatrist will have a further discussion with the patient regarding consent to the procedure.

7.8 Procedure to be followed when service users lack capacity to give or withhold consent

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves: Refer to the Hertfordshire Mental Capacity Act policy for further guidance and procedure – see Best Interest Decision form (ACSf765b).

Guidance is also available from the DOH ‘Reference Guide to Consent for examination or Treatment, (2009), Chapter 2, Adults without capacity and the Mental Capacity Act Code of Practice.

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in Consent Form 4 (form for adults who are unable to consent to investigation or treatment), along with the assessment of the patient’s capacity, why the health professional believes the treatment to be in the patient’s best interests, and the involvement of people close to the patient. However, if the patient is detained under the Mental Health Act and the treatment concerned is for mental disorder, this does not apply.

8 Process for recording Consent

It will not usually be necessary to document a service user’s consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the service user (for example if they have declined, or become very distressed about, similar care in the past), it would be helpful to do so.

For significant treatments including ECT the health professionals must document clearly both a service user’s agreement and the discussions which led up to that agreement. This may be done either through the use of a standardised consent form (see appendix), with further detail in the service user’s care record if necessary, or through documenting in the service user’s care record that they have given oral consent.

Consent is often wrongly equated with a patient’s signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is

rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

Completed forms should scanned onto the EPR. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.

9 Consent Forms

There are four versions of the standard consent form:

- **Form 1** for adults or competent children whose treatment involves general and/or regional anaesthesia, local anaesthesia or sedation,
- **Form 2** for parental agreement to investigation or treatment for a child or young person,
- **Form 3** for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care; and
- **Form 4** for adults who are unable to consent to investigation or treatment. The mental capacity assessment and best interest decision making assessment must be fully documented in the patient's records. Trust forms are available for this process and can be found through the following link.

The Trust predominately uses Consent for 1 for ECT treatment

10 Who can Obtain Consent

The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later. However for ECT the consent is normally sought by the named consultant for the service user's care.

If a patient attends for ECT and the consent form is unavailable or incorrectly completed, one of the ECT doctors can complete a consent form, but not a T4 for detained patients – that must be done by the RC.

11 Children and Young People

11.1 Children under 16 – the concept of "*'Gillick/Fraser'* competence"

Following the case of *Gillick v West Norfolk and Wisbech AHA* [1985], the courts have held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will have the capacity to consent to that intervention.

Following review of the Gillick case by Lord Fraser (1985) [not sure the year is correct but it may be] widely used to assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions, the term "*Fraser* competent" is widely used, and may apply to consent for treatment, research or tissue donation.

As the understanding required for different interventions will vary considerably, a child under 16 may therefore have the capacity to consent to some interventions but not others. As with adults, it should not be assumed that a child with a learning disability is not able to understand the issues.

If the child is *Gillick/Fraser* competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. However where the decision will have on-going implications, it is good practice to encourage the child to inform his or her parents unless it would clearly not be in the child's best interests to do so.

11.2 Young people aged 16 – 17

Young people aged 16 or 17 are entitled to consent to their own medical treatment, and any ancillary procedures involved in that treatment, such as an anaesthetic. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed patient capable of consenting to the particular intervention.

However, unlike adults, the refusal of a competent person aged 16-17 may in certain circumstances be over-ridden by either a person with parental responsibility or a court.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults should be used. If the requirements for valid consent are met, it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to that of the young person. It is, however, good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them.

The Children Act 1989 sets out persons who may have parental responsibility. These include:

- the child's mother
- the child's father, if he was married to the mother at the time of birth
- unmarried fathers, can acquire parental responsibility in several different ways:

  For children born before 1 December 2003, unmarried fathers will have parental responsibility if they: marry the mother of their child or obtain a parental responsibility order from the court, register a parental responsibility agreement with the court or by an application to court

  For children born after 1 December 2003, unmarried fathers will have parental responsibility if they: register the child's birth jointly with the mother at the time of birth, re-register the birth if they are the natural father, marry the mother of their child or obtain a parental responsibility order from the court, register with the court for parental responsibility

- the child's legally appointed guardian
- a person in whose favour the court has made a residence order concerning the child
- a local authority designated in a care order in respect of the child
- a local authority or other authorised person who holds an emergency protection order in respect of the child.

11.3 Child or young person with capacity refusing treatment

Where a competent child or young person of 16 or 17 refuses treatment, such a refusal can be over-ruled either by a person with parental responsibility for the child or by the court.

If more than one person has parental responsibility for the young person, consent by any one such person is sufficient, irrespective of the refusal of any other individual. This power to over-rule must be exercised on the basis that the welfare of the child/young person is paramount.

12 Lasting Powers of Attorney and Advance Decisions

12.1 Lasting Powers of Attorney

The Mental Capacity Act 2005 brought in a new system of Lasting Powers of Attorney (Replacing Enduring Powers of Attorney). A Lasting Power of Attorney (LPA) will give one or more people the power to make decisions about a patient's personal welfare, including medical treatment, if the patient does not have the mental capacity to make the decision.

12.2 Advance Decisions

The Mental Capacity Act 2005 gives patients in England and Wales a statutory right to refuse treatment through the use of an Advance Decision. An Advance Decision allows a patient with capacity of at least 18 years of age, to refuse specified medical treatment at some future time when they may lack capacity.

A person may have made an advance decision to refuse particular treatment in anticipation of future incapacity (sometimes previously referred to as a 'living will' or 'advance directive'). A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment. This is a well-established rule of common law, and the Mental Capacity Act 2005 now puts advance decisions on a statutory basis. The Act sets out the requirements that such a decision must meet to be valid and applicable. Further details are available in chapter 9 of the Mental Capacity Act (2005) Code of Practice, but in summary these are:

- the person must be 18 or over
- the person must have the capacity to make such a decision
- the person must make clear which treatments they are refusing
- if the advance decision refuses life-sustaining treatment, it must be in writing (it can be written by someone else or recorded in healthcare notes), it must be signed and witnessed and it must state clearly that the decision applies even if life is at risk
- a person with capacity can withdraw their advance decision at any time.

Healthcare professionals **must follow** an advance decision if it is valid and applicable, even if it may result in the person's death.

If they do not, they could face criminal prosecution or civil liability. The Mental Capacity Act 2005 protects a health professional from liability for treating or continuing to treat a person in the person's best interests if they are not satisfied that an advance decision exists which is valid and applicable. The Act also protects healthcare professionals from liability for the consequences of withholding or withdrawing a treatment if at the time they reasonably believe that there is a valid and applicable advance decision. If there is genuine doubt or disagreement about an advance decision's existence, validity or applicability, the case should be referred to the Court of Protection.

While a decision is awaited from the Court, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in the patient's condition.

13 Refusal / Withdrawal of Treatment

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the Mental Health Act, or if a Court authorises treatment

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then

changes their mind, the member of staff (and where possible the patient) should note this on the form.

Where a patient has refused a particular intervention, staff must ensure that they continue to provide any other appropriate care to which the patient has consented. Staff should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, health staff must explain to the patient the possible consequences of their partial refusal. If staff genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, they are not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, staff must on request be prepared to transfer the patient's care to that health professional.

If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment (whether contemporaneously or in advance), this decision **must** be respected, except in certain circumstances as defined by the Mental Health Act.

This is the case even where this may result in the death of the person.

A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for the practitioner, if at all possible, to stop the procedure, establish the person's concerns and explain the consequences of not completing the procedure. At times, an apparent objection may in fact be a cry of pain rather than withdrawal of consent, and appropriate reassurance may enable the practitioner to continue with the person's consent. If stopping the procedure at that point would genuinely put the life of the person at risk, the practitioner may be entitled to continue until that risk no longer applies.

Assessing capacity during a procedure may be difficult and, as noted above, factors such as pain, panic and shock may diminish capacity to consent. The practitioner should try to establish whether at that time the person has capacity to withdraw a previously given consent. If capacity is lacking, it may sometimes be justified to continue in the person's best interests but this should not be used as an excuse to ignore distress.

14. Training/Awareness

All staff undertaking consent require an understanding of the law of consent and the Trust policy, procedures and guidance in particular:

- The Consent to Treatment policy and the procedures they should follow when seeking consent
- The procedures for gaining consent for children and young people
- The procedures for adults without capacity to make a particular decision.
- They must also ensure that service users are provided with sufficient information about any proposed treatment.

Course	For	Renewal Period	Delivery Mode	Contact Information
Mental Capacity Act / Mental Health Act	All staff dealing directly with patients subject to the MHA	Every 3 years	Taught course / On line Training	For taught courses, the Learning & Development Team can be contacted via Discovery

15. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

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16. Process for monitoring compliance with this document

A variety of tools can be used to monitor compliance with this policy. These might include spot checks of electronic case notes, routine scrutiny of MHA related documents, and specific audits.

Regarding ECT, scrutiny will be undertaken by the ECT clinical team, the Trust MHA Office (for detained patients), the visiting ECTAS accreditation team, the CQC, and possibly others.

17. Version Control

Version	Date of Issue	Author	Status	Comment
1	Aug. 2002	Practice Standards Facilitator	Superseded	
2	Oct. 2005	Practice Standards Facilitator	Superseded	
3	Dec. 2007	Practice Standards Facilitator	Superseded	
4	Nov 2008	Practice Standards Facilitator	Superseded	
V5D3	July 2010	Practice Standards Facilitator	Superseded	Updated with DOH guidance 2009.
V6	30th January 2015	Consultant Psychiatrist – ECT Lead	Superseded	3 yearly review
V6.1	1st May 2015	Consultant Psychiatrist / ECT Lead	Superseded	Updated for Care Act 2014
V6.2	September 2015	Compliance & Risk Manager	Superseded	Addendum removed and care act added
V6.3	August 2018	Consultant Psychiatrist / ECT Lead	Superseded	Policy extension
V7	November 2019	Consultant Psychiatrist / ECT Lead	Current	

18. Archiving Arrangements

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

19. Associated Documents

- MHA Medical Treatment for Mental Disorder Policy
- Kingfisher Court Operation Policy Appendix – ECT Suite
- Audio/Visual Recordings of Service Users

20. Supporting References

- CQC: Electro–convulsive Therapy (ECT): Your rights about consent to treatment
- HMSO(2007) Code of Practice to the Mental Capacity Act 2005
- Royal College of Psychiatrists:
  (2009) ECT Accreditation Service (ECTAS) standards for the administration of ECT
  (2012) The ECT Handbook, 3rd edition.

Part 4 Appendices

Appendix 1 - 12 key points on consent: the law in England

Appendix 2 - Patient Information Leaflet – ECT Consent

Appendix 3 - Consent for Electroconvulsive therapy (ECT)

Appendix 4 - Consent Form 1

Appendix 5 - Consent Form 4 for adults who lack the capacity to consent to investigation or treatment

Appendix 6 - Confirmation or Withdrawal of Consent for Electroconvulsive Therapy (ECT)

Appendix 1 - 12 key points on consent: the law in England

When Do Health Professionals Need Consent From Patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly

the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusal of treatment

10. Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the fetus.

Adults who are not competent to give consent

11. **No-one** can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

Appendix 2

Information about Electroconvulsive Therapy (ECT)

Introduction

This leaflet is for anyone who wants to know more about ECT (Electro-convulsive therapy). It looks at how ECT works, why it is used, its effects and side-effects, and alternative treatments.

Although a safe and effective treatment, ECT remains controversial and we have included some of the different views about it.

Where there are areas of uncertainty, we have listed other sources of information that you can use. Important concerns are the effectiveness and side-effects of ECT and how it compares with other treatments. At the time of writing, these references are available free and in full on the Internet.

What is ECT?

ECT is a treatment for a small number of severe mental illnesses. It was developed in the 1930s and was used widely during the 1950s and 1960s for a variety of conditions. It is now only used for fewer, more serious conditions.

An electrical current is passed through the brain to produce an epileptic fit – hence the name, electro-convulsive. On the face of it, this sounds odd. The idea developed in the days before effective medication. Doctors noticed that some people with depression or schizophrenia, who also had epilepsy, seemed to feel better after having a fit.

More recent research suggests that the effect is due to the fit rather than the electrical current.

Q How often is it used?

It is now used less often. Between 1985 and 2002, its use in England more than halved, possibly because of better psychological and drug treatments for depression.

Q How does ECT work?

No-one is certain how ECT works. We do know that it can change patterns of blood flow through the brain and change the metabolism of areas of the brain which may be affected by depression. There is evidence that severe depression is caused by problems with certain brain chemicals. It is thought that ECT causes the release of these chemicals and, probably more importantly, makes the chemicals more likely to work and so help recovery. Recent research has also suggested that ECT can help the growth of new cells and nerve pathways in certain areas of the brain.

Q Does ECT really work?

It has been suggested that ECT works not because of the fit, but because of all the other things – like the extra attention, support and the anaesthetic – that happen to someone who has it.

Several studies have compared standard ECT with "sham" or placebo ECT. In placebo ECT, the patient has exactly the same things done to them – including going to the ECT rooms and having the anaesthetic and muscle relaxant – but no electrical current is passed and there is no fit. In these studies, the patients who had standard ECT were much more likely to recover, and did so more quickly than those who had the placebo treatment. Those who didn't have adequate fits did less well than those who did. Some of the patients who had "sham" treatment recovered too, even though they were very unwell; it's clear that the extra support does help. However, ECT has been shown to have an extra effect in severe depression – it seems, in the short term, to be more helpful than medication.

Pros & Cons of ECT

Q Who is ECT likely to help?

Someone who has severe depression, resistant mania or catatonia. ECT should be considered for the rapid treatment of severe depression that is life-threatening, or when other treatments have failed.

It should not be used routinely in moderate depression. It can be helpful for someone with moderate depression if they have not responded to several different drug treatments and psychological treatment.

Q Who is ECT unlikely to help?

ECT is unlikely to help someone with mild to moderate depression or most other psychiatric conditions. It is not used in schizophrenia.

Q Why is it given when there are other treatments available?

ECT has been shown to be the most effective treatment for severe depression. It would normally be offered if:

- several different medications have been tried, but have not helped
- the side-effects of antidepressants are too severe
- you have found ECT helpful in the past
- your life is in danger because you are not eating or drinking enough
- you are seriously considering suicide.

Q What are the side-effects of ECT?

ECT involves several treatments spread over a few weeks. As with any treatment, ECT can cause a number of side-effects. Some of these are mild and some are more severe.

- **Short-term**

Immediately after ECT, many people have a headache and some aching in their muscles. They may feel muzzy-headed and generally out of sorts, or even a bit sick. Some become distressed after the treatment and may be tearful or frightened during recovery. For most people, however,

these effects settle within a few hours, particularly with help and support from nursing staff, simple pain killers and some light refreshment.

There may be some temporary loss of memory for the time immediately before and after the ECT.

An older person may be confused for two or three hours after a treatment. This can be reduced by changing the way the ECT is given (such as passing the current over only one side of the brain rather than across the whole brain).

ECT causes contraction of the jaw muscles. Although the ECT Team will do all they can to minimise the risks, there remains a small chance of damage to the tongue, teeth and lips. There are particular risks where the teeth are less strong: for example if you have crowns, veneers, or implants, also bridges and partial dentures. Please let the team know have had cosmetic dental work or piercings undertaken.

There is a small physical risk from having a general anaesthetic – death or serious injury occurs in about 1 in 80,000 treatments, about the same as if you have an anaesthetic for dental treatment. However, as ECT is given in a course of treatments, the risk per course of treatment will be around 1 in 10 000.

- **Long-term**

Memory problems can be a longer-term side effect. Surveys conducted by doctors and clinical staff usually find a low level of severe side-effects, maybe around 1 in 10. Patient-led surveys have found much more, maybe in half of those having ECT. Some surveys conducted by those strongly against ECT say there are severe side-effects in everyone.

Some memory problems are probably present in everyone receiving ECT. Most people feel better after the course of ECT has finished and a few weeks have passed. However, some people do complain that their memory has been permanently affected, that their memories never come back. It is not clear how much of this is due to the ECT, and how much is due to the depressive illness or other factors.

Some people have complained of more distressing experiences, such as feeling that their personalities have changed, that they have lost skills or that they are no longer the person they were before ECT. They say that they have never got over the experience and feel permanently harmed.

What seems to be generally agreed is that the more ECT someone is given, the more it is likely to affect their memory.

Q What if ECT is not given?

- You may take longer to recover.
- If you are very depressed and are not eating or drinking enough, you may become physically ill or die.
- There is an increased risk of suicide if your depression is severe and has not been helped by other treatments.

Q What about driving?

Most people who are ill enough to require to ECT will be unfit to drive. After a course of ECT you should discuss with your doctor when you are well enough to resume driving. Sometimes disorientation and impaired visual functioning may go on for several months after ECT.

Q What are the alternatives?

- If someone with severe depression refuses ECT, the doctors can try a different medication, or combination of medications
- Offer intensive psychotherapy, although this will usually have already have been tried.

Given time, some episodes of severe depression will get better on their own, although being severely depressed carries a real risk of death by suicide.

Deciding to have (or not to have) ECT

Q Giving consent to having ECT

Like any significant treatment in medicine or surgery, you will be asked to give consent, or permission for the ECT to be done.

The doctor should explain (in a way that you can understand) their reasons for suggesting ECT, the possible benefits and any side-effects. If you decide to go ahead, you then sign a consent form. It is a record that ECT has been explained to you, that you understand what is going to happen, and that you give your consent to it. However, you can withdraw your consent at any point, even before the first treatment.

Q What if I really don't want ECT?

If you have very strong feelings about ECT, you should tell the doctors and nurses caring for you, but also friends, family or an advocate who can speak for you.

Doctors must consider your views when deciding what to do.

If you have made it clear that you do not want to have ECT, then you should not be given it, except in special circumstances (see below). You could write an 'advance statement' to refuse ECT if you become unwell again. Alternatively, you could appoint someone to be your Health and Welfare Attorney to make decisions on your behalf when you are not able to decide for yourself.

Q Can ECT be given to me without my permission?

Most ECT treatments are given to people who have agreed to it. This means that they have had:

- a full discussion of what ECT involves
- why it is being considered in their case
- the advantages and disadvantages
- a discussion of side-effects.

You cannot usually be given ECT against your wishes, even if you are sectioned under the Mental Health Act. It is the responsibility of the doctors and nurses involved to make sure that they have discussed this with you – and to document it.

Sometimes, you can become so unwell that you can't understand the information about ECT – if you are very withdrawn or have ideas that stop you from understanding your position (e.g you believe that your depression is a punishment you deserve).

In this situation, it may be impossible to give proper agreement or consent. When this happens, it is still possible to give ECT. The legal provisions for this differ from country to country, even within the United Kingdom.

Mental Health Act

In England and Wales, ECT can be given under the Mental Health Act. This means that two doctors and another professional, who is usually a social worker, need to agree that ECT should be given.

There must then be a second opinion from an independent specialist who is not directly involved in the person's care. The clinical team should also speak to family and other carers, to find out what they think about ECT, but also to find out if the patient had any opinion about it.

Mental Capacity Act

Sometimes - if a person doesn't have the capacity to give an informed consent - the team may decide the ECT can be given under the Mental Capacity Act. This is unusual, as in most cases, the Mental Health Act provides the best protection for a patient's rights. The Mental Capacity Act can only be used if the patient lacks capacity and a "decision maker" (usually the consultant in charge of their care) decides that ECT is in the patient's "best interests".

It is expected the decision maker will ask other people to try to find out what the person's views would have been. This would usually include family members and other people close to them. The decision maker should also make "all reasonable attempts" to help the patient to regain capacity to consent (if this is possible). An independent specialist is not needed, though the clinical team may request a second opinion from another consultant.

Whether ECT is given under the Mental Health Act or the Mental Capacity Act, the team must make regular assessments of the patient's ability to understand their treatment. Once the patient is able to give consent, the treatment can only continue if they do consent and must stop if they refuse.

Where is ECT given?

ECT is always given in hospital. As it is generally used in severe depression, you would usually need to stay in hospital. Some people do have ECT as a day patient, but you may need to check if your local service can do this.

How is ECT given?

The seizure is brought on by passing an electrical current across the brain in a carefully controlled way from a special ECT machine.

- an anaesthetic and muscle relaxant are given so that you are not conscious when the ECT is given.
- the muscle spasms that would normally be part of a fit – and which could produce serious injuries - are reduced to small, rhythmic movements in the arms, legs and body.

By adjusting the dose of electricity, the ECT team will try to produce a seizure lasting between 20 and 50 seconds.

Q Is there any preparation?

In the days before you start a course of ECT, your doctor will arrange for you to have some tests to make sure it is safe for you to have a general anaesthetic. These may include:

- a chest X-ray

- a tracing of your heart working (ECG)
- blood tests.

You will be asked not to have anything to eat or drink for 6 hours before the ECT. This is so that the anaesthetic can be given safely.

Q Where is ECT done?

ECT should always be done in a special set of rooms that are not used for any other purpose, usually called the “ECT suite”. This should be a separate area where you wait, have your treatment, wake up fully from the anaesthetic and then recover properly before leaving.

There should be enough qualified staff to look after you while you are there so that they can help you through any confusion or distress.

Q What happens during ECT?

- You should arrive at the ECT suite with an experienced nurse who you know and who is able to explain what is happening. Many ECT suites are happy for family members to be there - you may want to check with your local team that this is possible. You should be met by a member of the ECT staff who will do routine physical checks, if they have not already been done. They will check that you are still willing to have ECT and if you have any further questions.
- When you are ready you will be accompanied into the treatment area and be helped onto a trolley.
- The ECT team will connect monitoring equipment to check your heart rate, blood pressure, oxygen levels, ECG and EEG during the fit.
- The anaesthetist will give you the anaesthetic through a needle in your hand. Once you are asleep, they will give a muscle relaxant through the same needle. While you are going off to sleep, the anaesthetist will also give you oxygen to breathe.
- Once you are asleep and fully relaxed, a doctor will give the ECT treatment. Your fit will last between around 20 to 50 seconds. The muscle relaxant wears off quickly (within a couple of minutes) and, as soon as the anaesthetist is happy that you are waking up, you will be taken through to the recovery area where an experienced nurse will monitor you until you are fully awake.
- When you wake up, you will be in the recovery room with a nurse. He or she will take your blood pressure and ask you simple questions to check on how awake you are. There will be a small monitor on your finger to measure the oxygen in your blood, and you may wake up with an oxygen mask. You will probably take a while to wake up and may not know quite where you are at first. You may feel a bit sick. After half an hour or so, these effects should have worn off.
- Most ECT units have a “recovery” area for rest and light refreshments. You can leave when the staff are happy that your physical state is stable and you feel ready to do so. It usually takes around half an hour, from start to finish.

Q. What are bilateral and unilateral ECT?

In bilateral ECT, the electrical current is passed across the whole brain

In unilateral ECT, the current is just passed across one side. Both of them cause a seizure in the whole of the brain.

Bilateral ECT seems to work more quickly and effectively and it's probably the most widely used in Britain; however, there has been concern that it may cause more side-effects.

Unilateral ECT is now used less. It had been thought to cause less memory loss, but recent research has shown that it is necessary to use larger doses of electricity to make it as effective as bilateral ECT. If the dose of electricity is increased to make it equally effective, the risks of memory loss are as great as with bilateral ECT.

Sometimes ECT clinics will start a course of treatment with bilateral ECT and switch to unilateral if the patient experiences side-effects. Alternatively, they may start with unilateral and switch to bilateral if the person isn't getting better.

You may wish to speak to the doctor who is suggesting ECT for you to decide whether unilateral or bilateral ECT is best for you.

Q How often and many times is ECT given?

Most units give ECT twice per week, often on a Monday and Thursday, or Tuesday and Friday. It is impossible to predict how many treatments someone will need. However, in general, it will take 2 or 3 treatments before you see any difference, and 4 to 5 treatments for noticeable improvement.

A course will on average be 6 to 8 treatments, although as many as 12 may be needed, particularly if you have been depressed for a long time. If, after 12 treatments, you feel no better, it is unlikely that ECT is going to help and the course would usually stop. A member of the mental health team should check after each treatment to see how your are responding, and to check that you are not getting troublesome side-effects. Your consultant should see you after every two treatments. ECT should be stopped as soon as you have made a recovery, or if you say you don't want to have it any more.

Q What happens after a course of ECT?

Even when someone finds it effective, ECT is only a part of recovering from depression. Like antidepressants, it can help to ease problems so you are able to look at why you became unwell. Hopefully you can then take steps to continue your recovery, and perhaps find ways to make sure the situation doesn’t happen again. Psychotherapy and counselling can help and many people find their own ways to help themselves. Certainly people who have ECT, and then do not have other forms of help, are likely to quickly become unwell again.

The ECT Controversy

There are many areas in which people disagree over ECT, including whether it should even be done at all. People tend to have very strong feelings about ECT, often based on their own experiences. The main areas of disagreement are over whether it works, how it works and what the side-effects are.

Q Why is ECT still being given?

ECT is now used much less and is mostly a treatment for severe depression. This is almost certainly because modern treatments for depression are much more effective than they were in the past. These include psychotherapy (talking treatments), antidepressants and other psychological and social supports.

Even so, depression can for some people still be very severe and even life-threatening. The person may be barely able to talk, reluctant (or unable) to eat, drink or look after themselves. Occasionally a person may also develop strange ideas (delusions) about themselves or others. If

other treatments have not have worked, it may be worth considering ECT. It is a safe and effective treatment for severe depression.

Q What do patients think of ECT?

In 2003 researchers analysed all the work which had been done on patients' experiences of ECT. They found that the proportion of people who had had ECT and found it helpful ranged from 30% to 80%. The researchers commented that studies reporting lower satisfaction tended to have been conducted by patients, and those reporting higher satisfaction were carried out by doctors. Between 30% and 50% of patients complained of difficulties with memory after ECT.

Q What do those in favour of ECT say?

Many doctors and nurses will say that they have seen ECT relieve very severe depressive illnesses when other treatments have failed. Bearing in mind that 15% of people with severe depression will kill themselves, they feel that ECT has saved patients' lives, and therefore the overall benefits are greater than the risks. Some people who have had ECT will agree, and may even ask for it if they find themselves becoming depressed again.

Q What do those against ECT say?

There are different views and reasons why people object to ECT. Some see ECT as a treatment that belongs to the past. They say that the side-effects are severe and that psychiatrists have, either accidentally or deliberately, ignored how severe they can be. They say that ECT permanently damages both the brain and the mind, and if it does work at all, does so in a way that is ultimately harmful for the patient. Some would want to see it banned.

Q What happens in other countries?

At the moment, ECT is part of standard psychiatric practice in Britain and the majority of countries worldwide. Some countries (and some states in America also) have restricted its use more than in the UK, though only a few have prohibited its use.

Q How do I know if ECT is done properly locally?

The Royal College of Psychiatrists has set up the ECT Accreditation Service (ECTAS) to provide an independent assessment of the quality of ECT services. ECTAS sets very high standards for ECT, and visits all the ECT units who have registered with it. The visiting team involves psychiatrists, anaesthetists, and nurses. It publishes the results of its findings and also provides a forum for sharing best clinical practice. Membership of ECTAS is not compulsory, but every ECT unit should be able to tell you:

- if they have signed up to ECTAS;
- the result of their most recent report;
- who to speak to if you are concerned that your local unit has not been assessed.

A list of accredited site is available on the **Royal College of Psychiatrists' website**.

Q Where can I get more information?

Many ECT suites provide their own information packs. They should be able to give written information to you or your family/carers.

Further Information

National Institute for Health and Clinical Excellence (NICE)

- Electroconvulsive therapy (ECT): the clinical effectiveness and cost effectiveness of electroconvulsive therapy (ECT) for depressive illness, schizophrenia, catatonia and mania. (TA59 2003)
- Depression: the treatment and management of depression in adults (CG 90 2009)

Electroconvulsive Therapy Accreditation Services (ECTAS): Launched in May 2003, ECTAS aims to assure and improve the quality of the administration of ECT; awards an accreditation rating to clinics that meet essential standard.

Appendix 3

Consent for Electroconvulsive therapy (ECT)

1. Information for Service Users

1.1 Information is provided to service users orally and in written formats.

1.2 Before ECT treatment is agreed, the service user should be offered the Trust ECT information leaflet to read and consider.

1.3 For people detained under the Mental Health Act, the Care Quality Commission leaflet 'Information for Detained Patients about Consent to Treatment Electro Convulsive Therapy (ECT)' must be provided.

http://www.cqc.org.uk/sites/default/files/documents/20120821_mha_ect_booklet_final.pdf

1.4 The service user is informed how to obtain additional information and access to independent advocacy. Links are available from the Trust public website to information from:

The Royal College of Psychiatrists provides detailed information on ECT.
https://www.rcplondon.ac.uk/

The National Institute for Clinical Excellence - Understanding NICE guidance – information for service users, their advocates and carers, and the public
https://www.nice.org.uk/

1.5 Except in an emergency, the service user should be given at least 24 hours to reflect on information about ECT and have the opportunity to discuss with relatives, friends and advisers before making a decision.

1.6 The service user's relatives should wherever possible be informed about the treatment plan.

1.7 Service users who have not previously had ECT should where possible be offered the opportunity to visit the ECT Suite and discuss with ECT staff the practical details of the treatment.

1.8 The consenting service user must be made aware that if at any time he/she decides against further treatment, this decision must be honoured. Should he/she reconsider and later choose to have further treatment, a new consent form must be completed.

1.9 The treatment, care, and information service users are given should meet the individual's communication needs. For example, people with additional needs such as physical, sensory or learning disabilities and people who do not speak or read English.

1.10 Carers and relatives should be provided with the information and support they need.

1.11 For outpatients there are additional information requirements with regard to instructions for service users attending for treatment under a general anaesthetic.

2. Procedure for Consent to ECT Treatment

Consent for ECT must include written consent whether the service user is informal or detained under the Mental Health Act.

2.1 Refer to appendices of this document for the Consent for electroconvulsive therapy (ECT), Consent Form 1 and the Confirmation or Withdrawal of Consent for ECT form (appendix 6).

2.2 Valid consent should be obtained in all cases where the individual has the ability to grant or refuse consent.

2.3 The decision to use ECT should be made jointly by the individual and the clinician(s) responsible for treatment, on the basis of an informed discussion.

2.4 This discussion should be enabled by the provision of full and appropriate information about the general risks associated with ECT and about the risks and potential benefits specific to that individual.

This includes:

- The nature of the treatment and a description of the process
- The purpose and benefits of treatment, including likelihood of success
- The risks and likelihood of adverse effects, including cognitive impairment
- The likely consequences of not have ECT
- Treatment alternatives and confirmation that these will be available if the service user decides not to have ECT.

2.5 The proposed number of ECT treatments should be discussed with the service user.

2.6 Consent should be obtained without pressure or coercion, which may occur as a result of the circumstances and clinical setting, and the individual should be reminded of his/her right to withdraw consent at any point. There should be strict adherence to recognised guidelines about consent and the involvement of advocates and/or carers to facilitate informed discussion is encouraged.

2.7 If a person has difficulty communicating in English then information is provided through an interpreter and this is recorded in the service user's notes.

2.8 The service user is asked what additional information they require.

3. Informal Service Users

Following the doctor's explanation of ECT to the service user, a consent form MUST be signed by the service user if he/she agrees to the treatment. This form is held in the service user's care record and/or scanned into the electronic record and a copy given to the service user.

The consent form is completed after the service users has been has been advised of the risks and benefits of treatment and these risks should include those details on standard pre-printed Consent Form.

A written record should be kept of the assessment of competence and details of the process of consent in the care record.

A copy of the ECT Consent Form should be offered to the service user.

4. Detained Patients and those under 18 years of age

This section is based on the requirements of Chapter 24, Mental Health Act Code of Practice 2008, 'Treatments subject to special rules and procedures'

Refer also to the HPFT Medical Treatment for Mental Disorder under MHA Policy and Procedure Electro-convulsive therapy (ECT) under Section 58A.

4.1 Section 58A of the Mental Health Act 1983 as amended by the 2007 Act applies to ECT and to medication administered as part of `ECT. It applies to detained service users and to **all service users aged under 18 (whether or not they are detained).**

4.2 Detained service users who have the capacity to consent may not be given ECT treatment under section 58A unless they do in fact consent.

4.3 A detained service user who has capacity to consent may not be given treatment under section 58A unless the clinician in charge, or a SOAD, has certified that the service user has the capacity to consent and has done so.

4.4 There is **no** initial three-month period during which a certificate is not needed (even for the medication administered as part of the ECT).

4.5 No service user aged under 18 can be given treatment under section 58A unless a second opinion appointed doctor (SOAD) has certified that the treatment is appropriate.

4.6 For young people **under 18**, a SOAD certificate by itself is not sufficient to authorise the treatment, unless they are detained. Clinicians must also have the service user's own consent or some other legal authority, just as they would if section 58A did not exist. Refer to Chapter 36 of the Code of Practice – Children and young people under the age of 18.

4.7 **A service user who lacks the capacity to consent** under the Mental Capacity Act 2005 may not be given treatment under section 58A unless a SOAD certifies that the service user lacks capacity to consent and that:

- the treatment is appropriate;
- no valid and applicable advance decision has been made by the service user under the Mental Capacity Act 2005 (MCA) refusing the treatment.
- no suitably authorised attorney or deputy objects to the treatment on the service user's behalf; and
- the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

The clinician in charge should, if he/she considers the service user to be in need of ECT, contact the Mental Health Act Commission via the Mental Health Act Administrator, who will arrange for a Second Opinion Appointed Doctor (SOAD) to visit The SOAD will complete a SOAD certificate, after carrying out the necessary consultations, if they agree the treatment may proceed.

4.8 In all cases, SOADs should indicate on the certificate the maximum number of administrations of ECT which it approves.

4.9 Whether or not section 58A applies, service users of all ages to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose and likely effects.

4.10 Where the service user has given consent, the clinician in charge should obtain written consent using the ECT consent form in addition to MHA requirements.

5. Withdrawal of Consent for ECT Treatment

Informal service users and those detained under the Mental Health Act may withdraw their consent to ECT at any stage, regardless of the number of treatments administered.

If the clinician in charge considers the continuance of treatment for a detained patient to be necessary, a second opinion must be obtained.

If a service user withdraws their consent whilst attending the ECT clinic, the treating psychiatrist must immediately be notified by the nursing staff.

6. Urgent ECT Treatment

The Mental Health Act details circumstances in which urgent treatment, including ECT (or medication administered as part of ECT), may be given to detained service users without the service user's consent.

For ECT this applies only in the treatment is immediately necessary to:

- Save a patient's life
- Prevent serous deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed.

For details on urgent treatment refer to the HPFT "Medical Treatment for Mental Disorder under the MHA - Policy and Procedure" Urgent cases where certificates are not required.

Consent for electroconvulsive therapy (ECT)

Consent Form 1

Patient agreement to treatment

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names .....

Date of birth .....

Responsible health professional.....

Job title .....

NHS number (or registration number) .....

Male Female

Special requirements .....
(e.g. other language/other communication method)

To be filed in the ECT section of the health records / Scanned onto EPR

Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for
This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an *aide-memoire* to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.
The law on consent See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent www.doh.gov.uk/consent

Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose.Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form
If the patient is 18 or over and lacks the capacity to give consent, you should use form 4 (form for adults who lack the capacity to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:

- understand information about the decision to be made
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (by talking, using sign language or any other means).

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives **cannot** be asked to sign a form on behalf of an adult who lacks capacity to consent for themselves, unless they have been given the authority to so under a Lasting Power of Attorney or as a court appointed deputy."

Information
Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this in the form or in the patient's notes. Page 2

Patient identifier/label

Name of proposed procedure or course of treatment:

Electroconvulsive Therapy (ECT): A course of bilateral/unilateral electroconvulsive therapy up to a maximum of ……. treatments.
(This section must be completed. If laterality or a number is not stated, then treatment will not be given.)

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the patient. In particular, I have explained:
The intended benefits: improvement of depression
Other (specify):……
…….
Risks explained
Significant, unavoidable or frequently occurring risks:
(1) memory loss (possibly permanent) (2) post-treatment confusion
(3) risks relating to general anaesthesia (including rarely occurring fatality risk)
……
Transient side-effects
(1) headache (2) muscle aches (3) nausea (4) 'muzzy-headedness' (5) fatigue
……
Any extra procedures, which may become necessary during the procedure:
(1) Intubations (2) Transfer to general hospital if complication
Other procedure (please specify) ……

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

This procedure will involve: (1) general anaesthesia (2) muscle relaxation.

I have advised the patient that, for the first 24 hours after each ECT, they must:

- be supervised by a responsible adult (so also not to be in sole charge of a child)
- not sign any legal documents
- not drink alcohol
- not operate machinery, including kitchen appliances

They must also not drive a motor vehicle or ride a bicycle on the road for **48 hours** after each ECT if having it weekly or less often, and should not drive at all for the entirety of an acute (twice-weekly) ECT course.

ECT information leaflets provided (tick) **at least 24 hours in advance** □ yes □ no

□ Royal College of Psychiatrists □ Kingfisher Court □ CQC (for detained patients)

□ (Community patients) 24 post ECT supervision requirements □ 'Easy read' leaflet

Signed:…… Date ...…….

Name (PRINT) ……..……. Job title ...……..

Contact details (if patient wishes to discuss)…….……...

For patients detained under the Mental Health Act

(Please tick applicable box & attach appropriate form to consent form)

□ Patient consented - Form T4 completed

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed ……. Date ……..…….

Name (PRINT) ……..……

Copy accepted by patient: yes/no (please ring)

Patient identifier/label

Statement of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 3, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion……..
……
……
……

Patient's signature ……..Date……..

Name (PRINT) ……..

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature …… Date ……..…..……..

Name (PRINT) ……

Important notes: (tick if applicable)

See also advance directive/living will (e.g. Jehovah's Witness form)

Patient has withdrawn consent (ask patient to sign/date here)..……..…….

……

Consent form 4

Form for adults who lack the capacity to consent to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names .....

Date of birth .....

Responsible health professional.....

Job title .....

NHS number (or registration number) .....

Male Female

Special requirements .....
(e.g. other language/other communication method)

To be retained in patient's record

Guidance to health professionals (to be read in conjunction with consent/mental capacity policy)

This form should only be used where it would be usual to seek written consent but an adult patient (16 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has made a valid advance decision to refuse treatment that is applicable to the proposed treatment then you must abide by that refusal.. For further information on the law on consent, see the Department of Health's *Reference guide to consent for examination or treatment* (www.dh.gov.uk/consent).

When treatment can be given to a patient who is unable to consent

All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Capacity Act 2005. More information about the Act is given in the Code of Practice[1].
Treatment can be given to a patient who is unable to consent, only if:

- the patient lacks the capacity to give or withhold consent to this procedure AND
- the procedure is in the patient's best interests.

Capacity

A person lacks capacity if they have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of drugs or alcohol) that affects the way their mind or brain works which means that they are unable to make a specific decision at the time it needs to be made. It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision if they cannot do one or more of the following things:

- Understand the information given to them that is relevant to the decision.
- Retain that information long enough to be able to make the decision.
- Use or weigh up the information as part of the decision- making process.
- Communicate their decision - this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

You must take all steps reasonable in the circumstances to assist the patient in taking their own decisions. This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates (as distinct from an IMCA as set out below) or supporters. Sometimes it may be necessary for a formal assessment to be carried out by a suitably qualified professional.
Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be able to take other more straight-forward decisions or parts of decisions. Capacity can also fluctuate over time and you should consider whether the person is likely to regain capacity and if so whether the decision can wait until they regain capacity.

Best interests

The Mental Capacity Act requires that a health professional **must** consider all the relevant circumstances relating to the decision in question, including, as far as possible considering:

- the person's past and present wishes and feelings (in particular if they have been written down)

- any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors
- the other factors that the person would be likely to consider if they were able to do so.

When determining what is in a person's best interests" a health professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour. If the decision concerns the provision or withdrawal of life-sustaining treatment the health professional must not be motivated by a desire to bring about the person's death.
The Act also requires that, as far as possible, health professionals must consult other people, if it is appropriate to do so, and take into account of their views as to what would be in the best interests of the person lacking capacity, especially anyone previously named by the person lacking capacity as someone to be consulted and anyone engaging in caring for patient and their family and friends.

Independent Mental Capacity Advocate (IMCA)
The Mental Capacity Act introduced a duty on the NHS to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. IMCAs are not decision makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the *Act*.

Lasting Power of Attorney and Court Appointed Deputy
A person over the age of 18 can appoint an attorney to look after their health and welfare decisions, if they lack the capacity to make such decisions in the future. Under a Lasting Power of Attorney (LPA) the attorney can make decisions that are as valid as those made by the person themselves. The LPA may specify limits to the attorney's authority and the LPA must specify whether or not the attorney has the authority to make decisions about life-sustaining treatment. The attorney can only, therefore, make decisions as authorised in the LPA and must make decisions in the person's best interests.

The Court of Protection can appoint a deputy to make decisions on behalf of a person who lacks capacity. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court's authority or where there is no other way of settling the matter in the best interests of the person who lacks capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity then it is the deputy rather than the health professional who makes the treatment decision and the deputy must make decisions in the patient's best interests.

Second opinions and court involvement
Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court. Cases involving:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent
- cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests (include cases involving ethical dilemmas in untested areas)

Should be referred to the Court for approval. The Court can be asked to make a decision in cases where there are doubts about the patient's capacity and also about the validity or applicability of an advance decision to refuse treatment.

Patient identifier/label

All sections to be completed by health professional proposing the procedure

A Details of procedure or course of treatment proposed:

(N.B. see guidance to health professionals on page 2 of this form for details of situations where court approval must first be sought)

B Assessment of patient's capacity:

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because of an impairment of the mind or brain or disturbance affecting the way their mind or brain works (for example, a disability, condition or trauma, or the effect of drugs or alcohol) and they cannot do one or more of the following:

understand information about the procedure or course of treatment
retain that information in their mind
use or weigh that information as part of the decision-making process, or

communicate their decision (by talking, using sign language or any other means)

Further details (excluding where patient unconscious): for example how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful:

C Assessment of patient's best interests

I am satisfied that the patient has not refused this procedure in a valid advance decision. As far as is reasonably possible, I have considered the person's past and present wishes and feelings (in particular if they have been written down) any beliefs and values that would be likely to influence the decision in question. As far as possible, I have consulted other people (those involved in caring for the patient, interested in their welfare or the patient has said should be consulted) as appropriate. I have considered the patient's best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)

The treatment cannot wait until the patient recovers capacity because:

Staff should complete and attach the Best Interests Form

D Involvement of the patient's family and others close to the patient

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests", and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(to be signed by a person or persons close to the patient, if they wish)

I/We have been involved in a discussion with the relevant health professionals over the treatment of……(patient's name).

I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form.

I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision):

Name ……Relationship to patient……
Address (if not the same as patient)
……..……
……
……
……
……
……

Signature ……
Date……

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)
□ Yes □ No

Details:

Independent Mental Capacity Advocate (IMCA)
For decisions about serious medical treatment, where there is no one appropriate to consult other than paid staff, has an Independent Mental Capacity Advocate (IMCA) been instructed?
Yes No

Details:

Signature …….. Date……..

E The patient has an attorney or deputy
Where the patient has authorised an attorney to make decisions about the procedure in question under a Lasting Power of Attorney or a Court Appointed Deputy has been authorised to make decisions about the procedure in question, the attorney or deputy will have the final responsibility for determining whether a procedure is in the patient's best interests.

Signature of attorney or deputy

I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorney / as a Court Appointed Deputy (delete as appropriate). I have considered the relevant circumstances relating to the decision in question (see section C) and believe the procedure to be in the patient's best interests.

Any other comments (including the circumstances considered in assessing the patient's best interests)

Signature:…… Date:……

Signature of health professional proposing treatment
The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature:……Date ……...
Name (PRINT) …… ……Job title ……..……..

Where second opinion sought, s/he should sign below to confirm agreement:

Signature:……Date ..……..……...
Name (PRINT) …… ……Job title… …….……

Appendix 6

Confirmation or Withdrawal of Consent for Electroconvulsive Therapy (ECT)

Service User Name: Date of Birth:

NHS Number:

To be completed by a health professional each time the patient attends for the procedure, if the service user has signed a consent form in advance.

On behalf of the team treating the patient, I have confirmed with the service user that she/he has no further questions and wishes the procedure to go ahead.

DATE	TIME	NAME OF PROFESSIONAL	TITLE	SIGNATURE

If the service user has withdrawn consent:

Signature of Service User …….

Date: …….

CONFIRMATION OF CAPACITY STATUS FORM

Insert label here

***To be completed by the ECT nurse pre-treatment**

DATE:						
Treatment no.:						
Is there an impairment of, or disturbance in the functioning of the patient's mind or brain.						
With regards to the relevant information about ECT, can the patient:- understand? b) Retain c) weigh risk-benefits d) Communicate their decision about undergoing ECT						
<u>Conclusion</u>: Does the patient have capacity to consent to ECT?						
Additional supporting documents ie. Section 62, T4, T6, other.						
Comments:						
Staff name & Signature						

Insert label here

CONFIRMATION OF CAPACITY STATUS FORM

***To be completed by the ECT nurse pre-treatment**

DATE:						
Treatment no.:						
Is there an impairment of, or disturbance in the functioning of the patient's mind or brain.						
With regards to the relevant information about ECT, can the patient:- understand? b) Retain c) weigh risk-benefits d) Communicate their decision about undergoing ECT						
<u>Conclusion</u>: Does the patient have capacity to consent to ECT?						
Additional supporting documents ie. Section 62, T4, T6, other.						
Comments:						
Staff name & Signature						

Our Values

Welcoming Kind Positive Respectful Professional