

Introduction

• Electroconvulsive therapy (ECT) was first introduced as a treatment for psychosis in 1938 by Cerletti and Bini ⁽¹⁾. Though first used in the treatment of psychosis, by 1941 ECT was identified as an effective treatment for depression ⁽²⁾. However, with the introduction of pharmacological treatments for severe mental disorders, the use of ECT declined in the 1970's ⁽³⁾.

• The National Institute of Clinical Excellence (NICE) recommends that ECT is used in severe depressive illness, catatonia or a prolonged or severe manic episode, although acknowledges that it is sometimes used in the treatment of schizophrenia ⁽⁴⁾.

• The revised Royal College of Psychiatrists ECT handbook ⁽⁵⁾ comments on the lack of research into the use of ECT in the ID population, with the evidence base composed almost entirely of case reports.

• In 1999, a paper was published by Cutajar and Wilson, detailing the results of a survey carried out to examine the use of ECT by Consultant psychiatrists working with people with intellectual disability in the Trent region, UK ⁽⁶⁾.

• This survey, aims to capture more recent experiences of those who have prescribed, or have considered prescribing, ECT for patients with an ID. It will also help to gain better understanding of the limitations in the use of ECT which has thus far mostly been speculated.

Methods

• Psychiatrists working with people with an intellectual and/or developmental disability were invited to complete an electronic survey. Invitations were sent locally using internal mailing systems and distributed nationally via "Basecamp", a Royal College of Psychiatrists project management and collaboration system. Funding was obtained for the "Jisc online survey" platform via application to the (Nottingham) Mapperley Research Fund.

Results

• There was a total of 22 responses within the 2-week period that the survey was open

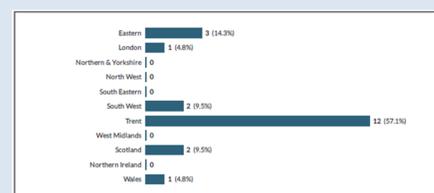
• The majority of the responses were from doctors working within the Trent region, however, there were responses from a total of 6 regions (**Graph 1**) spanning various training grades (**Graph 2**) and differing catchment sizes (**Graph 3**).

• 4 patients had received ECT in the past 5 years. All were treated for depression.

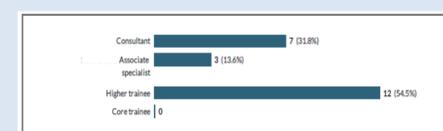
• In terms of difficulties encountered by clinicians in the prescribing of ECT for people with an ID, common themes spanned both the 1999 and current survey responses (**Table 1a and 1b**).

• 61% of all respondents felt that ECT was underused in people with an intellectual and/or developmental disability. This compares to 55.6% of the 1999 survey. (**Graph 4**). Reasons for the decisions are set out in **Table 2a** with a comparison to the 1999 survey in **Table 2b**.

Graph 1 (Regions offering responses)



Graph 2 (Training grades offering responses)



Graph 3 (Catchment area sizes of responders)

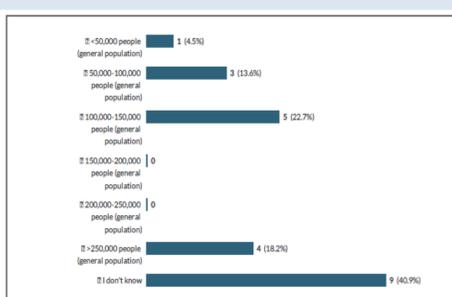


Table 1a (Current survey responses. Figures in brackets indicate the number)

Difficulty
Obtaining informed consent (1)
Having sufficient knowledge of the patient to understand their baseline (1)
Knowledge of the referral procedure (1)
Concern about capacity (1)
Patient co-operation (2)
Monitoring of fasting (1)
Difficulties in gauging memory loss (1)
ECT has not been considered (1)
Staff culture (1)

Table 1b (1999 survey responses. Figures in brackets indicate the number)

Difficulty
Obtaining informed consent (3)
Organizing transport (3)
Nil by mouth (2)
Resistance to anaesthetists/general psychiatrists (1)
No facility available locally (1)
Anticipatory anxiety by patient and special provisions (1)
Resistance by relatives (1)
One patient developed a hemiplegia the day before ECT was due
One patient developed a 'severe adverse reaction' (Status epilepticus) and no further ECT was given.

Graph 4 (Opinions regarding the usage of ECT)

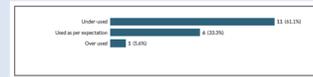


Table 2b (Opinions regarding the usage of ECT)

ECT is underused (10)	ECT is not underused (8)
Difficulties in diagnosing mental illness in intellectual disability (5)	Classical mental illness not seen in intellectual disability (1)
Consent issues (5)	Rarely require the speed of action of ECT (1)
Earlier diagnosis and treatment (2)	Effects of ECT are short term (1)
Irrational fear of worsening pre-existing organic damage (2)	Engenders suspicion of psychiatrists (1)
Greater acceptance of poor functioning by staff (2)	Useful in general psychiatry, not intellectual disability (1)
Resistance by carers/staff (2)	ECT is overused in general psychiatry (1)
Lack of understanding of mental health issues by professionals (2)	
No facilities for ECT locally (1)	
Fear of frightening patients	

Table 2a (Opinions, verbatim, on the usage of ECT)

ECT is underused	ECT is used as expected	ECT is overused
"Seems to be used a lot less than the general population despite rates of mental illness amongst pwid being reported as higher than the general population"	"I haven't yet had a patient as an ID SWI whom where I thought ECT was clearly indicated"	Very rarely justified
"General impression that it is underused, potentially impacted by diagnostic challenges within this group"	"There is less evidence to prove otherwise."	
"I have never had a patient with ID receive ECT"	"Haven't encountered it yet. But certainly rationale must be present for usage congruent to symptoms in other psychiatric presentations"	
"ECT might be under-used due to ethical issues (eg carers/families feel anxious about ECT maybe due to outdated expectations of what the procedure would be like)"		
"Consent issues"		
"Legalities"		
"Possibly underused given medicolegal issues"		
"Issues related to consent and capacity and also opposing views of families/carers"		
"I don't have patients under my care in past 5yrs on ECT, so wondering if this is underused?"		
"No referral"		
"Practical difficulties"		
"ID and current scrutiny"		
"Tendency to use as last resort"		
"Never seen it being used"		
"It is not a common practice to use ECT in patients with intellectual disabilities and it could be due to their perceived difficulty in understanding pros and cons of ECT"		

Discussion

• There has been a declining trend in the use of ECT within the intellectual disability population over the past 20 years with reasons behind this being more complex than simply that ECT was not clinically indicated.

• All of the patients in the current survey and the vast majority of those in the 1999 survey were prescribed ECT for the treatment of a depressive disorder. This is the case despite evidence that ECT has been considered in the management of a variety of presentations in people with IDD outside of a typical depressive picture (e.g. catatonia ⁽⁷⁾ ⁽⁸⁾ ⁽⁹⁾ ⁽¹⁰⁾ ⁽¹¹⁾ ⁽¹²⁾ ⁽¹³⁾ ⁽¹⁴⁾ ⁽¹⁵⁾ ⁽¹⁶⁾, severe challenging behaviour ⁽¹⁷⁾ ⁽¹⁸⁾ ⁽¹⁹⁾ ⁽²⁰⁾ and psychosis ⁽²¹⁾ ⁽²²⁾ ⁽²³⁾ ⁽²⁴⁾).

• The survey results highlight the need to consider factors that may limit ECT access to people with an IDD and to consider the ethics of treatment availability to a vulnerable population compared to that of the general population.

• In a landscape where pharmacological interventions for people with an IDD are, rightly, being scrutinised, there is an ever more increasing need to carefully consider the judicious use of non-pharmacological therapies.

Conclusions

The evidence of the use of ECT in people with an intellectual and developmental disability remains a challenge for clinicians (ECT Handbook). Whilst this survey does not offer robust research findings, it does highlight the potential declining trend in the use of ECT despite an acknowledgement from clinicians that ECT does potentially still have a role to play in the treatment of people with intellectual and developmental disabilities and offer some important areas to address in order to ensure that people with an IDD, who may otherwise have benefitted from ECT, are not disadvantaged in their access to ECT.

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