

The place of ECT in contemporary psychiatric practice

The Consensus Group Affiliated to the Special Committee*

While this second edition of the *ECT Handbook* was in production, the National Institute for Clinical Excellence (NICE) was commissioned to undertake a Health Technology Appraisal of ECT in the treatment of depressive illness, mania, schizophrenia and catatonia. The Royal College of Psychiatrists was consulted as part of the appraisal process and in particular was asked to produce a position statement about the place of ECT in contemporary psychiatric practice. The Special Committee on ECT consulted psychiatrists with expertise in the application of ECT, encompassing both academic and clinical experience. This included the outcome of consultation with consultant psychiatrists with responsibility for ECT clinics in trusts around the UK who attended the ECT Practitioners' Day at the King's Fund under the auspices of the College on 11 October 2002. This led to the formation of the Consensus Group, who later wrote this position statement. The Group consisted of psychiatrists from the Special Committee, other contributors to the present edition and delegates at the Practitioner's Day (see note below). The findings of two important systematic reviews sponsored by the Department of Health were presented and discussed on the day. These were the review of the efficacy and safety of ECT carried out by the UK ECT Review Group (2003) and that of consumers' perspectives carried out by the Service User Research Enterprise (Rose *et al*, 2003). These systematic reviews left several important clinical questions unanswered. It was therefore necessary to consider evidence apart from randomised controlled trials, tempered by the Group's expert judgement based on clinical experience. The Consensus Group produced the position

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statement on contemporary indications for the use of ECT, which was presented to NICE in October 2002. The main recommendations presented in that statement are considered below, along with the guidance produced by NICE and the Consensus Group's response to that guidance.

Recommendations of the Consensus Group's position statement

Major depressive episode/disorder

Electroconvulsive therapy may be the treatment of choice for severe depressive illness when there is an urgent need for treatment, for example when the depressive illness is associated with:

- attempted suicide
- strong suicidal ideas or plans
- life-threatening illness because of the patient's refusal of food or fluids.

Electroconvulsive therapy may be considered for the treatment of severe depressive illness associated with:

- stupor
- marked psychomotor retardation
- depressive delusions or hallucinations.

In the absence of the above, ECT may be considered as a second- or third-line treatment of a depressive illness that has not adequately responded to antidepressant drug treatment and where social recovery has not been achieved (e.g. an inability to return to work). Initial treatment failure may be defined as a lack of recovery after a course of an antidepressant drug given at a proven effective dose for at least 6 weeks (with the exception of elderly sufferers, who may take longer to respond to antidepressant drug treatment). A switch to an antidepressant drug with a different mode of action is the preferred second-line treatment. If the depressive illness persists, several options are available, namely, adding an augmenting agent, such as lithium carbonate or triiodothyronine, switching to a monoamine oxidase inhibitor for patients with atypical major depression, adding either cognitive therapy or another form of psychotherapy, or switching to ECT.

Patient choice is important. Some sufferers who have previously had a depressive illness may choose ECT because of their experience of medical treatment that was ineffective or intolerable, or previous experience of recovery with ECT.

Mania

The treatment of choice for mania is a mood-stabilising drug plus an antipsychotic drug. ECT may be considered for severe mania associated with:

- life-threatening physical exhaustion
- treatment resistance (i.e. mania that has not responded to the treatment of choice).

Patient choice and a previous experience of ineffective or intolerable medical treatment, or previous recovery with ECT, are again relevant.

Acute schizophrenia

The treatment of choice for acute schizophrenia is antipsychotic drug treatment. ECT may be considered as a fourth-line option, that is, for patients with schizophrenia for whom clozapine has already proven ineffective or intolerable.

Catatonia

Catatonia is a syndrome that may complicate several psychiatric and medical conditions. The treatment of choice is a benzodiazepine drug; most experience is with lorazepam. ECT may be indicated when treatment with lorazepam has been ineffective.

NICE guidance

In May 2003 NICE published its guidance on ECT for depressive illness, schizophrenia, catatonia and mania (NICE, 2003a). This was simultaneously endorsed by NHS Quality Improvement Scotland. The guidance about the indications for ECT in these conditions included the following statements:

‘ECT is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with:

- severe depressive illness
- catatonia
- a prolonged or severe manic episode.’

‘The current state of the evidence does not allow the general use of ECT in the management of schizophrenia to be recommended.’

‘As the longer-term benefits and risks of ECT have not been clearly established, it is not recommended as a maintenance therapy in depressive illness.’

‘The decision as to whether ECT is clinically indicated should be based on a documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anaesthetic, contemporaneous comorbidities, anticipated adverse events, particularly cognitive impairment, and the risks of not having treatment.’

‘The risks associated with ECT may be enhanced during pregnancy, in older people and in children and young people, and therefore clinicians should exercise particular caution when considering ECT in these groups.’

A media briefing released at the same time (NICE, 2003b) included the following statement:

‘The [Appraisal] Committee took special note of the evidence from observations of users’ experiences relating to the adverse effects of ECT. In particular, cognitive impairment following ECT was discussed in detail. It was apparent that cognitive impairment often out-weighed their perception of any benefit from ECT treatment. These factors featured significantly in the Committee’s decision to restrict the use of ECT to situations in which all other alternatives had been exhausted or where the nature of the mental illness was considered to be “life-threatening”.’

Response of the Consensus Group to the guidance

The guidance and the indications suggested in the Consensus Group’s position statement were in the main consistent regarding the contemporary indications for ECT in mania, acute schizophrenia and catatonia. They were not consistent about the place of ECT in major depression, the illness for which the treatment is most commonly prescribed. The Consensus Group therefore reconvened to produce the following response, which it is hoped will help practitioners to accommodate the NICE guidance in their clinical practice.

Observations on the NICE guidance on the indications for ECT in major depression

Divergence from the NICE guidance would occur if a practitioner were considering the prescription of ECT for depressive illness that was not life-threatening or severe, that was not demonstrably resistant to alternative treatments, or as continuation or maintenance treatment. In these cases the Consensus Group would make the following observations:

- Health professionals are expected to take NICE guidance fully into account when exercising their clinical judgement. NICE guidance

does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

- The NICE guidance on ECT does not have any legal jurisdiction over clinical practice, and its legal significance could be established only if it were cited in a court case.
- A documented assessment of the potential risks and benefits of treatment to which valid consent has been obtained would be essential to support any variance from the NICE guidance. The Royal College of Psychiatrists' Special Committee on ECT has already recommended the safeguard of obtaining a second opinion from an independent psychiatrist when the indication is potentially controversial. This may be prudent too were any variance from the NICE guidance being considered. The patient may also be able to express a clear view about the perceived severity of the illness and the role of ECT in its treatment; this should be documented.
- The thrust of the NICE guidance is that the therapeutic benefits of ECT may be outweighed by the distress caused when patients realise they have suffered lengthy or permanent retrograde amnesia. Patients who have never before been treated with ECT will be less able to consider the trade-off between the immediate benefit and this longer-term risk. Practitioners ought therefore to exercise particular circumspection in the use of ECT at variance with the NICE guidance in patients with depression who have never before been treated with ECT. It would be prudent to be particularly careful to discuss the topic of retrograde amnesia, particularly for personal memories, and to document this discussion.
- The cognitive adverse effects of ECT can be substantially reduced by the use of a unilateral electrode placement and, to a lesser extent, by the avoidance of substantially supra-threshold electrical doses. This strategy is strongly recommended as the initial treatment in any prescription beyond the NICE guidance. It would in any case be good practice in the treatment of illnesses that are not life-threatening or severe.
- Practitioners may also have to consider ECT beyond the NICE guidance when it is requested by a patient. The guidance makes reference to the view that the wishes of the patient must be of paramount importance. Further clarification from NICE suggests that this is not meant to support consumerism among patients, but to support the view that valid and informed consent is necessary for the appropriate prescription for ECT. The same circumspection and documented risk-benefit analysis would be required here, as in other indications.

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