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Edited by Lauren Rayner

ECTAS Newsletter

Hello and welcome to the fourth edition of the ECTAS Accreditation Service newsletter. This is your newsletter, so please let us know what you think about it. If you have any comments, queries or suggestions, please write, phone or email us and we will include your contribution in the next edition. We are also keen to hear about your experience with ECTAS and welcome feedback on the standards and all aspects of the accreditation process.

MEMBERSHIP UPDATE

ECTAS currently has 82 member clinics. Four new members have joined in 2006. Among these are the first two clinics in Northern Ireland to join ECTAS. We aim to recruit a further eight clinics by the end of 2006. Of the 82 current member clinics, 54 have now been accredited, 7 with excellence.

CYCLE TWO

From September the first clinics to join ECTAS will begin their second accreditation cycle. The second self- and peer reviews will provide an opportunity for clinic staff to show how their service has progressed and improved since their first peer review visit. Feedback from clinics

undertaking the first cycle indicates that the ECTAS accreditation process has been instrumental in bringing about widespread improvements in the provision of ECT, including: investment in new equipment, the introduction of new policies and procedures and better deployment of staff. The efforts of ECT staff to develop their service may result in more clinics achieving 'excellence' (Level 1 accreditation) at their Cycle Two peer review.

SNAP

Starting from September we will be using SNAP, an electronic data collection computer programme. All clinics beginning their second cycle will use SNAP to enter and submit their self-review data. SNAP is simple and easy to use. Online data collection tools will be accessible via the ECTAS website and clinic staff can complete the tools by following a set of straightforward instructions. When a questionnaire is completed you simply click 'submit' and the data will be sent straight to us.

LEAD REVIEWER TRAINING

The annual Lead Reviewer Training Day took place on

Monday 5th June. The event was well attended, both by current reviewers and other clinicians keen to get involved in the peer review process. Many thanks to all those who took part. We shall keep you informed of upcoming visits.

THE EMAIL DISCUSSION GROUP

The email discussion group has been particularly lively over the past 6 months. Important issues surrounding care, consent, efficacy and anaesthesia have been discussed and debated. The email discussion group gives ECTAS members an opportunity to share ideas, seek advice, make suggestions and offer support. As well as clinical queries, we welcome comments on the standards and the ECTAS process.

RECENT QUERIES AND DEBATE

Consent for Uni/ bilateral

The issue of whether consent forms should specify laterality has again sparked lengthy debate. Those arguing against the inclusion of laterality on consent forms felt that too little is known about the relative efficacy and risk of cognitive impairment for each modality for patients to give informed consent.

On balance, however, most people felt that patients should be included in the unilateral/ bilateral decision and that clinicians should specify laterality on the consent form. ECTAS maintains that patients have a right to know current thinking on the pros and cons of unilateral vs. bilateral ECT and that the choice of laterality should be discussed as part of the consent process. *'Consent form states whether the course is for bilateral or unilateral treatment'* is a Type 2 standard (4.28).

Frequency of ECT for Catatonia

A query was raised regarding the acceptable frequency of ECT for catatonic patients. The general consensus was that ECT should not be given more than two times a week, even in cases of catatonia. Andrew Easton asserted that there is no evidence that frequent treatment (3 or 4 per week) is more efficacious than less frequent administration. ECT usually produces positive results after two to three treatments. If there is no response with twice weekly ECT, the diagnosis and treatment plan should be re-examined.

Treating patients with high BMI

Advice was sought on how to prepare an obese patient for titration ECT and subsequent treatments. The implications of obesity for anaesthesia are gastric reflux, difficult airway and ventilation and a propensity to deoxygenate quickly. Thus, in preparation for ECT it was recommended that a thorough airway assessment should be conducted and any history of reflux disease detailed. Patients with very high BMI should be treated in a general hospital with critical care facilities. If reflux disease is indicated, the patient may require intubation after Rapid Sequence Induction. Several respondents advised that an antacid premed should be prescribed to minimise the chance of pulmonary damage in the event of aspiration.

Who should get consent?

There has been some debate over the question of who is qualified to obtain consent for ECT. It has been suggested by members of the group that it is acceptable for any health practitioner to gain consent, including SHOs and nurses. The Department of Health Reference Guide to Consent states that ultimate responsibility for ensuring valid consent lies with the clinician providing the treatment. However,

'The task of seeking consent may be delegated to another health professional, as long as that professional is suitably trained and qualified' (section 9, page 7). To clarify: SHOs and nurses are not suitably qualified to obtain consent. The task can be delegated, but only to consultant colleagues. ECTAS contacted the NMC professional advisory service with regard to this issue, and was advised that under no circumstances should nurses be consenting patients for ECT.

Participating in TV programmes on ECT

A discussion about the challenges involved in producing television programmes on ECT prompted considerable interest. The issue of consent was identified as an obvious concern. Before collaborating with filmmakers, clinicians must be completely satisfied that any patient participating has given valid informed consent. Generally, it was felt that it would be unfair to ask very depressed, psychologically vulnerable patients to give consent to appear in a television programme. Absorbing information on ECT and consenting to treatment is often traumatic in itself. Many patients would not have the capacity to fully appreciate the ramifications

of filming. It was agreed, however, that balanced, accurate documentaries on ECT were much needed as a means of demystifying the treatment and counteracting previous portrayals of ECT as authoritarian and inhumane. The idea of an 'advanced directive' was proposed as a possible solution to the problem of consent. Patients with a history of periodic ECT could be approached when well, and provided they still consented when in need of treatment, filming could go ahead. A number of respondents raised the problem of editorial control. Clinicians considering contributing to a television production must be confident that the director is committed to a presenting an informative and honest portrayal of ECT. ECT deserves some positive publicity, but it is important that clinicians are aware of potential pitfalls and proceed with appropriate caution.

RESEARCH UPDATES

Mapping ECT clinics

In December this year Dr David Bickerton, a SpR from Exeter undertook a survey to ascertain the number of NHS ECT clinics in England and Wales and collect figures on treatment. He sent out a questionnaire to Mental Health Trusts in England and Wales asking

them to name their clinics, whether any had closed or would in the near future, and also fill in the number of treatments carried out between January and March. Returns suggest that Trusts have begun amalgamating their ECT clinics in order to provide a more streamlined, cost effective service. Dr Bickerton's findings also indicate that the number of ECT treatments administered has declined significantly since 2002 when the last survey on ECT provision was conducted by the Department of Health. However, a low response rate of 40% precludes any definitive conclusions being drawn from the data. Dr Bickerton now plans to send a follow-up letter to non-responders with the aim of collecting a more comprehensive data set. The trends outlined above may have important implications for the future of ECT in the UK. Findings from this survey can be used to investigate the possible impact on service users and professionals.

Investigating retrograde amnesia: an update by Kerry Kershaw

Firstly, I would like to thank all those of you who responded to my piece in the previous edition of the ECTAS newsletter – It was really encouraging to hear from so many of you.

It's been a busy few months since the last newsletter; In March of this year I was fortunate enough to spend a week with Harold Sackeim and his team out in New York, and also met to discuss the research with former ECT recipient and director of the Committee of Truth in Psychiatry, Linda Andre. I received full MREC ethical approval to proceed with research earlier this month and have now started testing within South London and the Maudsley NHS Trust; testing at Central and North West London NHS Trust planned to start in the next few months.

If you are interested, have any questions/suggestions, or would like to discuss the possibility of being involved in this research, please do not hesitate to contact me by e-mail; psp01kk@gold.ac.uk.

Referring psychiatrists in need of update training

Dr Adrian Blaj, an SpR working with ECTAS has been researching the training needs of prescribing psychiatrists using data from the ECTAS 'referring psychiatrist' questionnaires. Dr Blaj used quantitative and qualitative analysis to examine the content of 275 questionnaires. The questionnaire covers a

range of issues important to the referral process, including; what information prescribing psychiatrists give to patients, how patients' response and side effects are monitored and whether they feel their own knowledge of ECT is adequate. Significant numbers of respondents reported a need for further training, particularly in the areas of information giving and obtaining consent. It is crucial that psychiatrists prescribing ECT receive regular updates on best current clinical practice. Dr Blaj's findings indicate that many referring psychiatrists feel their knowledge of ECT is lacking. To address this, ECTAS is organising a series of half-day update courses on prescribing ECT (see below).

'PRESCRIBING FOR ECT' UPDATE COURSE

In response to feedback from the referring psychiatrist questionnaires ECTAS will be holding a half-day update course on ECT for prescribing psychiatrists. The First National Report showed that 51% of referring psychiatrists surveyed would like further update training on current best practice in ECT. The *Prescribing for ECT* half-day course has been specifically designed to

meet this need. It will take place at the College Research and Training Unit on Monday 27th November. Please see the attached flyer for further details and an application form.

NALNECT

The National Association for Lead Nurses in ECT (NALNECT) is keen to recruit new members. Regional Special Interest Groups have been established in the South England, the Midlands, the North-west and the North-east. NALNECT is also now looking to establish groups in London and Wales. Joining a NALNECT Special Interest Group provides an opportunity to discuss current issues in ECT and share information and ideas on nursing care. If you are interested in getting involved, please contact Stephen Finch – Steve.Finch@rbh.nhs.uk

STANDARDS REVISION

We are keen to receive your comments on the ECTAS standards. If there are any standards that you feel should be included, removed or modified, please let us know by 31st August. Standards will be discussed at the next Reference Group meeting on 9th October.

Member Clinics

Member clinics that have not yet been accredited and are currently in the process of self- and peer-review

<p>Addington Ward, Kettering Becklin Centre, Leeds Birch Hill Hospital, Rochdale Callington Road Hospital, Bristol Chase Farm Hospital, Enfield Clatterbridge Hospital, The Wirral Coity Hospital, Bridgend County Hospital, Durham Diana Princess of Wales Hospital, Grimsby Downshire Hospital, Downpatrick Fairfield Hospital, Bury Farnham Road Hospital Forston Clinic, Dorset Green Lane Hospital, Devizes</p>	<p>John Connolly Wing, Southall Lagan Valley Hospital, Lisburn Priority House, Maidstone Newsam Centre, Leeds Royal Preston Hospital, Grimsby Stonebow Unit, Hereford Springfield Hospital, London St George's Hospital, Stafford Sutton Hospital, London Tameside Hospital, Ashton-under-Lyne West Cumberland Hospital, Cumbria Weston General, Weston Super Mare West Park Hospital, Darlington Wolverhampton City PCT</p>
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Accredited Clinics

<p>Ablett Unit, Denbighshire Addenbrookes Hospital, Cambridge Airedale Hospital, West Yorkshire Barnes Hospital, London Barnsley District General Hospital Bethlem Royal Hospital, London Bodmin Hospital, Cornwall* Broadoak Unit, Liverpool* Bushey Fields Hospital, Dudley Charlton Lane Hospital, Gloucester Cefn Coed ECT Suite, Swansea Cheadle Royal Hospital, Cheadle Cherry Knowle, Tyne and Wear Clos Bran Hospital, Carmarthenshire Derby City General Dorothy Pattison Hospital, West Midlands Edward Street Hospital, West Bromwich Fountain Way ECT suite, Salisbury Glenbourne Clinic, Plymouth Hadrian Clinic, Newcastle General Hospital Hartington ECT unit, Derby Hollins Park Hospital, Warrington Ladywell Mental Health Unit, Lewisham Lakeview Clinic, Coventry Littlemore Clinic, Oxford Maudsley Hospital, London* Millbrook Hospital, Nottingham</p>	<p>Mount Gould Hospital, Plymouth Needham Suite, York Newton Abbot Hospital, Devon Parkhouse Hospital, Manchester Parkwood ECT Suite, Blackpool Princess Marina Hospital, Northampton* The Priory Hospital North London The Priory Hospital, Roehampton* Prospect Park Hospital, Reading* Purbeck Suite, Poole Queens Medical Centre, Nottingham Royal Oldham Hospital, Oldham Sevenacres, St Mary's, Isle of Wight Shelton Hospital, Shrewsbury Somerset Partnership, Taunton Stepping Hill Hospital, Stockport St George's Hospital, Morpeth St Patrick's Hospital, Dublin* St Vincents, Dublin (formerly Clonskeagh) The Riverside Clinic, Uxbridge University College Hospital, Galway Warneford Clinic, Oxford Waterford Regional Hospital Whiston Hospital, Prescot Whitchurch Hospital Wigan & Leigh Hospital Wotton Lawn, Stroud</p>
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