



Notes of Meeting of the Special Committee on ECT and related treatments, MONDAY 19 JANUARY 2009.

1 Notes of meeting of 23 June 2008

The minutes of the meeting on 23rd June 2008 were approved.

2 Matters arising from the minutes

• **Membership of the committee**

Membership was discussed. It was further suggested that the committee should advertise and interview for 3 additional members. People joining the committee should be actively involved in ECT practice or research and prepared to be involved in preparation of the next handbook. The committee would also welcome applications from individuals with an interest in related treatments. A new representative would also be requested from NALNECT.

A question was asked about the College position on user/ carer involvement. The Committee noted that ECTAS has user and carer involvement and that the Handbook would benefit from a chapter on user and carer perspectives. It was felt that the ECTAS involvement did ensure appropriate and sufficient input from users and carers into College ECT discussions, and specific input for the handbook could be requested without requiring someone to attend all meetings of the committee.

3. New Handbook

The Chair offered to take on the role of editing the new ECT Handbook, and members agreed. Members confirmed that the plan was to produce two documents, a practical handbook of what should be done in ECT and a larger book of background theory. Chapters would be reviewed with the aim of producing a list of proposed chapters in 4-6 weeks to circulate to committee. The new editor would then identify authors for new chapters or to update existing chapters and would also contact the Head of Publications at the College about the process and ask to send out author invitations.

Members suggested that the 'adverse effects' required expansion, treatment modalities needed updating and expanding, and new chapter on user and carer perspectives should be included. It was agreed that the chapters for the longer 'theory' book should be produced first; they could then be used to create the shorter 'practice' document.

4. Training days

• **Feedback from Dec 2008**

From the Training Days in December 2008 was presented for discussion. Overall the responses were very positive and supported the restructuring of the Days. Members suggested that the meeting should be chaired and that it was reasonable to assume that people knew the background up until the first NICE standards, so that the Days only needed to cover developments since then.

Members discussed the conclusions of the workshop on adverse effects of ECT held at Competencies Day. People had asked what is the point of cognitive testing unless it informs treatment or treatment choice? Nearly everyone was using MMSE pre and post ECT and reorientation (but a protocol was needed to regularise the practice), and also made formal or informal enquiry about memory complaints.

- **Planning for 2009**

The proposed Training Day dates agreed were 19/11/09 and 20/11/09.

5. **Competencies**

The competencies are available on the website and no comments had been received. It was agreed that the competencies should be recirculated to the committee with the figures indicating how far they were met when participants were tested on them at a previous training day. Members would be invited to indicate within 2 months which competencies should be removed, changed or added. The drafting group would then review and agree the final competencies. Members discussed regional peer groups for lead ECT consultants. Once competencies are finalised they should be sent to all lead clinicians with details of their regional peer group. ECTAS would be asked to incorporate a requirement to meet these competencies into their inspection of clinics, and achieving the competencies should feed into consultant appraisal. It was also suggested that for trainees a DOPS could be part of achieving their competencies.

It was agreed that the committee should create some multiple-choice questions for participants to rate themselves at the Competencies Day. It was agreed that each person on the committee (including those not present at the meeting) should produce 3 questions (consisting of a stem and four statements).

6. **Driving and ECT**

Members received for information the leaflet from NHS Highland about driving and ECT. The DVLA advice (revised Sept 2008) was that people with severe depression should be told to stop driving until they achieved a 'period of stability' depending on the circumstances. The Chair reminded members that the restriction was to do with depression

and not with ECT. It was agreed to draw up a short statement to circulate to the committee for comment.

6. **ACT checklist**

Members received for information the ACT checklist.

7. **NICE depression & ECT guidelines**

Members discussed questions raised in relation to the update of the NICE HTA on ECT as part of the new Depression guidelines:

Q1: *When should ECT be given for depression?*

Members agreed that the definition of when ECT should be given was not correct – much of the evidence base referred to moderate depression. It was inappropriate to leave ECT to last on all occasions. If people had previously responded they should have the option of choosing ECT again. Treatment resistance and previous good response were arguments in favour of ECT.

Q2: *Is there now sufficient evidence to use non-dominant UL as first line instead of BL?*

This should be answered by reference to the guidance in the Handbook: it was an area of continuing clinical debate, and there was no consensus. Patient choice should be a significant factor. There was insufficient evidence to recommend bi-frontal ECT in practice.

Q3: *Should the continuation/maintenance recommendations be revised in the light of the continuation trial?*

Yes.

Q4: *Should there be as much emphasis on stopping ECT as soon as improvement has occurred as there is in the current guidance?*

No – Members would want to see the patient recovered, not just improved. The aim of treatment was to achieve remission. Members suggested that an ECTAS standard of measuring outcome would be helpful.

Q5: *Any other items to consider?*

No

The committee suggested that advice should be given around schizophrenia – it was not part of the depression guidelines, and it was not clear where it was considered. It was suggested that ECT should be considered in both the schizophrenia guidelines and bipolar guidelines.

8. **ECTAS**

The meeting was told that 115 of the 145 clinics in England were now signed up to ECTAS. The standards had been held constant, and no new ones would be introduced until all of the clinics met them.

9. **Next meeting:** 11 May 2009