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ECTAS Newsletter

Hello and welcome to the first newsletter of the ECT

Accreditation Service. This is your newsletter, so please let us know what you think about it. We would also like to hear about your experience with ECTAS and about any improvements you have made to your clinic as a result of participation. Please write, phone or email us and we will include your contribution in the next edition.

UPDATE

ECTAS has more than 60 members. So far, sixteen clinics have completed accreditation; two with excellence (members are listed at the end of the newsletter). Membership will increase steadily over the next few years. Ultimately, we hope to involve every ECT clinic in the UK.

The reference group has been busy revising the **ECTAS standards**. The second edition will soon be available at: <http://www.rcpsych.ac.uk/cru/TheECTASStandardsDec03.pdf>

The **data collection tools** are also reviewed in light of the first waves of reviews. Our aim is to streamline and simplify the process.

The first **Annual Forum** will be held on 20th April 2005 in Edinburgh. All are welcome. A booking form is attached.

THE ECTAS TEAM

Helen Caird, who was instrumental in establishing ECTAS, has left to pursue a career in psychology. All at the College Research Unit miss her enthusiasm. Goodbye Helen, thank you and good luck!

Joanne Cresswell is the new ECTAS project manager. Joanne continues to work half time as RMN and ECT clinical manager at South London and Maudsley NHS Trust.

Zoë Fortune takes over from Helen Caird as the ECTAS research worker. Zoë is the main contact for all ECTAS enquiries.

A CALL FOR SERVICE USERS

We want more input from service users in all aspects of the work of ECTAS. If you know of anyone who might be interested, please contact us and we will provide you with more details.

A CALL FOR REVIEWERS

Many thanks to those who have carried out

reviews for us; ECTAS could not function without you. As well as providing a service to the clinic under review, peer-review visits are a learning experience for the peer-review team and help peer reviewers prepare for their own ECTAS review. If you are interested in becoming a reviewer, please contact Zoë Fortune.

THE E-MAIL DISCUSSION GROUP

The email discussion group allows ECTAS members to talk to each other, share comments and ideas and ask questions you would like answers to. It has proved popular and there have been some lively debates about both new and old topics.

We have also used the e-mail discussion group to canvas members' opinions about which standards need to be updated or changed. Many interesting issues have been raised and these will be reflected in the revised edition of the standards.

Controversial areas

Etomidate versus Propofol

There has been a hot debate about the benefits of using Etomidate versus Propofol. Whilst it was agreed that there were differences between these agents, there was

no specific conclusion reached as to which was better, or which should be used in specific situations. Dr Caroline Gorst Unsworth, an ECTAS reviewer, is conducting a double-blind comparison at the Worthing Clinic. Caroline is looking for others to join the trial. If you are interested, please contact Zoë. Dr Declan McLoughlin has also conducted research about the anaesthetic protocol at the Maudsley. If you would like to know more about this, Zoë can put you in touch with Dr McLoughlin. On a separate note, Methohexitone is available in UK. Please contact ECTAS for details.

Sharing Protocols

The e-mail discussion group has also raised the issue of sharing protocols. It is clear that most people would be happy to do this. This is great news and will benefit all ECT clinics. In future, we will dedicate part of our website to protocols that can be downloaded for clinics to use.

ECT and Common Law

'In the absence of an English Incapacity Act, which is currently under debate, should patients who are passively consenting be detained under the Mental Health Act for treatment or detained under common

law?' The general understanding is that if a patient is incompetent but compliant and passively consenting to ECT, it is illegal to use the Mental Health Act and they should be treated under Common Law. This has raised some interesting points. Replies have been varied, raising the further question: 'how can someone that cannot comprehend and hence cannot object be included with those giving valid consent?' It was also pointed out that the concept of 'reasonable force' is included in case law which in effect means that a patient must demonstrate real resistance rather than briefly holding their arm away from the Venflon etc. However, other members of the group have replied stating that they have used ECT under Common Law and the local practice at South London and Maudsley NHS Trust is to obtain an informal second opinion, but clinics who do give ECT under Common Law have sought legal advice from their own hospital lawyers. Please note that the above applies until the outcome of the Mental Capacity Act and the new Mental Health Act Bill.

Consenting to unilateral or bilateral ECT

We currently have a standard that includes this, but the issue was raised as to whether any

reasonable, rational patient can give valid consent to this and whether any reasonable, rational psychiatrist can inform sufficiently to obtain a valid consent. Has enough research been carried out in the area to know the differences for certain? Patients are not asked to give valid consent to other technical aspects of the treatment, such as stimulus dosing, so is asking a patient to give consent to a unilateral versus bilateral decision unrealistic? It was pointed out that at the time of consenting a patient should have been included in the decision as to which placement to use, regardless if it was on the form or not. Surely if a patient is capable of consenting to treatment, it is not difficult to explain to them the differences between the placement and this should be discussed with them?

Day patient protocols

The question was raised as to whether it is more appropriate for a member of staff to sign saying that a patient has been given the correct information, verbally and in writing and their response recorded, than for a patient to sign a form to say that they will be accompanied home and will not drive etc? Replies suggested that this method would guarantee a patient was given the correct information and perhaps the best practice

is for the discharge nurse to do this, and a doctor to see the patient before they leave.

Identity bracelets

This controversial issue was raised in our Reference Group and it is to become a type 1 standard when the revised standards are published. We received many replies from the group on the topic and clinics appear to be split on the matter. Many of you appear to consider them a routine safeguard and a valuable contribution to the provision of ECT. However, it was also pointed out that it may be dangerous for a patient to wear, could increase 'labelling of patients' and where ECT is given in a small unit they are unnecessary as patients are accompanied to the ECT suite and through the entire treatment by a member of nursing staff who know them. It would appear that independent psychiatric hospitals veer towards not using identity bracelets whereas psychiatric units within general hospitals use them.

Accreditation of individuals or clinics?

An interesting question was raised by the email discussion group and is something that we have discussed in our own Reference Group. Should consideration be given to accreditation for an

individual rather than just a department? A personal ECT Accreditation could then stay with them and could be used as part of CPD. It was noted that some clinics have started to run individual internal certification courses, for example for junior psychiatric doctors to document ECT proficiency. A survey of the existing range of in-house certifications was suggested to look into the area. It was also pointed out that individual accreditation would give anaesthetists and nurses more impetus in securing money for 'essential developments' but conversely being an accredited worker in a clinic that is not suitable for accreditation would be stressful.

We strongly encourage all clinics to use the email discussion group as a forum to advertise vacancies in your clinics.

Please use the e-mail discussion group to give us feedback about any aspect and to make comments or suggestions about how we might do things better. zfortune@cru.rcpsych.ac.uk or phone on 020 7227 0890.

FREQUENTLY ASKED QUESTIONS

Why do we need a system of assuring the quality of ECT?

Although the use of ECT is controversial, research shows it to be an effective treatment. Having reviewed the evidence, NICE (the National Institute for Clinical Excellence) has endorsed it for the treatment of severe depression under certain circumstances. However, a warning from an editorial in the Lancet in 1981 is as relevant today as it was nearly 25 years ago – 'if ECT is ever legislated against or falls into disuse it will not be because it is an ineffective or dangerous treatment, it will be because [of a failure] to supervise and monitor it correctly'.

Regulation or accreditation of ECT was first proposed after the last national audit of ECT in 1996 which, consistent with the findings of an earlier survey, reported deficits in the quality of ECT administration. The potential impact of these deficits has been highlighted by the NICE guidance which links efficacy and side effects of ECT to the method of its delivery. Shortcomings have also been found in the way in which information has been provided to patients and consent is obtained; one-half of those given ECT report that they have not been given an adequate explanation (this is a precis of an article published recently in the Psychiatric Bulletin – Caird, H., Worrall, A. and

Lelliott, P. (2004), Psychiatric Bulletin, 28, 257-259.

Why do we have to pay for ECTAS?

ECTAS has no core funding, its only income is from member subscriptions. ECTAS is not run for profit; the subscription is set at a level that covers its true costs. The current fee is £2000 per clinic per annum. However, for trusts with more than one clinic, the second, third and fourth clinics receive a 15% discount.

What happens after we have been accredited?

You will receive a letter from us stating your accreditation status, and comments about your clinic from the meeting of the Accreditation Advisory Committee. Your clinic will be accredited for three years subject to an annual self-review. The self-review tools for the second and third years are simply clarifying that the standards are still being met within your clinic. If you have moved facilities or any other major changes have been made, a peer-review team will visit your clinic and carry out a new environment and facilities checklist.

What happens if our clinic is not accredited?

Your clinic will be given the opportunity to

improve. This is known as deferral and you will be given approximately three months to make any relevant changes. Once we have received written confirmation that the changes have been made, your clinic will be re-considered by the Accreditation Advisory Committee. We would like to see all clinics achieve accreditation status and we will help you through the process and offer help and advice on changes that need to be implemented.

If you would like to write something for the newsletter, please email it to us at the address below and we will try and include it in future editions.

Forthcoming Events

**Wednesday 20th April, 2005
Edinburgh**

ECTAS Annual Members' Forum

Contact Zoë Fortune for more details:

zfortune@cru.rcpsych.ac.uk

**Thursday 21st April, and
Friday 22nd April 2005
Edinburgh**

Royal College Training Day
and Practitioners Day

Contact Emma George for more details:

egeorge@cru.rcpsych.ac.uk

**Thursday 19th May, 2005
Perth, Scotland**

SEAN Network Meeting

See the Scottish ECT Audit Network (SEAN) for more details:

www.sean.org.uk

Member Clinics

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

Ablett Unit, Denbighshire
Addenbrookes Hospital, Cambridge
Airedale Hospital, West Yorkshire
Ash Court Clinic, North Tyneside General Hospital,
Tyne and Wear
Barnsley District General Hospital
Becklin Centre, Leeds
Bethlem Royal Hospital
Bushey Fields Hospital, Dudley
Cefn Coed ECT Suite, Garngoch Hospital,
Swansea
Dorothy Pattison Hospital, West Midlands
Cherry Knowle Hospital, Tyne and Wear
Cheadle Royal Hospital
Clos Bran Hospital, Carmarthenshire
Clonskeagh Hospital, Dublin
Derby City General
ECT Clinic for South and West locality,
Newton Abbot
Edward Street Hospital, West Bromwich
Fairfield General Hospital, Bury
Fountain Way ECT Department, Salisbury
Glenbourne Clinic, Derriford Hospital,
Plymouth
Hadrian Clinic, Newcastle General Hospital
Hartingdon ECT Department, Derby
John Elliot Unit, Birch Hill Hospital, Rochdale
Kettering General Hospital
Ladywell Mental Health Unit, University
Hospital, Lewisham
Lakeview Clinic, Coventry
Littlemore Mental Health Centre, Oxford
Maudsley Hospital

Melbury Lodge, Royal Hampshire County
Hospital
Montpellier Unit, Gloucestershire
Mount Gould Hospital, Plympton
Needham Suite, Bootham Park Hospital, York
Newsam Centre, Leeds
Parkwood ECT Suite, Blackpool
Princess Marina Hospital, Northampton
Purbeck Suite, St Ann's Hospital, Poole
Queens Medical Centre, Nottingham
Royal Oldham Hospital
Sevenacres Hospital, Isle of Wight
Shelton Hospital, Shrewsbury
Somerset Partnership NHS Trust, Taunton
St George's Hospital, Northumberland
St George's Hospital, Stafford
St Patrick's Hospital, Dublin
Stepping Hill Hospital, Stockport
Tameside Hospital, Ashton-under-Lyne
The Mount, Leeds
The Priory, Marchwood, Southampton
The Priory, North London
The Priory, Roehampton
The Riverside Clinic, Hillingdon Hospital,
Uxbridge
University College Hospital, Galway
Warneford Clinic, Churchill Hospital, Oxford
Warrington ECT
Waterford Regional Hospital, Ireland
Whiston Hospital, Prescot
Whitchurch Hospital, Cardiff
Wigan and Leigh ECT
Wootton Lawn ECT, Stroud

Accredited Clinics

Bethlem Royal Hospital
Cheadle Royal Hospital
Clonskeagh Hospital
Dorothy Pattison Hospital, West Midlands
Glenbourne Clinic, Derriford Hospital, Plymouth
Ladywell Mental Health Unit, University Hospital,
Lewisham
Littlemore Clinic, Oxford
Maudsley Hospital*
Mount Gould Hospital, Plymouth
Parkwood ECT Suite, Blackpool
Purbeck Suite, St Ann's Hospital, Poole
Queens Medical Centre, Nottingham
St Patrick's Hospital, Dublin*
The Cauldon Centre, Coventry
The Riverside Clinic, Hillingdon Hospital, Uxbridge
Waterford Regional Hospital

* Accredited with excellence

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