

July 2005  
Issue 2

**Inside this issue:**

Editorial

ECTAS Update

Handbook

Service Users

Healthcare  
Commission

The email discussion  
group

Contact Us



Charity reg no:  
228636



The Royal College of  
Psychiatrists' Research  
Unit  
4<sup>th</sup> Floor  
Standon House  
21 Mansell Street  
London  
E1 8AA  
[www.rcpsych.ac.uk/cru](http://www.rcpsych.ac.uk/cru)  
[www.rcpsych.ac.uk/cru/  
ECTAS.htm](http://www.rcpsych.ac.uk/cru/ECTAS.htm)

Edited by Zoë Fortune

# ECTAS Newsletter

Hello and welcome to the second edition of the 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 recent ECT Training and Practitioners Days organised by the College held in Edinburgh in April were a great success.

The Annual Forum was unfortunately postponed due to lack of numbers and also the difficulty of travel to Edinburgh. We hope that the Annual Forum will now be held in late November/ December and it will be held at a venue in London.

The Annual Report is currently being written as we now have complete data from 50 clinics that have been through the self-review process. We hope that it will be available and distributed to clinics in April.

We have moved! Our offices are now located in Aldgate on the 4<sup>th</sup> Floor of Standon House. There is also a separate

## HANDBOOK

The second edition of the ECT Handbook, edited by Dr Allan Scott has now been published. Appendices include an examples of an out-patient protocol, consent form; suggested templates for authorisation for incapacitated compliant patients and emergency treatment; nursing guidelines for ECT; stimulus dosing and continuation protocols. The handbook can be ordered through the college publications website: <http://www.rcpsych.ac.uk/publications/index.htm>.

Now that the handbook has been released, we will be looking into putting examples of protocols on our website.

### **NALNECT**

ECTAS is now working with NALNECT, the National Association for Lead Nurses in ECT. The committee develops documents, links with other bodies, training, databases, supports other ECT groups and research into ECT. Within the past year, NALNECT has published an ECT nurse guidance document on the RCN website, and supported the nurse guidelines appendix in the new ECT Handbook. They are currently in the process of developing an ECT nurse competencies document. 2 new regional groups have been set up this year with NALNECT's help: The All Wales ECT Network and the East Midlands ECT Nurse Group. The first National ECT Nurse Training Conference is due to take place on 6<sup>th</sup> September 2006 and NALNECT now has its own section on the NIMHE Website. Committee members have recently contributed suggestions on the ECTAS standards and the group is supportive of research initiatives suggested by Professor Keith Matthews at the Practitioners Day in April. For more information on NALNECT contact Brian Mathews on [brian.mathews2@ntlworld.com](mailto:brian.mathews2@ntlworld.com) or Yvonne Flynn on [Yvonne.Flynn@humber.nhs.uk](mailto:Yvonne.Flynn@humber.nhs.uk).

### **A CALL FOR REVIEWERS**

Once again, many thanks to all those who have been carrying out reviews on behalf of ECTAS. The reviews are a chance to visit other clinics and share ideas and we hope that they are interesting for both the reviewers and the clinic teams. We recently held another lead reviewer training day and another one will be held in the autumn. If you think you may be interested in becoming either a reviewer or a lead then please contact Zoë Fortune for more information.

### **SERVICE USERS**

Many thanks to Alison Cobb who helped us to recruit service users through a MIND mailing link. We had a good response and our first service user forum was held in March. There was an extremely interesting discussion about the standards and useful feedback about how service users can become more involved in the process. We are looking at ways in which service user involvement can be increased and many of the issues raised will be brought up at the next reference group.

### **ANNUAL SELF-REVIEWS**

We have now been in operation for over a year and the first wave of clinics that underwent the accreditation process have now completed their annual self review or are in currently completing it. The

annual self-review is a process designed to ensure that the conditions for accreditation continue to be met. The annual self-review takes approximately 3 months to complete, consists of a health record audit of 20 patients, an observation of 5 patients undergoing ECT and also a self-report about any changes that have been made to environment & facilities and staffing. We also ask for an up-dated list of the staff that are working in the clinic so that we can keep our records up to date and ensure that the relevant staff members are receiving regular updates from the email discussion group. Finally, we would also like to know what action has been taken on the suggested changes from the previous year's report. The paperwork is much less than the first year! If you would like to suggest any changes to any stage of the review process then please let ECTAS know.

### **HEALTHCARE COMMISSION**

Following discussions with the Healthcare Commission, they have issued this statement: *'ECTAS accreditation is one of the information sources the Healthcare Commission will use to direct its inspection activities in its core standards assessment of mental health services.'* We have also sent a list of accredited clinics and their trusts to the Healthcare Commission and we will be up-dating this list after every Court of Electors.

## THE E-MAIL DISCUSSION GROUP

The email discussion group has been steadily growing in size as both membership and our bank of reviewers increases. There have once again been some lively debates.

As you know, the group can be used as a forum for the exchange of ideas as well as a place to share thoughts about the standards and our service.

### *Controversial areas*

#### **Dedicated suites**

The issue of multi-purpose ECT suites has arisen as it has been noted that several of our clinics have dual use. A question was put to the group about whether this is a good thing. It would appear that most people can see the merit in both sides. Sharing a suite might allow for equipment upgrade without eating into the ECT budget and can be argued to be an effective way of managing resources as long as equipment can be stored and no timetable clashes occur. However, it was also pointed out that a dedicated ECT suite may be 'nicer' for service users as it allows for personal touches in the clinic specific to ECT; a picture on the ceiling above the trolley for example. There may also be problems with timetable clashes and it could, in some cases, reinforce the idea that ECT is an out-dated treatment

and should not be talked about.

#### **Information leaflets and protocols**

Many people have requested information leaflets in different languages and other protocols. Several of you have been kind enough to forward us any protocols you have that may be of use to other clinics as well as patient information sheets that you have translated. We hope to put these on the website very shortly, where you will be able to access and download them all. However, in the meantime we have just received a copy of the patient information sheet in Arabic from Jonathan Waite at Queens Medical Centre so if you would like a copy of this then please let us know.

#### **Patient Information video**

A short while ago we asked if anyone had a patient information video that they would be willing to share. It was pointed out that there are problems with videos. One clinic in particular spent a lot of money on the production of one only for it to be rejected by the Health Authorities patient representative group, who claimed it was pro-ECT. However, Bolton Hospital have a video for sale at £30 which has been approved by their own hospital trust. If you would like a copy please contact us and we will be able to put you in touch with them. We did have a couple of replies

suggesting that the video idea in general needs updating to be more in line with modern technology. A DVD was suggested and the construction of a multimedia CD ROM with video clips, hotlinks to web pages, e-mail discussion and references, allowing both patients and staff to access whatever level of information they require. This would be much easier to keep up to date.

#### **Banned ECT**

Richard Barnes wrote to the group with a query regarding banned ECT. He wished to clarify whether ECT is banned in certain European countries and a number of states in the USA or whether this is in fact an urban myth. We have had a couple of replies about this so far. Dr Durga Harsh suggested that banned or not, ECT is now featuring less in the treatment plan of patients and more as a cost/ benefit issue in managers meetings. He further suggested that as there is a lack of funding, it is the College's prerogative to promote this treatment. Declan McLoughlin suggested that anyone interested in the issue of whether ECT is banned should read the paper by Philpot et al, (2002), *Barriers to the use of electroconvulsive therapy in the elderly: a European survey*. *European Psychiatry*, 17(1),41-45.

#### **Discontinuation policies**

A question was raised regarding discontinuing ECT

due to poor response. Should the discontinuation policy only be triggered when the patient is deemed to have failed to respond or should it contain steps designed to focus the team's attention on a patient's possible lack of improvement? Dr Carl Littlejohns suggested that the step-wise approach might be the best format. For example, if there is no response after 4 treatments then the monitoring clinician would ensure that the patient's treatment parameters were being closely monitored. In this way easily identifiable reasons for poor response would be picked up sooner, as would patients likely to need a lot of sessions, and perhaps patients at higher risk of cognitive problems. Declan McLoughlin replied, saying that in their treatment pack, the referring physician is allowed to prescribe only two treatments in advance. Before starting the ECT course an initial CGI score must be entered into the form and follow-up CGI scores must be entered every two treatments thereafter in order for the course to proceed. This allows both the referring physician and the ECT team to formally, but relatively easily, monitor response to treatment. Their informal policy is for the team to raise the issue with the referrer if there is no evidence of response after 6 treatments and the need to continue ECT is questioned if there is no meaningful improvement by 6-12 treatments. The ECT Treatment Pack contains room for up to 12 treatments with an

aim of reminding referrers to reconsider the need to go beyond 12 treatments and review progress. It is a type 2 standard that it should be documented that consent has been checked before each ECT session (this can be done verbally as part of the nursing checklist).

### **Recording of subjective experience of ECT**

A question was asked about how clinics record their patients' subjective experience of ECT. When is it done and by whom? Susan Benbow informed the group that the procedure at Wolverhampton is to ask patients to complete a form between ECT treatments feeding back whether they have had any side effects (from a list) and whether they are better or not. Although not always completed, this form can then be carried with the patient to their next treatment to help decisions about dosing etc. The form is specifically for the patients to fill in, not the ward staff, and there is a separate one for them.

### **Unilateral musings**

There has been some debate amongst the group about unilateral ECT and the side effects. It was suggested that non-dominant unilateral ECT causes less verbal memory impairment than bilateral ECT, that we do not know the impact of bilateral and non-dominant on non-verbal memories (visuospatial etc)

and therefore we should be cautious in moving to high dose unilateral because of the unknown visuospatial consequences and stick to bilateral until this has been clarified.

Chris Freeman has replied to these comments as follows: The justification for moving to unilateral ECT is because of the long-term permanent effects. Patients often complain of personal and remote memories that are accessed via verbal cues. Deficits in learning new material (anterograde amnesia) generally return to normal 3 to 6 months after a course of ECT. It has been found that in remote memory, both personal and impersonal memories are affected, there is no recency effect and memories of high personal salience are no more affected. There have also been documented cases of visuospatial skills impairment post ECT such as becoming lost in familiar surroundings after a course of ECT. It has also been suggested that visuospatial deficits occur equally with both bilateral and unilateral ECT. These visuospatial problems can be overcome whereas a remote memory cannot be recovered. Dr Chris Freeman therefore concludes that even if the short term unwanted effects of bilateral and high dose non dominant unilateral ECT were equal there would be a case for using unilateral ECT because of its sparing effects on remote verbal memories.

This would not apply to remote visuospatial memories if they exist.

### **Rare cases**

The email discussion group has also proved a useful forum for advice. People have sought advice on possible complications in ECT such as the presence of a cordell hearing aid. Advice was also sought about whether ECT can be given 3 times a week in cases of extreme urgency and if requested by the psychiatrist (although this is contrary to NICE guidance). Dr Chris Freeman suggested a measure to ensure that this is done in the safest possible way is the use of ultra brief pulse (2.5msec with a Thymatron, 1 msec with a Mecta). When using this, go well above the threshold which should be low with ultrabrief pulses. Other members of the forum suggested that in this rare case ECT could be given 3 times a week but the possible negative side effects may be more likely and this needs to be taken into account.

A discussion also arose about how to treat a patient with a cordell bone anchor. Several anaesthetists replied suggesting that the hearing aid should not cause a problem for ECT although the wisest course of action is obviously to remove it.

### **CNST**

ECTAS asked the group what they thought about

approaching the Clinical Negligence Scheme for Trusts to see if they will recognise ECTAS Accreditation in their standards and reviews. Trusts could possibly benefit from reduced premiums paid to the pooled risk fund. A reduction of £2,000 per year per clinic would of course pay for ECTAS membership and in risk terms would represent good value. Responses to this idea were positive although it would depend on to what degree ECT represented a claim burden and whether type 1 standards would reduce this claim.

### **Stimulus dosing**

Dr Carl Littlejohns raised the question of what dose 'steps' people are currently using. Dr Caroline Gorst-Unsworth replied saying that at Worthing they use the Duke Schedule which is roughly a 50% increase. The rate of threshold increase varies between patients. The new handbook does contain an example of a stimulus dosing protocol.

### **Electrode contact**

The issue of impedance and electrode contact has arisen once again. It was suggested that with the Thymatron IV it can be extremely difficult to get good enough contact with stick-ons, hands-free electrodes or hand-held. Suggestions as to how to get round this problem include using a sandbag or pillow to put beside the patient's head in order to allow firm pressure

on the treatment electrode and asking the ODP to hold the patient's head for unilateral ECT to allow firm pressure. It was also suggested that consideration could be given to changing the anaesthetic.

### **Thiopentone**

Thiopentone was suggested as a good anaesthetic to use for ECT cases and Jonathan Waite found that it causes fewer problems than Propofol. Andrew Easton stated that Thiopentone can be much less problematic in terms of seizure threshold in some individuals but this needs to be balanced with the effect on the recovery profile. He also states that there have been some cases where the dose of electricity has dropped by >30% with an improved seizure profile on switching to Thiopentone.

### **Finally...**

I (Zoë) will be leaving ECTAS shortly after a year working on the service. I have enjoyed working here immensely and I hope that my work here has helped to establish ECTAS as an important body for the improvement in health services. I will miss working with you all!

## Member Clinics

Member clinics that have not yet been accredited are either currently in the self- and peer-review stages of the process or have been deferred whilst changes are made.

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  
Cherry Knowle Hospital, Tyne and Wear  
Cheadle Royal Hospital  
Clos Bran Hospital, Carmarthenshire  
Clonskeagh Hospital, Dublin  
Derby City General  
Dorothy Pattison Hospital, West Midlands  
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  
Hartington 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  
The Mount, Leeds  
Mount Gould Hospital, Plympton  
Needham Suite, Bootham Park Hospital, York  
Newsam Centre, Leeds  
Parkwood ECT Suite, Blackpool  
Princess Marina Hospital, Northampton  
The Priory, Marchwood, Southampton  
The Priory, North London  
The Priory, Roehampton  
Purbeck Suite, St Ann's Hospital, Poole  
Queens Medical Centre, Nottingham  
The Riverside Clinic, Hillingdon Hospital,  
Uxbridge  
Royal Oldham Hospital  
St George's Hospital, Northumberland  
St George's Hospital, Stafford  
St Patrick's Hospital, Dublin  
Sevenacres Hospital, Isle of Wight  
Shelton Hospital, Shrewsbury  
Somerset Partnership NHS Trust, Taunton  
Stepping Hill Hospital, Stockport  
Tameside Hospital, Ashton-under-Lyne  
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

### Contact Us

#### **Joanne Cresswell**

Email: [jcresswell@cru.rcpsych.ac.uk](mailto:jcresswell@cru.rcpsych.ac.uk)

Phone: 020 7227 0890

#### **Zoë Fortune**

Email: [zfortune@cru.rcpsych.ac.uk](mailto:zfortune@cru.rcpsych.ac.uk)

Telephone: 020 7227 0890

#### **Email discussion group**

[ECTAS@cru.rcpsych.ac.uk](mailto:ECTAS@cru.rcpsych.ac.uk)

#### **ECTAS**

[www.rcpsych.ac.uk/cru/ECTAS.htm](http://www.rcpsych.ac.uk/cru/ECTAS.htm)