Consent procedures and electroconvulsive therapy in South Africa: impact of the Mental Health Care Act

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Abstract
The introduction of the new Mental Health Care Act (MHCA) No 17 of 2002 has highlighted the ethical treatment in least restrictive environments for patients suffering from mental illness. The legislation has highlighted several shortcomings in the consent procedures that were previously utilised for psychiatric patients. Electroconvulsive Therapy (ECT) is a controversial treatment modality hence consent procedures for its use are particularly important. The use of ECT is a highly regulated and legislated treatment in most countries, but not in South Africa. Up until the introduction of the MHCA, and its implementation in December of 2004, legislation and monitoring of the use of ECT in South Africa had been conspicuous by its absence. The MHCA will potentially have an impact on the practice of ECT in a variety of ways. This paper is intended to highlight, for the ECT practitioner, both the implications of these changes as well as propose new consent procedures for ECT.

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Introduction

''Psychiatric ethics is, by definition a body of rules and principles in a state of flux, adapting to changes in psychiatry and psychiatry's place in the world at large.''[1]

The four basic tenets that govern medical bioethics are usually considered to be autonomy, nonmaleficence, beneficence and justice. The Health Professions Council of South Africa includes respect for persons, human rights, integrity, truthfulness, confidentiality, compassion, tolerance, professional competence and self-improvement, and community in its core ethical values.[2] The theoretical underpinnings of these tenets are predominantly the philosophies of utilitarianism (consequentialist formulation) and the deontological formulation. In South Africa, in the present day the utilitarian school of thought is playing an increasingly active role in our daily decision making processes in the arena of mental health. This theoretical framework takes cognisance of the limited financial resources, skilled manpower, and specialist facilities that our mental health care practitioners (MHCP) and psychiatric patients face in their day-to-day lives. The deontological formulation on the other hand, posits immutable values that are to take precedence above all else, for example ''do no harm''. With the introduction of the Mental Health Care Act (17 of 2002)[3] into a health care system generally poorly resourced, staffed and ill prepared for the changes the Act would bring, it is increasingly difficult to implement ethical clinical practice that is devoid of conflict amongst the ethical tenets listed above. In particular the tenets of autonomy and beneficence appear to precipitate a struggle in the minds of overburdened MHCP's. A psychiatric treatment modality that highlights this dilemma is electroconvulsive therapy (ECT). ECT is a controversial treatment modality at present and it generates debate in both professional and lay press. In contemporary psychiatric practice ECT is largely considered to be an accepted treatment modality with demonstrated efficacy, supported by various studies as reflected in detailed review articles.[3-9] The indications for ECT are considered to be, for the most part, the mood disorders,

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schizophrenia, catatonia, and severe psychiatric conditions occurring in pregnancy.[1,3-9] These indications have been the subject of numerous publications and are adopted in well recognised ECT clinical guidelines.[10,11] One of the major limitations of ECT is the neurocognitive side-effects that accompany its administration.[12,13] However, with recent research on the effects of changes in electrode placement and dosing strategies, it is possible to minimise these side-effects in the majority of patients.[12,14] Despite these recent advances in the practice of ECT it remains a highly regulated and legislated treatment modality in most countries. It has been shown that the more legislated the procedure becomes the less frequently it is used.[15] Reasons for this legislation are numerous, and for the most part fall outside the scope of this paper. In brief, from an ethical perspective the psychiatrist (medical fraternity) and his/her desire to treat a patient as required by the principle of '' beneficence'' (the prevention or removal of harm and promotion of well being) is being increasingly offset by the principle of patient ''autonomy'' and various informed consent protocols as well as that of ''nonmaleficence'' (primum non nocere, first do no harm). The argument is that paternalistic psychiatrists are conducting ECT on patients whose rights they are violating, by utilising inadequate procedures for obtaining informed consent, thus undermining autonomy. This treatment is also potentially harmful thus not adhering to the tenets of nonmaleficence.

The increasing risk of litigation in the field of medicine has had a role to play in the aforementioned phenomenon both as cause and effect. In the United States where ECT related legislation is amongst the most restrictive in the world, certain states are now no longer permitted to perform ECT at all. In others, its use is closely monitored and is restricted to certain conditions and patients groups.[15] As the new South Africa evolves in its fledgling democracy the incidence of medical litigation is rising alarmingly, with over 1100 ongoing claims or reported matters in South Africa currently.[16] Recent press reports relating to health matters in South Africa has not been complimentary in terms of service delivery and malpractice.[17] At the same time, media and lay perceptions of ECT are generally negative. This has in part been fuelled by the emotive notion of subjecting a person's brain to a strong electrical current, the increasing knowledge of the side-effects of ECT, and at times, the indiscriminate use of ECT in poorly controlled settings with poor outcomes for the patients concerned. It is not only within the realms of lay media that controversies emerge. Even within the medical and mental health fraternity, there is marked disagreement and apathy regarding ECT as a treatment modality.[15,18] On both sides of the Atlantic psychiatrists have to face emotive and polarised views regarding ECT. Rose et al, writing in the British Medical Journal has stated emphatically that ''Electroconvulsive therapy is one of the most controversial treatments in medicine''.[19] Indeed these authors indicate the spectrum of opinion ranges from ''effective and potentially life saving'' through to the extreme of ''unhelpful and harmful and campaign energetically for it to be banned.''[19] In the United States of America, Herman et al summarised the situation as such: ''lack of consensus can be seen in attitudes of mental health professionals toward the efficacy and safety of ECT; surveys of psychiatrists and other clinicians show marked disagreement regarding its value''.[15] As a consequence of this highly charged and emotive situation one cannot afford the ''luxury of assumption'' that standard consent procedures and protocols will suffice when it comes to ECT, regardless of the mental state of the patient at the time. The fundamental utility of ECT as a medical procedure is both questioned and debated even in the professional literature. Indeed, no other psychiatric treatment modality is specifically targeted for legislation in the manner that ECT is. In the United Kingdom, ECT is a procedure that attracts ''special safeguards under common law'', and indeed, proposed future mental health legislation will place the decision to perform ECT in the hands of a tribunal.[19] In South Africa the MHCA also recognises the uniqueness of ECT and legislates specific requirements regarding useage.[3]

ECT in South Africa: shortcomings in current practice

The South African government has introduced various policies like the principals of Batho Pele or ''people first'' in an effort to change the public perceptions of service delivery and to ensure improved quality of care. The MHCA has introduced policies that echo these sentiments, in particular ''least restrictive'' treatments are enforced and the adoption of the ''assisted'' and ''involuntary'' classifications of mental health care users has attempted to create an environment that is congruent with the needs and rights of the user (by increasing their autonomy).[3] Whilst ECT has also been highlighted for legislative restructuring in the MHCA, these changes are unfortunately insufficient to ensure that ECT is practised in an acceptable manner. This situation is plainly evident if one compares South Africa and international circumstances. In many countries, psychiatrists have to undergo specific training in the use of ECT. These psychiatrists are then registered as ECT practitioners and are consequently afforded the ''privileging'' rights to utilise the procedure in the treatment of their patients.[10,11] In South Africa this situation does not exist. It is indeed possible for a local registrar to complete their specialist training without ever having performed (or even witnessed) ECT. South Africa is surprisingly not alone in this situation.[18] The big difference however is that South African psychiatrists, regardless of ECT experience during the course of their training or afterward, will be entitled to utilise the procedure without any supervision or monitoring once they enter into private practice. There are simply no ECT training requirements specified by the Health Professions Council of South Africa, or in the MHCA. The MHCA simply states that the person must be ''trained''.[3]

As no clinical guidelines exist for the practice of ECT in South Africa, and no audit of ECT practice has ever been undertaken here, it is not possible to comment on how the procedure is actually practised. However, the very lack of monitoring or audit raises the issue as to whether we are providing the ''best possible treatment'' in this area. The single biggest shortcoming in local ECT practice is likely to be in the area of disclosure. Failure of adequate disclosure in this instance would include, disclosure of practitioners' training inadequacies in competence to prescribe and perform the procedure, through to inadequacies of

disclosure of procedural risk. This statement should not come as too much of a shock to local ECT practitioners. In countries where these items are regulated, with clear guidelines for ECT practitioners to follow, the data on ECT audits makes for sobering and disturbing reading.[19-21] It is unlikely that in South Africa, with its complete absence of guidelines, that an ECT audit conducted here would show that our local ECT practitioners fare any better than our overseas counterparts.

With the introduction of new mental health legislation in South Africa, it is appropriate at this time to consider some of the medico-legal and ethical implications of conducting ECT. It is an opportunity for clinicians to examine their practice and to develop ethically and clinically sound approaches to using this important and controversial treatment modality. In addition, mental health review boards and provincial health authorities have an important responsibility to monitor how ECT is practised in South Africa. These statutory bodies need clear and accurate information in order to make sound judgements. Unfortunately there is a dearth of local ECT practice guidelines or literature in this regard. This article will specifically examine consent to ECT in relation to the Mental Health Care Act, No 17 of 2002, and will propose a ''modal'' consent procedure for ECT. This effort is in keeping with an ongoing international agenda striving to improve consent procedures generally.[21]

Consent to ECT

Once the decision to consider ECT as a treatment modality has been finalised by the treating doctor or team, certain prerequisites should be complied with in order to fulfil the basic principals of the MHCA. The decision must be discussed with the patient and preferably also the family members concerned. During this time, consideration must be given to the patient's current mental state, their capacity to consent to ECT treatment, MHCA stipulations under which the patient is being treated, as well as the urgency with which such treatment is required. All reasonable efforts should be made to ensure that the patient has been given every opportunity to make an informed decision and in so doing to give informed consent for the procedure. ''Informed consent'' is not specifically defined in the HPCSA handbooks of good clinical practice or of ethical guidelines.[2, 22] However, it can be defined as being made up of three components. Firstly full information, secondly voluntary participation, and thirdly competence or capacity.[1] These three aspects, once adequately addressed, should then ''facilitate adequately informed individual patient choice based on their personal values''.[18] In many medical disciplines (e.g. surgery) the critical issues revolve around information, and more specifically adequate disclosure of risk.[20,21] Risk disclosure has been shown to be very poor, leading some authors to suggest that informed consent is ''mythical'' and like a ''fairy-tale'' when it comes to advancing patients rights to self determination.[20] In the case of ECT, recent publications have shown that despite efforts on the part of practitioners, patients perceptions are not good. Indeed a full one-third of patients in a report from the United Kingdom indicated that they felt coerced into having ECT.[23]

In the psychiatric environment the critical issues usually revolve around the third aspect, competence. However, when it comes to ECT, clearly risk disclosure is also a critically important item to consider. So how does one determine competence or capacity in a psychiatric context? A detailed analysis of this falls outside the scope of this article. Briefly, the HPCSA does provide some useful guidelines in the assessment of capacity to make decisions.[22] The MHCA General Regulations of 2004 stipulate in regulation 35, that regardless of the patient's status (voluntary, assisted or involuntary) those who are capable of informed consent must decide about their treatment.[24]

The following sequence in obtaining informed consent is suggested:

1. Determine competence
2. Provide full relevant information (and enable user to question)
3. Determine voluntariness and willingness
4. Provide opportunity to withdraw consent

An area of concern for MHCPs is likely to be a consideration of the medico-legal status under which the user is being treated. A suggested approach for voluntary, assisted and involuntary users is outlined here.

Voluntary mental health care users (MHCA Chapter 5, section 25)

A mental health care user who is capable of consenting to the treatment of his/her mental disorder should be capable of consenting to ECT. However, in terms of the above mentioned suggested approach, the MHCP must determine the user's competence to make this particular decision. The user should be given information on their condition and the possible treatment modalities. The advantages and disadvantages of each treatment modality should be discussed. In particular, in relation to ECT, the advantages of a good and reasonably quick response should be described. The procedures that the user would undergo should be clearly explained, as well as the possible side-effects. A user should be given time to consider their decision, and to consult with family and/or other users who have received ECT. A patient information sheet should be provided which outlines all the relevant issues relating to the administration, risk and benefits of the procedure. A proposed patient information sheet is provided later in the text. If a voluntary mental health care user chooses not to have ECT, and refuses to sign consent for the procedure after a full explanation has been given, other treatment modalities must be utilised.

Assisted mental health care users (MHCA Chapter 5, section 26)

A person with a severe mental illness that affects their capacity to consent to the point where they are incapable of making an informed decision regarding treatment of his or her mental illness and who requires treatment for his or her health or safety (or the health or safety of others) is considered an assisted mental health care user. Such a person is usually made an assisted mental health care user following an application by a close family member (the applicant). Even if a person has been admitted to hospital as an assisted mental health care user, it should not be assumed that s/he is incapable of consenting to ECT, and competence

to consent should be determined in each individual. Should the user not be capable of giving informed consent, the use of ECT must be discussed with the applicant (usually a family member) as well as with the user concerned (as far as possible). The same information listed above (patient information sheet) should be given to the applicant and user as well. Again, if possible, the decision should not be rushed. The applicant must then sign the informed consent form. If s/he refuses to sign consent for ECT, then other treatment modalities must be employed.

What if the applicant/family member agrees but the user, who is considered incapable of giving informed consent, actively refuses to have ECT? This is not an uncommon situation. Enforcing ECT in these circumstances is problematic. In our opinion it should not be undertaken without the knowledge of the local mental health review board and should be reserved for truly life threatening situations. Second opinions and the opinions of senior academics should also be sought prior to commencing the treatment.

If a family member/applicant is not available who does one approach for consent? It does happen that patients are admitted to hospital ''as assisted mental health care users'' when a family member is not available. If no next-of-kin is available to give consent, the decision as to whether or not to give ECT should be made by the head of the health establishment; this after adequate motivation from the treating team, and adequate explanation to the user to ensure that s/he does not refuse to have ECT.

Involuntary mental health care users (MHCA Chapter 5, section 32)

A person with a severe mental illness that affects their capacity to consent and who is also a danger to themselves or others and who refuses treatment for their mental condition meets the criteria to be admitted and treated as an involuntary mental health care user. If the user's condition is such that ECT is considered to be a potentially effective treatment, then the user should not be denied ECT. However, the treating team would have to justify its use on clinical grounds (for example, severe suicidality, severe psychomotor retardation/catatonia, severe agitation on the basis of psychotic symptoms), as well as the reason for the treatment to be given while the person is an involuntary user. Again, the applicant and the user (as far as possible) must be informed of the need for such treatment, as well as provided with an information sheet. If the applicant agrees, s/he should sign consent for ECT. If the applicant does not agree, the treating team would have to consider whether there was sufficient indication for ECT as the only effective treatment or life-saving recourse, in which case the team would approach the head of health establishment or medical superintendent for the consent, in adition to consultating with the mental health review board.

Recovery of capacity to consent (MHCA Chapter 5 section 31)

When the treating physician/team considers that the mental health care user has recovered to such an extent as to be in a position to provide informed consent, efforts to procure this consent should be initiated. This is particularly important in patients that have previously been treated as assisted or involuntary users, with the consent being provided by an applicant or other designated person. Should the patient then agree to the use of ECT s/he should then be afforded the opportunity of signing his or her own consent. This process may or may not, involve a change in the patients' treatment status in terms of the MHCA.

Consent for how many treatments?

Consent for ECT should be for each treatment and not for a course of treatment. Any patient who has capacity to sign his or her own consent may withdraw this consent at any stage.

Patient information sheet

Our proposed patient information sheet (Appendix 1) has been prepared in such a way as to only occupy an A4 sized page in Times New Roman font size 8. We propose that it should appear on the reverse side of the consent form, a copy of which should be given to the patient and/or applicant. Preparing the information sheet in all official languages would be optimal. This information sheet should contain all the essential information a patient, or their family, or court appointed curator should need in order to make an informed decision regarding consent for ECT, including detailed information relating to risk. A copy of this sheet given to the patient will allow for regular review of the decision to consent on an ongoing basis as the patient's mental state changes. It will also allow the patient to refresh his or her memory during the course of ECT should memory problems arise. It also forms a guide for interpreters and other members of the treating team who are not medically qualified to obtain consent by giving all the appropriate information. This information sheet is unlikely to be without shortcomings. As such, it should serve as a model to stimulate debate and discussion in an effort to ach ieve some uniformity in the consent process for ECT. Patient information sheets are available in one form or another in many countries and they seem to reflect, in part, the legislative atmosphere in which ECT is practiced in the country concerned.[10,11] Multiple examples are readily available on the internet. For South Africa, a clear and easily understood form, which lends itself to easy translation would probably be appropriate.

Consent Forms

Examples of consent forms appear in Appendix 2 and 3. As indicated there is a voluntary form for all patients who are capable of informed decisions relating to ECT. There is then a consent form for assisted and involuntary patients who are incapable of consenting, and whose consent is signed by a third party. We propose that, these forms should in the future be submitted to the Department of Health for auditing and analysis. Much needed local data relating to ECT use can be obtained in this manner. The merits of stipulating a specific diagnosis on the consent form can be explored. This will help with analysis of data and record keeping. However it may be considered by some to be an infringement of confidentiality rights as people other than the treating doctor or team will then have access to the information. This and other issues should be debated in wider forums for a consensus to be reached.

Conclusion

The implementation of the MHCA has necessitated changes to the manner in which consent for ECT is procured.[3] We have made some attempts at addressing the issue in this paper. The aim of these suggestions is to stimulate debate regarding these issues and is certainly not presented as the panacea to the present challenges facing mental health care practitioners. The ultimate goal however should be the devising of a consent procedure and format that can be implemented across the country that will reflect the spirit of the new Act.

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Appendix 1: Electroconvulsive Therapy Patient Information Sheet

Why use ECT? *Why ECT has been recommended for you should been explained by your mental health care practitioner. ECT is a highly effective treatment for certain conditions and is particularly effective in severe mood disorders and in some types of psychiatric emergencies and for patients who cannot use psychiatric medications for whatever reason. ECT involves a series of treatments that are administered in a specially equipped ECT unit at the hospital. The treatments are usually given in the morning before breakfast. A guarantee cannot be given that a particular doctor will perform the procedure or the anaesthetic. The people involved will however have the appropriate experience and expertise necessary to perform the treatment.*

General Anaesthetic: *Because the treatments involve general anaesthesia you will have had nothing to eat or drink for several hours before each treatment, usually overnight. You will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of your situation prevents this. Before the treatment, an anaesthetic doctor will give you medication either by injection or by gas mask that will quickly put you to sleep. You will be given oxygen to breathe. You will then be given another medication that will strongly relax the large muscles of your body. Other medications may also be given depending on your needs. As part of the consent procedure you have to consent to being given a general anaesthetic.*

Procedure and Safety Precautions: *Because you will be asleep, you will not experience pain or discomfort or remember the procedure. Monitoring sensors will be placed on your head and body. Blood pressure cuffs will be placed on your arm and leg. A bite block will be placed in your mouth to protect your teeth and tongue. A carefully controlled amount of electricity generated by a special ECT machine will then be passed between two electrodes that have been placed on your head. You may receive bilateral ECT or unilateral ECT. In bilateral ECT, one electrode is placed on the left side of the head, the other on the right side. In unilateral ECT, both electrodes are placed on the same side of the head, usually the right side. Electrodes placed on the right side are likely to produce less memory difficulty than if they are placed on both sides. However for some patients both sides may be used as it may be a more effective treatment. Your mental health care practitioner will carefully consider the choice of ECT and discuss this with you. The electrical current administered produces a seizure in the brain. The amount of electricity used to produce the seizure will be adjusted to your individual needs, based on the judgment of the ECT doctor. The medication used to relax your muscles will greatly reduce the contractions in your body that would otherwise accompany the seizure. The seizure will last for twenty to forty second approximately. During the procedure, your heart, blood pressure, and brain waves will be monitored. Within a few minutes, the anaesthetic medications will wear off and you will be woken up. You will then be observed until it is time to leave the ECT area, to return to your unit for breakfast.* ***ECT Course:*** *The number of treatments that you will receive cannot be known ahead of time. A typical course of ECT is six to twelve treatments, but some patients may need fewer and some may need more. Treatments are given either twice or thrice a week. Your written consent will be needed for each treatment. ECT is expected to improve your illness. However you may recover completely, partially, or not at all. After ECT your symptoms may return. How long you will remain well after completion of a course of ECT cannot be known ahead of time. Unfortunately relapse rates after a course of ECT are high if other medications are not used as well. To make the return of symptoms less likely after ECT you will need treatment with medications, psychotherapy, and perhaps further ECT. The treatment you will receive to prevent the return of symptoms will be discussed with you by your mental health care practitioner.* ***ECT Risks and Side Effects:*** *To reduce the risk of complications, you will be examined medically by the doctor and probably have some blood tests, a chest X-ray and an ECG (heart recording) before starting the ECT. The medications you have been using for your condition may be adjusted in order to be better suited for the ECT. You must inform your doctor if there is any possibility that you are pregnant or if you suffer from other medical conditions. Like other medical treatments, ECT has risks and side effects. In spite of the precautions mentioned, it is possible that you may experience a treatment complication. As with any procedure using general anaesthesia, there is a remote possibility of death from this or from the ECT itself. The risk of death from ECT is very low, about one in 10,000 patients. This rate may be higher in patients with severe medical conditions like diabetes and uncontrolled high blood pressure for example. ECT very rarely results in serious medical complications, such as heart attack, stroke, embolism, respiratory difficulty, or continuous seizure. More often, ECT results in irregularities in heart rate and rhythm. These irregularities are usually mild and short lasting, but in some instances can be life threatening. With modern ECT technique, dental complications are infrequent and bone fractures or dislocations are very rare. If serious side effects occur medical care and treatment will be instituted immediately as facilities to handle emergencies are available. However it may be necessary to transfer you to another hospital should serious complications occur. Any procedure in addition to those described on this form will only be carried out if it is necessary to save your life or to prevent serious harm to your health. Frequent minor side effects include headache, muscle soreness, and nausea. These side effects usually respond to simple treatment. After you awaken from each treatment, you may be confused. This confusion usually goes away within a few hours. During the treatment course you may have difficulties in attention and concentration and other aspects of thinking. These problems rapidly go away after completion of ECT. Memory loss is a common side effect of ECT. The memory loss with ECT has a characteristic pattern, including problems remembering past events and new information. The degree of memory problems is often related to the number and type of treatments given, the other medications being used and the severity of the mental illness being treated. A smaller number of ECT treatments is likely to produce less memory difficulty than a larger number. The problems with memory are greatest during the time shortly after the ECT is received. As time after completion of treatment increases, memory improves. You may experience difficulties remembering events that happened before and while you received ECT. The difficulties with your memory for past events may extend back several months before you received ECT, and less commonly, for longer periods of time. While many of these memories should return during the first few months following the course of ECT, you may be left with some permanent gaps in memory. For a short period following ECT, you may also experience difficulty in remembering new information. This difficulty in forming new memories should be temporary and usually disappears within several weeks after stopping the ECT. A minority of patients report problems in memory that remain for months or even years. The reasons for these long-lasting memory problems are not understood. As with any medical treatment, people who receive ECT differ considerably in the extent to which they experience side effects. However the majority of patients state that the benefits of ECT outweigh the problems with memory.* ***Personal Precautions:*** *Because of the possible problems with confusion and memory, you should not make any important personal or business decisions during or immediately following the ECT course. During and shortly after the ECT course, and until discussed with your mental health care practitioner you should refrain from driving, transacting business, or other activities for which memory difficulties may be problematic.* ***Questions?*** *You are free to ask your mental health care practitioner or members of the ECT treatment team questions about ECT at any time during or following the ECT course. Your decision to agree to ECT must be made voluntarily, and you may withdraw your consent for further ECT at any time. You will be given a copy of this consent form to keep.*

Appendix 2

CONSENT FOR ELECTROCONVULSIVE THERAPY (ECT) FOR ALL MENTAL HEALTH CARE USERS WITH CAPACITY TO CONSENT IN TERMS OF THE MHCA 17 OF 2002

CONSENT FORM ONE

1. ECT must only be conducted within the terms of the MHCA with particular reference to Chapters III (8,9,17) and V (25,26,32) of the Act and to General Regulations, Chapter 5, section 33 & 35. 2. ECT may only be carried out in health care facilities authorised and licensed to do so by the Provincial Government. 3. This consent form must be used in conjunction with the Patient ECT Information Sheet. 4. Consent must be obtained with the help of an interpreter if the patient is not proficient in English. 5.This form is only for the use of mental health care users who have the capacity to consent regardless of their status outlined in 1.	**Hospital Number:** **Patient Name:** **Date of Birth/Age:** **Ward:** **Sex:** **Race:** Hospital Sticker **Hospital:** **City:** **Province:** **Dr in Charge:**

I, _____, presently a _____ mental health
First Name Surname Insert one: voluntary, assisted, involuntary

care user at _____ have discussed the use of ECT for the
Hospital

treatment of my condition with my mental health care practitioner _____
Name/s of Mental Health Care Practitioner/s

I have been informed of and understood and discussed the following:

1. The procedure of ECT and what it involves.
2. The potential benefits of ECT.
3. The potential risks and discomforts of ECT to me and my health.
4. I have had all my questions relating to ECT answered to my satisfaction.
5. I have been given a copy of the Patient ECT Information Sheet and Consent Form.
6. I reserve the right to withdraw my consent for ECT at any time without fear.
7. The person obtaining my consent may not be the person performing the procedure.
8. In order to have ECT I agree to the administration of a general anaesthetic.
9. If I receive the ECT as an outpatient I will not drive a car on the day concerned.
10. In signing this consent I agree to have ECT only on the stipulated date below.

This consent was obtained by _____ on the _____
MHCP: Print name and qualifications Date

For **Unilateral / Bilateral** ECT to be performed on the _____
Delete as appropriate Date

Signed: _____ Date: _____
MHCP

I swear that I am the mental health care user named above and that I voluntarily consent to treatment with ECT on the date indicated above.

Signed: _____ Date: _____

Witness: _____ Date: _____
NOTE: the witness must not be the person obtaining the consent.

Appendix 3

INFORMED CONSENT FOR ELECTROCONVULSIVE THERAPY (ECT) FOR MENTAL HEALTH CARE USERS INCAPABLE OF INFORMED CONSENT IN TERMS OF THE MHCA 17 OF 2002

CONSENT FORM TWO

1. ECT must only be conducted within the terms of the MHCA with particular reference to Chapters III (8,9,17) and V (25,26,32) of the Act and to General Regulations, Chapter 5, section 33 & 35. 2. ECT may only be carried out in health care facilities authorised and licensed to do so by the Provincial Government. 3. This consent form must be used in conjunction with the Patient ECT Information Sheet. 4. Consent must be obtained with the help of an interpreter If the patient is not proficient in English. 5.This form is only for the use of mental health care users who DO NOT have the capacity to consent as outlined in 1.	**Hospital Number:** **Patient Name:** **Date of Birth/Age:** **Ward:** **Sex:** **Race:** Hospital Sticker **Hospital:** **City:** **Province:** **Dr in Charge:**

I,_____, the _____ of the
First Name Surname Insert: spouse, partner, guardian, parent, next of kin, curator

ASSISTED/INVOLUNTARY mental health care user named _____
Delete as appropriate First Name Surname
at _____ have discussed the use of ECT for the treatment of her/his condition
Hospital
with the mental health care practitioner _____.
Name/s of Mental Health Care Practitioner/s

I have been informed of and understood and discussed the following:

1. The procedure of ECT and what it involves.
2. The potential benefits of ECT.
3. The potential risks and discomforts of ECT to the patient and their health.
4. I have had all my questions relating to ECT answered to my satisfaction.
5. I have been given a copy of the Patient ECT Information Sheet and Consent Form.
6. I reserve the right to withdraw my consent for ECT at any time without prejudice.
7. The person obtaining my consent may not be the person performing the procedure.
8. In order to have ECT I agree to the administration of a general anaesthetic.
9. If the patient receives ECT as an outpatient she/he will not drive a car on the day concerned.
10. In signing this consent it is agreed that ECT will only be given on the stipulated date below.

This consent was obtained by_____ on the _____
MHCP: Print name and qualifications Date

For **Unilateral / Bilateral** ECT to be performed on the following date_____
Delete as appropriate
Signed:_____ Date:_____
MHCP

I swear that I am the _____to the mental health care user named above and that I
Insert: spouse, partner, guardian, parent, next of kin, curator
consent to ECT being performed on the patient named above on the date indicated above.

Signed:_____ Date:_____

Witness: _____ Date:_____
NOTE: the witness must not be the person obtaining the consent.