Response to the Royal College of Psychiatrists' critique of our audit of ECT usage

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We thank the Royal College of Psychiatrists (RCPsych) for their response (Sivasanker et al., 2021) to our audit of Electroconvulsive Therapy (ECT) (Read et al., 2021).

Our audit

In March 2021 we published our second audit of how ECT is administered and monitored. As in our first review (Read et al., 2018), most recipients were women and over 60. Four NHS Trusts had given ECT to a child (under 18). More than a third of patients were given ECT without consent, under the Mental Health Act. As before, most Trusts were unable to report how many patients were offered psychological therapy before being given ECT. Most Trusts were not using standardised measures of depression or cognitive dysfunction. Fewer than one in five had any outcome data during treatments. None had follow-up data. There was a 47-fold difference in usage between the highest and lowest using Trusts.

The RCPsych response

The RCPsych made two substantive points.

Assessing cognitive damage

The RCPsych objected to our stating that 'ECT clinics can gain ECTAS "accreditation" for using the tests that the RCPsych itself has identified as inappropriate.' We cite, again, their own 2013 ECT handbook to corroborate our statement:

> 'The mini-mental state examination (MMSE) is widely used …. but is the wrong test used in the wrong place at the wrong time'. (Waite & Eaton, 2013, p. 81)

The RCPsych defence against our statement was:

> 'The ECTAS standards (ECTAS, 2020) give examples of scales that can be used as guidance for clinics but does not stipulate the cognitive assessment tool'.

This is an example of why ECTAS may not be fit for purpose. They are admitting that ECT clinics can gain ECTAS accreditation regardless of whether the tool it uses to assess for cognitive damage will actually detect cognitive damage. Furthermore, one of the two 'examples' given by ECTAS (2020), is still the MMSE.

Our audit had revealed that, after nearly 20 years of ECTAS' efforts to 'improve the quality of care', only 24% of ECT clinics reported using any standardised tool at all, and 44% of those that did were, in appropriately, using the MMSE.

This is a serious safety matter. Persistent or permanent memory loss is reported by between 12% (Sackeim et al., 2007) and 55% (Rose et al., 2003), with particularly high rates in women and older people. In the U.S.A. the Food and Drug Administration (2021) mandates that there must be a sign next to every ECT machine stating: 'The long-term safety and effectiveness of ECT treatment has not been demonstrated.' Somatics (2018), a manufacturer of ECT machines, includes 'permanent memory loss' and 'permanent brain damage' in its list of risks.

Is ECTAS a monitoring body?

The RCPsych's response to our audit risks creating the impression that their primary agenda, rather than addressing the substantive safety issues identified, is to establish that ECTAS is not a monitoring, or regulatory body.

Our audit did not claim ECTAS is a regulatory body. There *is* no effective regulatory body. The regulatory Care Quality Commission (CQC) acknowledges they 'do not currently identify it [ECT] as an aspect of services that must be checked on inspections, and about which data is routinely collated' (Wyman, 2021). The CQC, however, lists ECTAS as one of the accreditation schemes whose reports they rely on instead of checking (CQC, 2021). So, ECTAS is, albeit indirectly involved in the regulatory process, ineffective as it is..

The RCPsych also argues that ECTAS doesn't 'monitor'. ECTAS is one of the RCPsych's 'Quality Networks. 'The Oxford Dictionary defines the verb 'monitor' as: 'observe and check on quality/progress' or 'keep under systematic review'. The front page of the RCPsych's

ECTAS website says its purpose is ‘to assure and improve the quality of the administration of ECT’ (RCPsych, 2021). One cannot ‘assure’ without some form of monitoring.

We were quite surprised at the RCPsych’s statement that they take no responsibility for monitoring. We have seen many claims (from Trusts, government officials, and ECT advocates) that ECT is ’tightly regulated’ backed up by referring to ECTAS, the RCPsych, CQC or the National Institute for Health and Care Excellence. (NICE). NICE obviously sees the RCPsych’s ECTAS as an important monitoring and quality assurance body. Its draft *Guidelines for Depression in Adults*, released for consultation in November 2021, states that ‘Clinics providing ECT should be ECTAS-accredited, provide ECT services in accordance with ECTAS standards, and submit data on each course of acute and maintenance ECT they deliver as required for the ECTAS minimum dataset’ (NICE, 2021, pp.49-51). In 2019 a woman’s heart stopped during a second seizure on the same day as receiving ECT. At the inquest, a psychiatrist told the jury ‘There are incredibly strict protocols and the Royal College of Psychiatry keeps a very careful watch over places that administer it’ (Garvey, 2020).

The way forward

Our audits (Read et al, 2018, 2021; Harrop et al. 2021) suggest that currently nobody is keeping a ‘very careful watch’ on ECT. Given the obvious conflict of interest in having psychiatry monitor (or accredit) how its members administer this treatment, the nature of the RCPsych’s response to our raising concerns is understandable. But is it helpful in terms of patient safety?

Following a damning review of the use of ECT in Britain 40 years ago, a Lancet Editorial argued:

> Every British psychiatrist should read this report and feel ashamed and worried about the state of British psychiatry. If ECT is ever legislated against or falls into disuse it will not be because it is an ineffective or dangerous treatment; it will be because psychiatrists have failed to supervise and monitor its use adequately. It is not ECT which has brought psychiatry into disrepute. Psychiatry has done just that for ECT. (Lancet, 1981)

In the absence, 40 years on, of effective action from the RCPsych or the CQC, or NICE, or NHS Trusts, we support the campaign for a new, independent, enquiry into the administration of ECT (Johnstone &Cunliffe, 2020). It is backed by many mental health and health organisations, including Mind, Headway (the brain injury association), the Royal College of Nursing, the Association of Clinical Psychologists, and more than 20 cross party MPs including the shadow mental health minister.

We are pleased ECTAS invited one of us (SC) to speak at their annual event in November 2021, and glad that RCPsych ex-president Wendy Burn is liaising with the first author of our audit of ECT information leaflets (Harrop et al., 2021) about amending the RCPsych leaflet. These are promising first steps towards collaboration for greater patient safety. We offer, in Table 1, some suggestions for ECTAS, and the independent review, to consider.

Table 1. Ten examples of accreditation requirements ('Type 1 standard'[1]) that could enhance patient safety

Specified tests that have been demonstrated to be appropriate to assess for all potential cognitive and other damage[2] to be administered after every ECT session

Doctors to document patients' initial seizure threshold, electrical dose (Hertz, pulse width, pulse type, percentage of power electrode placement, medication, etc)
An estimate of the pre-morbid cognition, motor function, auditory/visual processing, neuro vascular health and cardiac function to be established prior to onset of ECT.
Doctors to document the length of time postictal suppression lasts, how long coma activity lasted, and how long muscle relaxants impaired breathing without ventilation
Psychiatrists to be trained by neuropsychologists/neurologists about the effects of electrical field strengths and how to identify brain injury; training of ECT clinic staff to include listening to the stories of injured patients and patients helped by ECT
ECT clinics to use an evidence-based patient information leaflet that neither exaggerates efficacy, nor minimizes adverse effects, and which includes patients' rights, meeting an established standard of accuracy,[3] eg Mind's leaflet
6- and 12-month follow up assessments to be conducted for cognitive and other damage, and rehabilitation and compensation offered for any memory loss/brain damage identified.
Clinics to inform patients, referrers, Trust managers and CQC, whether a clinic is accredited, and if not, why not (e.g. 'first application in process', 'failed' [and why]; OR clinicsnot conforming to all Type 1 standards to be suspended until failures are rectified, or to be closed.[4]
ECTAS clinic reports to be made public, and easily accessible for patients and families
Severe adverse effects, including deaths, to be reported to CQC and Medicines and Healthcare products Regulatory Agency

1 'Type 1: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. . . . To achieve accreditation, a team must meet 100% of type 1 standards' (ECTAS, 2020)

2 in line with those suggested by Robertson and Prior (2006) and Lomas et al. (2021)

3 see Harrop et al. (2021)

4 Only 75% of ECT clinics in England, Wales and Northern Ireland that are ECTAS members currently meet ECTAS accreditation requirements (ECTAS, 2021); and not all clinics are members.

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