

Notes taken from the meeting of the Special Committee on ECT and related treatments Monday 23 June 2008

1 Notes of meeting of 14 January 2008

The minutes of the meeting on 14 January were approved.

2. Topics for the next handbook

The committee received the list of topics for the Handbook review as it currently stood. Members were reminded that it had previously been agreed that the revision should be postponed for a year (from 2009 to 2010). Members discussed the format and content of the Handbook. It was agreed that there was a market for two different types of book – a handbook, and a textbook. As a standard-setting organisation, it was appropriate for the College to publish a handbook, but there was also demand for a textbook, which could be financially successful. It was also suggested that the Handbook's layout could be changed, to provide a shorter document more useful for day-to-day reference, supplemented by items such as evidence and reviews.

It was agreed that the main item for discussion at the next meeting should be the Handbook – a full reconsideration of its purpose, layout and content.

3. Report to CEC

A draft report from the Committee to CEC was tabled. Members ratified the report for presentation to the July meeting of CEC.

4. Training courses

Members noted the new three-day courses for nurses being offered by the CETC. These provided specific in-depth training for nurses to be able to demonstrate appropriate competencies in ECT. At the last meeting the Committee had agreed to reconfigure the training days so that the first day was relevant to all team members, and the second contained content specific to psychiatrists (including trainees, prescribers, and ECT consultants). Members discussed how to achieve this reconfiguration, and agreed a revised draft programme, which also included items to cover the main competencies identified by attendees at last year's days as requiring attention. Items for future development could include service user and/or carer involvement in the days, and offering a post-course on-line competency assessment.

5. ECT protocols

The committee received four sample protocols from those which had been drawn up by ECTAS: these protocols were examples which Trusts could use as a basis for drawing up their own local documents: they were informed by best practice

from ECTAS-enrolled clinics, but were not compulsory. It was agreed to circulate all of the protocols for comment.

6. **Competencies**

The competencies were still in draft form: they would be put on the Committee web page for comment, and would be finalised after 12 months.

7. **Driving and ECT**

The Chair had consulted the DVLA about their recommendations on driving following ECT. The DVLA did not make any specific recommendations about ECT. However, they did have a clear policy that anyone with moderate to severe depression (as defined by their expert – not as defined by NICE) should not drive for 'a reasonable period' following recovery. They had clarified that 'reasonable' meant 3 months. For people with severe depression, that period was 6 months following recovery. The way recovery was achieved was irrelevant; if a patient underwent ECT this had no effect one way or another on the DVLA's recommendations.

Members agreed that the Committee could not alter the DVLA rules; it was, however, important to make clear to patients that the requirements about driving were completely unrelated to ECT, and would not be affected by the patient undergoing it. The current College recommendation that people should not drive or operate heavy machinery for 24 hours after ECT was standard advice for those having a general anaesthetic, and was not related to the ECT. This should be made clear, and patients should be advised to consult the DVLA about their fitness to drive with regard to their depression.

8. **Next meeting**

Monday 19 January 2009.

9. **AOB: ECT and cognitive impairment**

A systematic review of cognitive impairment following ECT had recently been published. It had shown that the most effective method for assessing impairment was the use of AMI plus modified mini mental state (MMMS) assessment. It had been shown that there was a correlation between those patients with the greatest impairment preceding ECT, and those who suffered the most side effects from the treatment. It was therefore useful to carry out a MMMS assessment before treatment, as well as after. There was some evidence to show that post-treatment cognitive impairment did not become fully apparent until the patient had returned to normal situations, and assessments carried out immediately after treatment, within the clinic, would not necessarily show this up. However, in situations where there was limited follow-up, it might only be possible to carry out the assessment immediately, and this was better than none.

To be circulated for information.