

WELCOME!

Welcome to the 20th edition of the ECTAS newsletter! Thank you to everyone who contributed to this edition, we hope you enjoy reading it.

ECTAS Forum

2019 has been a great year so far for ECTAS. We held the largest ECTAS forum to date 'The Evolution of ECT' - presentations included: [Genetics of ECT International Consortium \(gen-ECT-ic\)](#); ECT for schizophrenia; neuromodulation clinics; magnetic seizure therapy (MST) and ECT in the movies; how the media has portrayed ECT through the years. If you would like a copy of the presentations from the forum please contact the ECTAS team (ECTAS contact details on page 10).

Standards

We're currently revising the ECTAS standards in preparation for publication of the 15th edition in Spring 2020. The standards are reviewed every two-years to ensure that they are up-to-date with current legislation, practice and guidance. This also ensures that member clinics are able to feedback any issues or suggestions they have regarding the standards. All feedback is reviewed by the ECTAS advisory group, a multi-disciplinary group of consisting of psychiatrists, anaesthetists, ODPs, nurses and service users. Many of these people also represent other professional bodies, and all work in ECTAS member clinics.

Special Interest Day

In October 2019 we are holding a special interest day in on the topic of Anaesthesia for ECT. Registration is open so book your place if you would like to attend! You can also follow the event on twitter using [#AnaesthesiaECT](#).

ECTAS Team

The ECTAS team has had some staffing changes over the past few months and we now have a full team in post. Eve Blanchard as Programme Manager, Vicky Cartwright as Deputy Programme Manager and Sinead Rogers as Project Officer.

For the next part of the year we will continue to facilitate peer-review visits and will be developing the 8th ECTAS National report. We look forward to seeing you all in the upcoming reviews and peer-reviewer training session in November!



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 020 3701 2653

 ECTAS@rcpsych.ac.uk

CASE REPORT:

ECT IN POST ENCEPHALITIC PATIENTS

A 66 year old patient developed viral encephalitis – a diagnosis that was made some weeks after the initial symptoms. MRI scanning demonstrated bilateral basal ganglial necrosis.

Investigations at this time showed oligoclonal bands in CSF, high T2 and FLAIR signal in basal ganglia. Methylprednisolone and IVIg led to some improvement, however, she had severe clinical depression with somatic symptoms, she described an ongoing pain in the mouth.

She developed severe depression a few months later; her mood was profoundly low with no reactivity and she was extremely agitated. Treatment with a modest dose of venlafaxine (150mg) and quetiapine produced no benefit but remained unaltered over a 6 month period. She was particularly distressed by odd sensations, numbness and tingling, periorbitally; this was attributed to a post encephalitic thalamic syndrome.

She was then admitted to a neuropsychiatric unit where symptoms of severe depression with suicidal ideation remained despite switching to olanzapine 10mg.

She was noted to have some signs of Parkinsonism (L>R) which was felt to be secondary to the necrosis, and may have been exacerbated by olanzapine. Soon after this she made a serious attempt to hang herself in her room and was transferred to a psychiatric unit.

At was apparent that she was in need of an urgent course of ECT for her severe depression. Unfortunately her husband, did not support this treatment plan and insisted that she was suffering from dopamine deficiency syndrome. Explanations to the contrary were to no avail - at least initial. He requested evidence of its efficacy in terms of a randomised controlled trial; of course none could be found. The British Encephalitis association medical information department was contacted in case that had some reports of ECT efficacy in this clinical context; they simply cautioned that ECT should be used in such patients.

Neurology had recommended stopping the olanzapine and beginning a three-week trial of L-dopa. It was hoped this would improve the

Parkinsonism as well as her mood. Carbamazepine was also started for her oral symptoms. Despite treatment with L-dopa and carbamazepine, the patient showed no improvement in mood or somatic symptoms. During this three-week trial, the patient was not on any other antidepressant medication and she remained very depressed.

Medical History

Antidepressant medication, vortioxetine 5mg, was reintroduced and ECT was eventually started. She had 14 applications over two months. Improvements were slow at first but relatives began to notice definite changes in mood by the fifth treatment. The patient also reported improvements in mood and reduction in somatic symptoms. The patient continued to recover, she was taken off one to one observations, she appeared brighter and more engaged and was able to spend more time off the ward with family. She was discharged home soon after the 14th treatment, the patient was monitored by the community team for two weeks with no further ECT.

The case illustrates that severe depression is severe depression what ever the apparent precipitant and that our most effective form of treatment should be made available as soon as possible - this might have prevented the severe suicide attempt. In an age of evidence based medical practice we are at risk of denying patients potential highly effective treatment.

The patient and her husband are now advocates of ECT and have offered to support other families and patients who are contemplating a course of ECT.

Dr Catherine Graham
F2 Psychiatry
Avon and Wiltshire Partnership NHS Trust

Dr Jonathan Hewitt
Consultant Old Age Psychiatry
Avon and Wiltshire Partnership NHS Trust



CASE REPORT: TREATING A PATIENT WITH PSEODOCHOLINESTERASE DEFICIENCY

We recently treated a patient with documented hereditary pseudocholinesterase deficiency (Scoline apnoea) which meant that the use of suxamethonium would be contra-indicated for her treatment. Patients with this condition take longer than normal to metabolise suxamethonium (and mivacurium) due to congenital absence or malfunction of the enzyme that breaks down suxamethonium. There are 4 different genes (usual, dibucaine resistant, fluoride resistant and absent) resulting in 16 possible genotypes and 10 phenotypes. 6 of the phenotypes are associated with a marked reduction of the hydrolysis of suxamethonium. Periods of paralysis can vary from 40 minutes up to 11 hours. Incidence in European Caucasians is estimated at 1:3000. Males are twice as commonly affected than females. Other racial groups exhibit a lower incidence. Other than complications around the use of suxamethonium or mivacurium, there are no other clinical implications of this condition.

Our treatment suite within the psychiatric department is isolated from the main hospital. We use an anaesthetic machine with oxygen cylinders as we have no piped oxygen. We do not have volatile anaesthetic gases although we do have access to theatres for treatments if necessary.

Following discussion with the treatment suite team we decided to institute therapy using induction and maintenance with propofol (via a target controlled infusion (TCI) device). Relaxation was achieved using atracurium given at around 25% of an intubating dose. Modified ECT was completed without incident. Reversal of neuromuscular blockade was confirmed with a peripheral nerve stimulator prior to discontinuing the propofol infusion. For our patient we did not need to use neostigmine and glycopyrrolate although we would have used this if required. The dose of atracurium chosen suitably modified seizures without resulting in prolonged paralysis (<10 minutes).

The use of operating theatres can often over-medicalise a therapeutic intervention for our patients. As far as is possible, we try to minimise

theatre use. It was easier to bring a TCI device from theatres than to take the patient in the opposite direction and allowed her to complete her treatment in a familiar environment.

Dr Paul Kirk
Consultant Anaesthetist
North Manchester General Hospital

ECTAS PEER REVIEWER TRAINING

Peer reviews are a great way to meet other professionals from clinics around the UK and Ireland, and offer the opportunity to share ideas and good practice. They also count towards CPD, and ECTAS can provide proof of attendance if needed. The one-day training courses are for staff working in ECTAS member services and people who have received ECT and would like to visit other services as a peer reviewer.

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We will be holding peer reviewer training day towards the end of 2019:

Tuesday 26th November 2019—London

If you are interested in attending this training please contact ECTAS@rcpsych.ac.uk



CASE REPORT: ECT: A LIFE COURSE APPROACH FOR RECURRENT DEPRESSIVE DISORDER

SUMMARY

We describe the case of an 89-year-old woman (deceased) with a 60-year history of recurrent depressive disorder treated with electroconvulsive therapy (ECT). It is estimated that she received up to 400 ECTs over her life course as her symptoms would not respond to oral medication. Despite extensive exposure to ECT, there was only minimal cognitive impairment and an excellent safety record, even in later life, as she became increasingly frail from multiple comorbidities. Over the years, there has been a drive to reduce the frequency of ECT administration. However, this case illustrates how in some patients ECT may be vital for acute episodes of severe depression as well as for maintenance therapy. This case report adds to observational evidence that maintenance ECT may be an underused treatment for recurrent depression and also recommends that greater emphasis be given to incorporating carers' views when planning individualised treatment approaches

BACKGROUND

The role of electroconvulsive therapy (ECT) in depression has been an area of ongoing debate. There has been a reduction in use of what has been historically a highly effective treatment and there is a move to decrease use to last resort only. This case illustrates the utility of ECT in recurrent depressive disorder over a lifespan. Our female patient would not respond to any other alternate agents trialled and would each time decompensate, particularly in later life, to life-threatening complications. Often, it was not until after the insistence of her son (her carer) that she would eventually be given ECT to which she would usually respond quickly. In later life, she required ongoing symptom stabilisation using maintenance ECT.

The public's perception of ECT is often negative due to barbaric images of the treatment portrayed in the media over the past century. This case illustrates that the carer or patient view and response can be the driving force for ECT and this is an important guiding principle in complex clinical cases like this.

CASE PRESENTATION

Our patient's first psychiatric presentation was with postpartum depression in the early 1950s which was successfully treated with ECT. She had ongoing depressive episodes in the intervening years, requiring several courses of ECT as outlined below. With each relapse of severe depression, she presented in a very characteristic way with periods of unresponsiveness, an expressionless face and staring eyes. She would also adopt bizarre postures and catatonic symptoms. In addition to a very low mood, she was often irritable and there appeared to be a transformation in her personality. When depressed, she would self-neglect, including poor oral intake and rapid weight loss. This often led to severe constipation, sometimes requiring surgical intervention. Constipation was noted to exacerbate her deterioration in mental state. She also socially disengaged from people and refused to take medication. She presented with psychotic features, including persecutory delusions, as she believed that carers were talking about her, and she was often physically and verbally aggressive to her son and staff. She also experienced visual and auditory hallucinations.

Medical History

Our patient's medical history included anaemia, hypothyroidism and a hiatus hernia. She also suffered from recurrent vomiting with constipation which was extensively investigated but no cause was found.

She was also diagnosed with Paget's disease; she had two episodes of hypercalcaemia, as well as stage 4 chronic kidney disease towards the end of her life. She also had ischemic risk factors including high blood pressure and hypercholesterolemia which were controlled with medication. She was reported to have had a transient ischemic attack (TIA) in 2005.

Personal history

Her mother had suffered with depression. Our patient was a nursery nurse, then moved onto privately running her own under 5's nursery school which she managed successfully for many years until she retired at the age of 65. She married in 1950 and had two sons. Her husband died in 1992 of cancer.

Social history

She had lived in the same town since 1947. After her husband's death, she lived with her son, who was her carer, in the family home. She moved to residential care in 2009 and 2014 she moved into a nursing home. There was no other significant alcohol or other substance history.

INVESTIGATIONS

Her Mini Mental State Examination (MMSE) scores normally dropped when she was depressed to between 18/30 and 24/30. Improvements in her MMSE coincided with post-ECT recovery periods

in line with pseudodementia. For example, in 2005, it was noted that she made a dramatic recovery after eight sessions of ECT and her MMSE tested after ECT at that time was 30/30. In April 2013, her MMSE was 28/30 following a course of 12 emergency ECT treatments. Head CT report in the same month in 2013 showed generalised involational volume loss of the brain parenchyma, periventricular low attenuation of deep white matter and changes consistent with small vessel disease. It appears that ECT did not have a great effect on her cognitive functioning despite the number of treatments she underwent.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis in this context would be recurrent depressive disorder (International Classification of Diseases, Tenth Revision, (ICD-10) F33). This would subsume previous diagnostic categories of endogenous depression and melancholia which would have been previous descriptions of this phenomenon. At times of presentation, there would be diagnostic migration over the lifetime course between moderate episodes, severe without psychotic and severe with psychotic episodes, as would be expected in the disorder (F33.1–F33.3). Alternative diagnoses which could be considered are bipolar affective disorder (ICD-10 F31); however, there was no history of experiencing manic episodes. A second diagnosis to consider is schizoaffective disorder, (ICD-10 F25), against this would be, (1) the psychosis would always come on in the context of a depressed mood, and, (2) the prominence of the mood symptoms.

TREATMENT

Between 1954 and 2013, our patient had 24 psychiatric admissions, the first in 1954 and the last in 2013. Each admission was for severe depression with psychotic features. Since 2002, she spent 150 weeks in hospital. ECT was given as a course of treatment in every one of her hospitalisations. She continuously received medical therapy between episodes and only stopped taking medication when her mental state deteriorated. Until 2009, her son administered all of her medication to her, and both her son and the professionals are clear that her mental health did not deteriorate because of non-compliance with drug treatment, but rather that it was not effective.

Between the years 2001 and 2011, she suffered more frequent episodes of depression requiring ECT and inpatient care for increasingly longer periods as her physical health deteriorated. From 2006 until 2014, she was managed continually using bilateral maintenance ECT with a frequency of approximately 2–3 weeks, alongside drug therapy. It is estimated that she received up to 400 ECTs over her life course as,

despite ECT being effective in the short-term, maintenance treatment did not appear to prevent relapses given on a 2–3 weekly schedule. We summarise the medical therapy, tried without success over the past 10 years of our patient's life, in [box 1](#) as well as the adverse reactions to ECT that she experienced.

Box 1 Alternative medications trialled and adverse reactions to electroconvulsive therapy (ECT)—summary of the past 10 years of notes

Medications tried:

- ▶ 2002: Trifluoperazine, venlafaxine and dothiepin combination
- ▶ 2005: Flupenthixol 10 mg intramuscular weekly, mirtazapine 30 mg
- ▶ 2007: Olanzapine 2.5 mg, reboxetine 4 mg
- ▶ 2006: Mirtazapine and quetiapine
- ▶ 2009: Reboxetine 4 mg and citalopram 30 mg; amisulpride 50 mg nocte
- ▶ 2010: Quetiapine, reboxetine 4 mg, clonazepam 0.5 mg
- ▶ 2013: Citalopram 20 mg once daily and sodium valproate 200 mg two times a day
- ▶ 2014: Sertraline and sodium valproate changed to sertraline, quetiapine 75 mg

Lithium had been trialled early on in the course of her illness, but she became extremely confused and extremely irritable after 1 day on lithium and could not tolerate it

Adverse reactions to ECT:

- ▶ 2006—Unconscious for 2 h—difficult to rouse
- ▶ 2010—She experienced confusion and complete loss of memory—could not recognise her own son—for 3 days after ECT

OUTCOME AND FOLLOW-UP

At the end of her life, our patient became increasingly frail with several admissions to general hospital medical wards with falls, confusion and vomiting. She was managed in the community with aftercare provided under section 117 of the Mental Health Act, whereby Mental Health and Social Services have a duty to provide aftercare services to patients who have been detained under the Mental Health Act. When in remission, the patient would choose ECT as a preferred treatment and was in agreement to having maintenance ECT from 2006 until 2014 when it was stopped due to her becoming physically frail. At her last best interests meeting, she was determined to be non-capacitous due to being mute, very underweight and having frequent vomiting (this was investigated without any conclusive outcome).

It was the recommendation of the responsible consultant psychiatrist that she was not fit for an anaesthetic, so a decision was made to admit her to a general medical ward that same day where she deteriorated further.

Her son had wondered if in the final few months of her life she had been given ECT one last time the outcome could have been different as she had been more physically unwell in the past and recovered with ECT against the odds on several occasions prior. This illustrates the difficult balance of harms and benefits in giving ECT in an elderly population and the importance of consideration of carers' views in the treatment of recurrent illnesses.

DISCUSSION

ECT is a very powerful intervention used to treat severe psychiatric illness, particularly severe depressive disorder. In psychotic depression, especially in the elderly population, some studies have recorded a remission rate with ECT that is double the rate of remission compared with treatment with tricyclic antidepressant treatment, even when augmented with antipsychotics.¹ ECT also avoids the long-term adverse physical health effects of drug treatment.¹

ECT is the only treatment in psychiatry that is stopped when someone gets better. Despite its high efficacy, a major downside of ECT is the high rate of relapse after treatment² ranging from 50%³ to 80%⁴ relapse within a year.

There are lots of theories on how ECT works, but there are still large gaps in our understanding of its mechanism of action; however, this is also the case with antidepressants.⁵ ECT is sometimes used as a continuation or maintenance treatment in people who have been known to respond to ECT in order to try and prevent further relapses and recurrences of the index illness.⁶

The evidence for using ECT as a maintenance therapy is gradually increasing. Earlier National Institute for Health and Care Excellence (NICE) guidelines (2003) did not recommend ECT as a maintenance therapy, whereas NICE 2009 took a more neutral stance for patients with depression, recommending that it could be used in severe cases such as psychotic depression or life-threatening states.⁶

A 2010 study looking at ECT for prevention of depressive relapse² concluded that ECT could be used as a safe and effective method in relapse prevention. In the same year, O'Connor *et al*⁷ reported a reduction in hospitalisations using maintenance ECT, although it was not possible to prove that this was solely due to ECT, and it is recognised widely that people undergoing ECT have a lot more contact with clinicians and special care given to them that is different from other treatment options.⁶

In 2012, a review of the literature by Rabheru⁸ suggested that for those who have not responded well to medications but have responded to ECT,

maintenance ECT must be presented as an option to the patient and the family for consideration. A recent systematic review has provided more evidence for efficacy of continuation and maintenance ECT therapy; however, the studies included within it were highly prone to bias.⁹ In addition, evidence for the safety and efficacy of ECT in the older population is provided by a case report of a patient who received 172 ECT treatments, up to the age of 89.¹⁰

A similar case has been reported of a 74-year-old patient who received 430 ECT treatments as maintenance therapy over 31 years, from the age of 43, treating psychotic depression.¹¹ No cognitive deficits were found. Another study covered a period of 12 years of ECT.¹² In our case report, we observe that the use of maintenance ECT in later life, every 2–3 weeks, resulted in little or no long-term worsening of cognitive side effects, which is supported by previous evidence from case reports,¹¹ 13 case series,¹⁴ 15 a cohort study¹⁶ and a systematic review.¹⁷ In addition, a case report from 1985 showed that following 1250 ECT treatments, no observable gross or histological evidence of brain damage was found at postmortem.¹⁸

One previous case report suggests that three weekly ECT led to relapse, whereas two weekly ECT prevented relapse.¹⁹

Learning points

- We describe a case report of a woman with a 60-year history of recurrent depression with repeated response to electroconvulsive therapy (ECT) where the benefits of prolonged ECT outweighed the risks. Despite extensive exposure to ECT over the course of her lifespan, there was only minimal cognitive impairment and an excellent safety record even in later life as she became increasingly frail from multiple comorbidities.
- Maintenance ECT appears to be an underused treatment option for treatment-resistant depression.
- Although there is a move to decrease the use of ECT, this case report adds to anecdotal literature supporting maintenance ECT as a safe and beneficial treatment to be offered on a case-by-case basis.
- Perhaps most importantly, this case illustrates the importance of carers' views in decisions about first-line treatment choices in recurrent illness.
- More robust research is needed that looks at different outcomes and the efficacy of maintenance ECT over longer time periods of follow-up.

following 1250 ECT treatments, no observable gross or histological evidence of brain damage was Found at postmorte.¹⁸

One previous case report suggests that three weekly ECT led to relapse, whereas two weekly ECT prevented relapse.¹⁹ In our case report, owing to lack of control, we could not definitively state whether maintenance ECT clearly reduced relapse rates or even rehospitalisation. However, from the family's point of view, they were very satisfied by ECT treatment as they believe that ECT prolonged her life by years and allowed rapid remission of symptoms and improvement in her quality of life where medication repeatedly failed. Further research into the prediction and prevention of depressive relapse after ECT is needed. In addition, more randomised control trials are needed to determine whether continuation or maintenance ECT schedules are better given on a set schedule or more flexibly at varied intervals after the initial series of treatment ECTs.⁹ Also, more emphasis should be given to carers' views in the first-line treatment of recurrent depression.

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Contributors SC, MBS and VC wrote the main draft. KKK and MBS suggested the case and advised on the overview and direction of the report; they also suggested the references and reviewed the manuscript.

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Sarah Carney
Kent and Medway NHS and Social Care Partnership
Trust, Ashford, UK

Musa Basseer Sami
Kent and Medway NHS and Social Care Partnership
Trust, Canterbury, UK

Victoria Clark
Kent and Medway NHS and Social Care Partnership
Trust, Folkestone, UK

Kompancariel Kuruvilla Kuruvilla
Kent and Medway NHS and Social Care Partnership
Trust, Ramsgate, UK

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Kent and Medway
NHS and Social Care Partnership Trust

COMMUNITY ECT AS AN ALTERNATIVE TO HOSPITAL ADMISSION IN YORK

The last few decades of mental health have seen a consistent move from in-patient based care to the community, and with it development of home-based treatment teams as alternatives to hospital admission. The demand for traditionally hospital-based therapeutic interventions has crossed over into the community including electro-convulsive therapy (ECT).

The York Crisis Resolution and Home Treatment Team (CRHTT) covers a population of 291,000 people in York and the more rural surrounds including several sizeable market towns. The team operates 24 hours a day 7 days a week. There is a home-based treatment caseload averaging 25 patients; we can facilitate ECT for these patients in the community working with associated teams: - York has a specialist ECT team who offer twice weekly treatment - ECT currently takes place at the York Hospital in the day surgery unit - this is a short distance from the CRHTT base. The York Teaching Hospitals Trust supply Consultant Anaesthetists. York has two community mental health teams.

In the last few years we have been trying to develop a more robust community ECT pathway as an alternative to hospital admission utilising the home-based treatment model. Community treatment is usually more acceptable to patients and carers and significantly less costly than in-patient admission. As indications for ECT include cases with a high risk of suicide or severe self-neglect, careful risk assessment is essential when considering community-based treatment. Consideration also has to be given to the physical health risks of ECT and how to manage these in the community. ECTAS standards are incorporated into an ECT booklet which facilitates the necessary documentation of medications, physical health, indication, risk vs benefits of treatment, consent, capacity and prescription of treatment. Progress and on-going capacitous consent for treatment is monitored twice weekly with a medical review within 24 hours of each proposed treatment - and objectively monitored by CGI score and periodic cognitive assessment with the MOCA.

The most challenging elements of successful community ECT include the resource demands in terms of staffing; and effective communication and allocation of roles and responsibilities between the many involved teams. The York ECT team request qualified staff accompany out-patients to ECT and back home where they then need to be accompanied by a responsible adult in the next 24 hours.

The approach in York between the teams has been flexible to account for unpredictable staffing and service demands on individual teams week by week. This can lead to confusion regarding leadership, and roles and responsibilities, as each new case arises and preparations for the course of treatment are made. Currently maintenance ECT cases are managed exclusively within the CMHTs. New courses of ECT for current CMHT out-patients are jointly managed by the CMHT and CRHTT with the Care Co-ordinator and Consultant Psychiatrist from the CMHT taking the lead. Where facilitated discharge from an in-patient admission is required, the ECT is jointly managed between the CRHTT and in-patient team.

Improving the clarity of roles and responsibilities and improving the efficiency of shared community ECT is an on-going piece of work in York. In spite of this we have now successfully managed several cases with this approach with good outcomes.

Dr James Sampford
Consultant Liaison Psychiatrist
Tees, Esk, and Wear Valleys

Viki Smith
Advanced Nurse Practitioner
Tees, Esk, and Wear Valleys

**The ECT Team Day and
ECT Prescribers Day will
take place on the 28th
and 29th of November
2019.**

**To book your place
please contact:**
Sarah.Morrissey@rcpsych.ac.uk
Emma.George@rcpsych.ac.uk

NURSES TRAINING COURSES 2020

NALNECT and ECTAS have been working hard behind the scenes to implement more training opportunities at varying levels for nurses working in ECT. We are excited to announce that we now have three levels of training available.

Foundation Course for ECT Clinic staff

This course is aimed at health care professionals who work in ECT clinics including health care assistants, ODP's and recovery staff.

Duration: 2 day course
Day 1: 12th February 2020
Day 2: 25th March 2020
ECTAS Member rate: £120 for two days

Experienced Nurses in ECT Course

This course is aimed at registered nurses with at least 3 year's experience within an ECT clinic setting and nurses would have previously completed the 2 day foundation course.

Duration: 1 day course
Date: 10th June 2020
ECTAS Member rate: £100

Nurse administered ECT course

This course is aimed at Band 6 and above nurses in/or preparing for a Lead Nurse role and preparing for nurse administered ECT. Nurses should have previously attended the 2 day foundation course.

Duration: 1 day course
Date: 24th June 2020
ECTAS Member rate: £100

Please contact ECTAS@rcpsych.ac.uk for further information.

THE ECTAS MINIMUM DATASET COLLECTION

Every year ECTAS runs the minimum dataset collection. Acute data collection runs on a rolling basis and starts on April 1st of every year and carries on through to March 31st the following year. The 2019–2020 dataset is currently open via the following link:

<https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/ectas/minimum-dataset>

ECTAS
ECT ACCREDITATION SERVICE

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ID.end Completion date of interview
Date

ECT Accreditation Service

**Data Set Questionnaire 2019/20
Acute courses of ECT**

Please complete one questionnaire for each patient that **FINISHED** an acute course of ECT between 1 April 2019 and 31 March 2020 (**DO NOT** include patients on continuation/maintenance ECT). This questionnaire should be completed after the end of the course of ECT.

1. Name of Trust

2. ECT Clinic

3. Age of patient

4. Gender of patient Female Male

5. Reason for referral for ECT:

--Click Here--

Severe depression that is life threatening, and where a rapid response is required, or where other treatments have failed
Moderate depression that has not responded to drug treatments and psychological treatment
Catatonia
Prolonged or severe manic episode
Other, please state



All clinics have an allocated username and password to access this link, if you require a reminder please contact ECTAS and ask for the login information to be resent. **You will need to enter one questionnaire for every patient who has finished an acute course of ECT during the data collection period.**

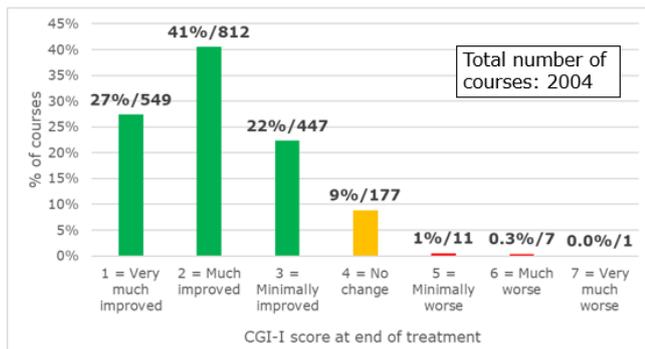
THE ECTAS DATASET 2018/19

In 2018/19, 77 clinics in England, Republic of Ireland, Wales and Northern Ireland (79% of ECTAS members) submitted data. During the data collection period, 2004 courses of ECT were given to 1862 people. 142 people received more than one acute course of treatment. 90% of patients showed improvement after treatment. The full Dataset report for 2018–2019 will be published Winter 2019.

The ECTAS Dataset 2018/19

Acute ECT data collection: 1st April 2018 – 31st March 2019

90% of patients showed improvement after treatment



Gender

1321 (66%) of the people who received an acute course of ECT were female, and 683 (34%) were male. The proportion of females to males has remained fairly constant.

Age

Respondents were asked to give the ages of people who received an acute course of ECT. The mean age was for females was 61.5 and for males was 61.3.

Reasons for referral

Respondents were asked to list the reason for referral. They were presented with a drop down menu with 5 options to choose from. The results are detailed in the table below.

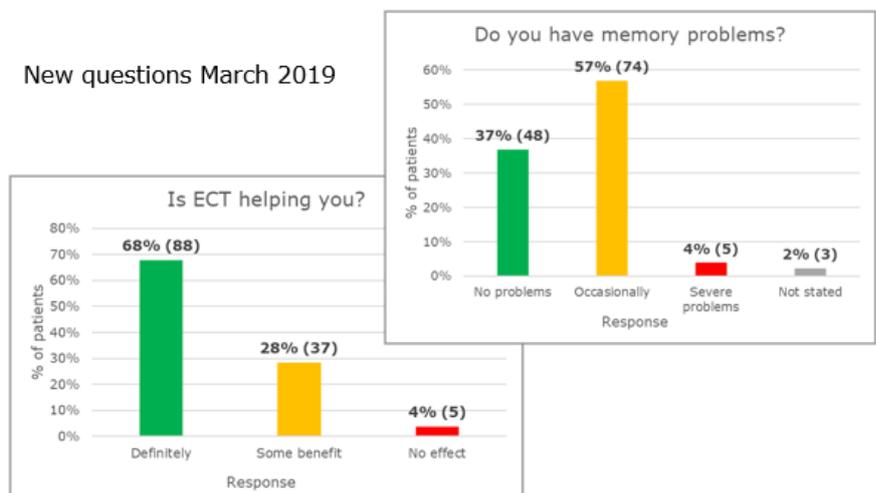
Diagnosis	No of people	% of people
Severe depression	911	45%
Moderate depression	852	43%
Other	121	6%
Catatonia	65	3.2%
Prolonged or severe manic episode	55	2.7%

This year, new questions were added to the maintenance ECT data collection. Clinics asked patients "Is ECT helping you?" and "Do you have memory problems?". 68% of patients said ECT was 'definitely helping them' and only 4% reported that ECT 'had no effect'. When asked about memory problems 57% reported that they did experience this occasionally and 37% reported no problems with their memory.

The ECTAS Dataset 2018/19

Maintenance ECT data collection: March 2019

New questions March 2019



COMMENDATION DOMAINS

ECTAS is introducing commendation domains. There are four areas of practice where a commendation can be awarded:

1. Patient Experience
2. Training
3. Documentation
4. Monitoring & follow-up



If a clinic meets all the standards in a particular domain for commendation, they will be eligible for a commendation award in addition to their accreditation.

For example: To achieve the patient experience commendation:

- A) Patients must have attended the meetings on the peer review visit and
- B) The feedback gathered on the day from patients should match the standards

Join the discussion! Email 'join' to ECTAS@rcpsych.ac.uk

You can pose questions, share ideas and network with other ECT teams across the UK!

CONGRATULATIONS!

Congratulations are due to the following clinics, who have all been accredited since the previous edition of the newsletter (2017):

- Ablett (Denbighshire)
- Addenbrookes (Cambridge)
- Antelope (Southampton)
- Blackburn
- Bluetstone Unit
- Bowmere Hospital
- Bradgate (Leicester)
- Broadmoor (Hampshire)
- Broadoak (Liverpool)
- Bushey Fields (Dudley)
- Callington Road (Bristol)
- Carol Foster (Sidcup)
- Cefn Coed (Swansea)
- Chase Farm
- Downshire (Downpatrick)
- Edith Cavell (Peterborough)
- Elm Mount (Dublin)
- Farnham Road (Surrey)
- Green Lane (Wilshire)
- Hadrian (Newcastle)
- Holywell Clinic (Antrim)
- Julian Clinic (Norwich)
- Knowsley Resource and Recovery Centre, (Prescot)
- Morpeth (Northumberland)
- Needham (York)
- Northwick Park (Harrow)
- Oldham
- Oleaster (Birmingham)
- Omagh Hospital and Primary Care Complex ECT Service
- Prospect Park (Reading)
- Purbeck (St Annes)
- Radbourne (Derby)
- Rivington Unit (Bolton)
- Royal Preston
- Ryedale Suite (Middlesbrough)
- St Charles (London)
- Stepping Hill (Stockport)
- Stonebow (Hereford)
- Sunflowers Court (London)
- Tameside (Lancashire)
- The Redwoods Centre
- Tower Hamlets
- University College Hospital (Galway)
- Wedgwood (Bury St Edmunds)
- Wonford House (Exeter)
- Wotton Lawn (Gloucester)

DATES FOR THE DAIRY!

Date	Event	Venue
04/10/2019	Special Interest Day - Anaesthesia in ECT	RCPsych, London
08-09/11/2019	European Forum for ECT (EFFECT) Meeting	Budapest, Hungary
26/11/2019	Peer Reviewer Training	RCPsych, London
28/11/2019	ECT Team Day	Birmingham Conference & Events Centre
29/11/2019	ECT Prescribers Day	Birmingham Conference & Events Centre
12/02/2020	Foundation Course for ECT Clinic Staff (Day 1)	RCPsych, London
25/03/2020	Foundation Course for ECT Clinic Staff (Day 2)	RCPsych, London
13/05/2020	NALNECT Forum	University of Birmingham
10/06/2020	Experienced Nurses in ECT Course	RCPsych, London
24/06/2020	Nurses administered ECT Course	TBC - will be run in a clinical setting
14/07/2020	Peer Reviewer Training	RCPsych, London

Contact the ECTAS team:

We love hearing from our members and helping to facilitate communication amongst our teams—after all, it's what being part of a network is all about!

If you would like to more information regarding the contents of this newsletter, have any ideas for something you would like to see next time, or would like to contact us about anything else then do get in touch!

Royal College of Psychiatrists Centre for Quality Improvement
21 Prescot Street
London E1 8BB

ECTAS shared mailbox:
ECTAS@rcpsych.ac.uk

Eve Blanchard, Programme Manager
Eve.Blanchard@rcpsych.ac.uk

Vicky Cartwright, Deputy Programme Manager
Vicky.Cartwright@rcpsych.ac.uk

Sinead Rogers, Project Officer
Sinead.Rogers@rcpsych.ac.uk



Website: <https://www.rcpsych.ac.uk/ectas>

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