

RESPONSES TO QUESTIONS ARISING FROM ECTAS EMAIL DISCUSSION GROUP ON ECT AND RELATED TREATMENTS

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A summary was prepared of email threads where there was either no clear answer or lack of agreement on best practice. Items were raised and individually discussed at the Special Committee on ECT¹.

1. **Bi-frontal ECT** – The Committee did not support the view that this treatment should be routinely available in all clinics, namely that all clinics should offer bi-temporal, bi-frontal and unilateral. A small number of published studies show that it is as effective as bi-temporal ECT and may have fewer side effects in terms of cognitive impairment. The Committee felt the evidence was inconclusive and further studies were needed both in terms of its efficacy and side effect profile. The Committee felt that the preferred option, with minimising cognitive impairment as the main aim, was high dose right unilateral ECT.
2. **Consenting to modality of treatment²** – The Committee’s unanimous view was that patients should be fully informed about the nature of the treatment they were being given including the electrode position and that many patients could make an informed choice between unilateral and bilateral ECT.
3. **Does high dose unilateral ECT (5 times + above threshold) have the same side effects as bilateral ECT** – The Committee’s view was that it does not. All forms of unilateral ECT cause less cognitive impairment than bilateral ECT. The Committee pointed out that the uni versus bi studies from Scandinavia in the 1960s used old fashioned sine wave ECT³ giving many times the current dose and still showed unilateral ECT had fewer cognitive side effects.
4. **Frequency of ECT** – The Committee’s view is that there was no evidence to support the routine use of ECT 3 times a week or greater and that ECT consultants asked to do this should refuse. The Committee did accept that in very ill patients, patients with catatonia or depressive stupor, it might be appropriate to give ECT 3 times in the first week but even then not on consecutive days. There was no justification for treating a patient on, say, Thursday, Friday, Saturday, but it might be appropriate to schedule a first treatment in a very ill patient on a Saturday or Sunday, if the next scheduled session was not, say, until Tuesday.
5. **The treatment of incapacitous but passively consenting patients⁴**
The Committee supported the view that it was appropriate to treat such

patients under common law and not to use the Mental Health Act and that both the law and the ECHR⁵ supported this view.

6. **Memory testing and ECT** – The Committee accepted that there are no reliable or valid tests of autobiographical memory that are brief enough to use in routine clinical practice.

The Committee accepted that the mini mental state examination (MMSE) is not designed for this purpose and has little efficacy.

However, the Committee felt that the MMSE had two functions:

- i. It would act as a screen for marked cognitive impairment.
- ii. It would help inform the patient that any memory impairment was taken seriously (therefore prompting reporting of any problems).

The Committee felt that other brief tests might be added such as digit span backwards (a test of central executive function) and that individual assessment of personal memories might contribute. They accepted that there was an urgent need for work in this area.

7. **Nurse led clinics** – There was a single enquiry about this which did not get any responses. As far as the Committee knows there are no nurse led ECT clinics in the UK.
8. **Consenting patients for ECT** – The issue here is whether a consultant is the only person who can gain the consent of patients to ECT. The guidance is that the person who obtained consent should be able to carry out the procedure themselves (though might not be doing so on this occasion) and be able to explain all the pros and cons of the treatment and its alternative. The Special Committee's view was that consent should be obtained by a consultant or by another competent doctor designated by the consultant. The Nursing and Midwifery Council states that consent to the treatment should not be obtained by a nurse.
9. **Where does the ECT consultant need to be during ECT clinics?**
The lead consultant for ECT should be immediately contactable by phone or bleep during ECT clinics. However the consultation does not need to be the administering doctor or in direct supervision (physically present in clinic) PROVIDING a competent doctor (assessed as competent for ECT) is in the suite.
10. **Dental damage in ECT** – The Special Committee noted that this was something that had not been given much space in the ECT handbook⁶ and that this would need to be amended in the next edition. In the meantime the dental risk protocol from Birmingham will be shortened and modified for routine clinical use. (For example there may be some situations where it is more appropriate for a patient to have their

dentures left in to protect remaining peg teeth than to have them removed).

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November 2006.

¹ The Special Committee on ECT is convened by the Royal College of Psychiatrists and includes representatives of psychiatry, anaesthesia and nursing

² Modality of treatment refers to the placement of electrodes on the head. For bilateral ECT they are placed on each side of the head; in unilateral ECT they are placed on one side and at the front

³ Sine wave ECT is no longer in use in the UK. It is still in use in the USA.

⁴ An incapacitated compliant patient is “sufficiently mentally ill to prevent a proper understanding of what is being proposed and why, but does not indicate an unwillingness to accept the treatment”. (*The ECT handbook*, Second Edition)

⁵ ECHR – European Court of Human Rights

⁶ The ECT Handbook, Second Edition (the Third Report of the Royal College of Psychiatrists’ Special Committee on ECT) Council Report CR128. 2005. Edited Allan I F Scott



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