

Electro-convulsive Therapy, its Use and Effects.

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April 1998.

*"Salford Community Health Council - promoting
equal opportunities in the local Health Service."*

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Foreword

Electro-convulsive therapy (E.C.T.) is one of the most controversial medical treatment being practised today. Despite this controversy, however, there has been almost no public debate in Salford about E.C.T. and its use. Even various innovative approaches to seeking users', survivors' and carers' views on mental health services had never even elicited any comments or concerns about it.

Unusually for a community health council (C.H.C.), Salford C.H.C. was prompted by this silence to investigate E.C.T. and its use in the Mental Health Services of Salford. As this report testifies, the project was a long and detailed one. The C.H.C. hopes that it has done justice to the subject and more especially to those people who have had E.C.T. or who will be given it in the future.

Salford C.H.C. would like to thank the following people for their help, advice and support during the Project:

- All the users, survivors and carers who gave their time and views on what for some of them is a distressing subject.
- Staff and managers of the Mental Health Services of Salford N.H.S. Trust: Peter Clarke; Steve Colgan; Avril Harding; Les Hardy; Keith Hyde; Gillian Moss; Malcolm Rae.
- Everyone else in Salford who helped with to the Project: Margaret Argyle; Liz Farrell and Jackie Muskett of the Library at Salford and Trafford Health Authority; Pat Garrett, Muriel Mann and the members of Survivors in Salford; Sam Portnoy.
- Everyone else who contributed to the Project, including: the Association of Community Health Councils for England and Wales; Pat Butterfield and E.C.T. Anonymous; Patricia Dawson and the Scottish Association of Health Councils; Alex Doherty; John Foot; Sue Kemsley; Ian Parker and the members of the North West Right to Refuse Electroshock Campaign; Jacky Ward-Panter of North West Mind.

Salford C.H.C. hopes that the report, and the responses to its contents and recommendations, will help to create better and more effective mental health services for the people of Salford and those further afield.

*Chris Dabbs,
Chief Officer. 27 April, 1998.*

1. Introduction.

As part of its Work Plan for 1996/97, Salford Community Health Council (C.H.C.) agreed to undertake a project into the use of electro-convulsive therapy (E.C.T.) in Salford. A project team was established, whose members were:

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Mrs. Margaret Argyle
Ms. Hazel Blears
Dr. Mark Gabbay
Mr. Sam Portnoy
Rev. Ken Stokes

1.1 Aims:

The aims of the Project were:

1. To assess the use of E.C.T. in Salford.

2. To establish survivors' views about the use of E.C.T.

1.2 Objectives:

The objectives of the Project were:

1. To collate information about E.C.T., its use, effectiveness and side effects.
2. To identify criteria and guidelines against which to assess the use of E.C.T.
3. To identify and assess the use of E.C.T. in Salford.
4. To establish the views of survivors in Salford who have had E.C.T.

1.3 Terminology:

The issue of terminology is a sensitive one. Salford C.H.C. recognises that different people use different terms and strongly object to others. In this report, the term "patient" is used to describe those people having or about to have E.C.T., and the term "survivors" for those people who have had E.C.T.

2. Electro-convulsive Therapy and Its Use.

2.1 Electro-Convulsive Therapy.

E.C.T. involves passing an electric current through a person's brain while they are under a general anaesthetic and have been given a muscle relaxant. This produces a convulsion (muscular contractions) modified by the anaesthetic.

There is evidence that seizures were used since the Nineteenth Century to treat schizophrenia (starting in 1834 in Hungary). These seizures were induced via various means such as with insulin and other so-called pharmacological means.

Electro-convulsive therapy (E.C.T.) was first used as a treatment for mental illness in 1938 by Cerletti and Bini (50), and then developed as a mainstream treatment. E.C.T. was used before the development of modern anaesthetics and muscle relaxants. It also predated drug treatments for depression. As such, it has had a significant historical role in influencing the perceptions of people towards mental illness and the potential of different treatments.

In the 1950s and 1960s antipsychotic, antidepressant, and anti-manic drugs were discovered (169). Although E.C.T. was partially replaced by drug treatments with reduced side effects, it continued to be used on a large number of people, the level of which tended to stabilise in the early 1980s.

Internationally, E.C.T. is banned in Italy, while its use is limited in Canada and the Netherlands. E.C.T. is used much less in other European countries than in Great Britain. For example, in West Germany in 1986, E.C.T. was used in 26% of state psychiatric hospitals, 40% of psychiatric departments of general hospitals and in 78% of university hospitals. A total of 500 people had E.C.T. in 1986, (compared with some 22 000 in England) (93). The use of E.C.T. is rare and discouraged by the authorities in Austria, China and Japan.

E.C.T. is perhaps the most controversial treatment currently used by the medical profession. While some survivors report it as helpful or life-saving to them, others find it much less helpful, and many view it as a damaging and threatening tool of psychiatric oppression. Especially controversial are:

- what conditions it is used to treat
- who is given E.C.T.
- its administration
- training of clinical staff
- variations in use and practice
- precisely how it works
- its effectiveness
- its risks and side-effects

- consent to treatment

2.2 What conditions is E.C.T. used to treat?

E.C.T. is principally used to treat depressive disorders, but is also used for mania, schizophrenia and various neuropsychiatric conditions. It has, however, been pointed out that many patients given E.C.T. have more than one diagnosis (125). One national survey of survivors found that E.C.T. had also been used for post-natal depression, anxiety, hypomania, post-traumatic stress disorder and puerperal psychosis (163).

2.2.1 E.C.T. and depressive disorders.

Although there are considerable variations between psychiatrists, E.C.T. is usually used as a treatment for depression when:

- other treatments (such as antidepressants) have not worked; or
- a patient is considered unable to tolerate or reliably take antidepressant medication; or
- E.C.T. is believed to be the safer option (for example, due to the side effects of antidepressants); and/or
- a rapid result is required when a person is very severely ill (for example, if they are acutely and actively suicidal, extremely distressed and/or refusing to eat and drink).

It is, however, notable, that many people who get E.C.T. remain on some form of medication as well.

In one survey of old-age psychiatrists, depressive psychosis was identified as the condition for which E.C.T. was felt most often to be useful (10).

2.2.2 E.C.T. and mania.

E.C.T. is also used to treat a number of people with mania. It should not, however, be used as a first-line treatment for mania unless the illness is genuinely life-threatening (79), as drugs such as haloperidol, phenothiazine and lithium are the mainstay of treatment for manic illness.

2.2.3 E.C.T. and schizophrenia.

It is argued that E.C.T. can be effective in schizophrenia, but mainly for those people with the positive symptoms of type 1 (acute) schizophrenia, and not for those with type 2 (chronic) schizophrenia unless there is co-existing depression (76). It is, however, important to note the arguments attacking the whole concept of schizophrenia as a concept developed by psychiatrists (156).

2.2.4 E.C.T. and neuropsychiatric conditions.

E.C.T. is still regarded as being useful as a specific treatment for some neuropsychiatric conditions, including catatonic schizophrenia (although this is now rarely diagnosed). E.C.T. has also been used to treat schizophrenia where neuroleptics are contraindicated due to neuroleptic malignant syndrome, and to treat neuroleptic malignant syndrome itself. (61)

E.C.T. is not in general use for Parkinson's Disease. E.C.T. is not normally used to control epilepsy and related disorders, as drug treatments are now considered more appropriate. Likewise, it should not be used to treat violent or offending behaviour; diabetes or obsessive-compulsive disorders (61).

2.3 Who is given E.C.T.?

About 22 000 people are given E.C.T. in England each year (93).

2.3.1 E.C.T. and gender.

By far the majority of people who are given E.C.T. are women, especially older women. One study in Sheffield found that twice as many women as men were given E.C.T. (100), reflecting consistent findings elsewhere.

One national survey of survivors found that women who had E.C.T. were much more likely to be diagnosed with depression (62.2%) than men (47.7%). By contrast, men (34.6%) were more than twice as likely to be diagnosed with schizophrenia (163). This raises a question about the causes of these figures, including whether they are a result of social circumstances, stereotyping and/or other factors.

2.3.2 E.C.T. and age.

One study in 1980 (125) considered 2 594 courses of E.C.T. in detail. Patients' ages could be broken down thus:

Age	Number*
16-19	35
20-29	247
30-39	335
40-49	365
50-59	571
60-69	522
70-79	357
80+	75
Total	2,507

* Note: the age of a few patients was not recorded (125).

This work suggests an average age for E.C.T. patients somewhere in their fifties. This is supported by a study which found patients were aged from 19 to 83 years, with a mean of 53.6 years (132). The apparent variation in average ages may be due to the comparative rates of use of E.C.T. by adult and old-age psychiatrists.

2.3.3 E.C.T. and people under 18 years old.

E.C.T. is very rarely the first line of treatment for children and young people under 18 years, although the Royal College of Psychiatrists "can envisage situations where this might be so" (Freeman (ed.), 1995: 18). Organisations such as Mind continue to campaign for a ban on E.C.T. for young people under 18, as is the case for young people under 16 years in Colorado in the United States. There is very little good research on the effects of E.C.T. when used on children and young people.

There is no evidence that E.C.T. is used on children aged 12 years or younger and there are no clear indications for this (61). In the ten years to 1992, at least 60 young people (aged 12-17 years) were given E.C.T. (60), with over 60% of these being aged 16-18, although the methodology for this has been questioned, not least that it is based on a survey of child and adolescent psychiatrists, when most young people who are given E.C.T. are those under adult psychiatrists.

2.3.4 E.C.T. and older people.

A significant proportion of people who get E.C.T. are over 65 years old. One study in Sheffield found that the average age of E.C.T. patients was 68 years (ranging from 20 to 92) (100). The Royal College of Psychiatrists states that "treatment is not contraindicated by age alone" (Freeman (ed.), 1995: 17). Older women are the group most likely to get E.C.T.

2.3.6 E.C.T. and ethnicity.

There are no national statistics on the ethnicity of people who are given E.C.T. This information is neither required nor collected by the Department of Health.

2.3.6 E.C.T. and pregnancy.

One review of 300 case reports concludes that E.C.T. is "a relatively safe and effective treatment during pregnancy if steps are taken to decrease potential risks", although it found a small number of significant complications (including miscarriages, stillbirth, and congenital abnormalities) and milder problems (including benign fetal arrhythmias, mild vaginal bleeding, abdominal pain, and self-limited uterine contractions) which may or may not have been a result of the E.C.T. (109).

Later work suggests that complications reported for pregnant patients who had E.C.T. during pregnancy have not been conclusively associated with the treatment 95. Likewise, however, very little is known of the risks of antidepressant medications for a foetus.

The E.C.T. Handbook states that E.C.T. can be given to pregnant women (61). It states that:

- E.C.T. may be prescribed with confidence for pregnant patients in the second and third trimesters of pregnancy:
 - (a) where patients display symptom patterns strongly indicative of a good response to E.C.T.;
 - (b) when rapid control of symptoms is required;
 - (c) where there is an increased risk of toxicity to both mother and foetus when effective dosages of psychotropic drugs are used as an alternative.

- Little is known about the effects of E.C.T. in the first trimester of pregnancy.
- There is no evidence of a need for routine sophisticated monitoring of maternal and foetal status.
- It is advisable to discuss the case with the patient's obstetrician when a psychiatric decision is taken to administer E.C.T. to a pregnant patient.
- High-risk pregnancies are not an absolute contraindication to E.C.T., provided that the patient is jointly managed by a psychiatrist and an obstetrician, and that facilities exist for careful monitoring of maternal and foetal status. (Freeman (ed.), 1995: 22).

2.4 Administration of E.C.T.

2.4.1 Description.

In its patient fact sheet on E.C.T., the Royal College of Psychiatrists describes what should happen when a patient has E.C.T., for which they should fast for at least six hours beforehand:

"For the treatment you should wear loose clothes, or night clothes. You will be asked to remove any jewellery, hair slides or false teeth if you have them.

The treatment takes place in a separate room and only takes a few minutes. Other patients will not be able to see you having it. The anaesthetist will ask you to hold out your hand so you can be given an anaesthetic injection. It will make you go to sleep and cause your muscles to relax completely. You will be given some oxygen to breathe as you go off to sleep. Once you are fast asleep, a small electric current is passed across your head and this causes a mild fit in the brain. There is little movement of your body because of the relaxant injection that the anaesthetist gives. When you wake up, you will be back in the waiting area. Once you are wide awake, you will be offered a cup of tea." (Royal College of Psychiatrists, 1995b: 2).

This description does not mention the following:

- the injections for general anaesthetic and the muscle relaxant are given separately
- the anaesthetist gives the person oxygen with a face mask and a pressure bag;
- the use of padded electrodes - bilateral E.C.T. (on the temples) or unilateral E.C.T. (on the same side of the head);
- a gag will be placed in the person's mouth to prevent them biting their tongue.

Some also question the use of the terms "small current" and "mild fit" in this description, arguing that the seizures and other effects are much more substantial than this.

2.4.2 Good practice and guidelines.

E.C.T. should be given according to the good practice guidelines set out by the Royal College of Psychiatrists. The wide variation in its rates of use does raise the question of how consistently and rigorously standard criteria are used. To accompany The E.C.T. Handbook (61), the Royal College of Psychiatrists produced within it Checklists for Good Practice in E.C.T. (139). This document gives guidance to psychiatrists on the following (with more detail on each included in The E.C.T. Handbook):

Resources and equipment.

Preparation for E.C.T.

Prescription of E.C.T.

Administration of the anaesthetic

E.C.T. stimulus parameters and seizures

Monitoring seizure activity

Restimulation policy

Recovery

Continuity of care

Monitoring clinical response.

The Mental Health Act Commission stated in 1997 that it was "considering ways in which to ensure that [the E.C.T.] Handbook's recommendations are adopted." (Mental Health Act Commission, 1997: 105). The Commissioners have a responsibility to ensure that treatment given to patients detained under the Mental Health Act meets their standards. This involves reviewing issues about informed consent, the provision of second opinions, and the facilities and staff where the treatment is provided.

Some psychiatrists argue that E.C.T. should be reserved as a treatment of last resort. Others, however, argue that it is not necessary for all other methods to be exhausted before its use, especially for conditions such as pregnancy, acute and severe suicidality, or an inability to tolerate antidepressant medications (127).

2.4.3 Dosage.

The dosage of electric current should be enough to induce a fit, with the amount of electrical energy used being an important variable (26). If the dose is too low, a fit does not occur. The amount needed to do this is about twice as high for men than women, and increases with age. The Royal College of Psychiatrists states that "the seizure threshold may be relatively high in some elderly patients and these patients may require a relatively high stimulus charge" (Freeman (ed.), 1995: 17). If the dose is too low, there will be little or no effect. The higher the dose above the threshold, the greater the risk of negative side-effects. It should be noted that muscle relaxants sedate the brain, thus increasing the seizure threshold. The Royal College produces detailed guidance on "stimulus dosing" in its E.C.T. Handbook (61).

2.4.4 Frequency and number of treatments.

E.C.T. is usually given to a person two or three times a week. It should not be given on a daily basis (61). One study concluded that E.C.T. twice a week is as effective as E.C.T. three times per week and has less severe cognitive effects (96), although the higher number is still used in many places. The number of treatments varies between patients, usually ranging between two and 12 treatments. Most people respond to a course of between four and eight treatments. Older people and men may need more than this. The Mental Health Act Code of Practice states that the proposed maximum number of applications of E.C.T. should be recorded on form 38 which is completed if the patient consents (36).

2.4.5 Anaesthesia.

Despite detailed guidance on anaesthesia for E.C.T. from the Royal College of Psychiatrists (61), there is strong evidence to indicate that the anaesthetic standards of care and facilities for patients getting E.C.T. are substantially inferior to those of other patients and commonly fall short of accepted national guidelines (such as those set by the Association of Anaesthetists of Great Britain and Ireland, the Royal College of Anaesthetists and the Working Group on Mental Illness of the Clinical Resource and Audit Group of the Department of Health at The Scottish Office 26) (94). As the Registrar of the Royal College of Psychiatrists wrote: "Surgical procedures which are carried out under general anaesthetic are undertaken to exacting quality standards, and the College believes that the same should apply to E.C.T." (Thompson, 1997).

Questions have been raised about the level of anaesthesia given to E.C.T. patients. It has been suggested that patients who receive E.C.T. in the United Kingdom commonly receive 50-60% more anaesthesia than patients in the United States (39).

In addition, calls have been made to investigate the approach to patients who smoke. Patients undergoing anaesthesia are routinely discouraged from smoking. Many anaesthetists will not deal with patients who will not or cannot resist their habit. Yet there is anecdotal evidence that E.C.T. patients will be allowed to smoke before treatment in order to calm them down.

2.4.6 E.C.T. and nursing.

The role of nurses in the administration of E.C.T. has, until recently, been given relatively little consideration. Following an appendix in the Royal College of Psychiatrists' E.C.T. Handbook (61), the Royal College of Nursing's E.C.T. - Guidance for Nurses attempts to redress this imbalance, taking the view that "High quality provision of nursing care does a great deal towards improving the experience of the treatment for the patient" (Royal College of Nursing, 1997: 4). It recommends:

- the primary concern must always be the well-being of the patient and not an individual nurse's feelings regarding the treatment
- all aspects of nursing care surrounding the treatment should be carefully planned
- nurses who do not feel competent or adequately skilled to escort patients throughout the treatment should not take on this role until training has been provided
- a named E.C.T. manager with responsibility for the overall management of the physical environment, the E.C.T. facility

and the maintenance of equipment, working with the consultant with lead responsibility for the treatment service

- nurses who escort patients should be registered nurses familiar with the patient, should remain with them at all times and be responsible for the monitoring of vital signs, post-treatment confusion and disorientation during the recovery phase (documented on a post-E.C.T. check list)
- only qualified nurses familiar with the E.C.T. machine and procedure, and under the verbal directions of the treating psychiatrist, should carry out the process of pressing the treatment button on the machine (where this exists) to trigger the stimulus and test function. (137).

There is also additional guidance available on the role of the "ward nurse" and the "E.C.T. nurse" (26).

2.4.7 Post-treatment care and observation.

There are concerns about the post-treatment care and observation of people who have had E.C.T. E.C.T. can affect the short-term memory of many patients who may, therefore, forget warnings about not being alone, going home alone or drinking alcohol.

Although the length of stay of outpatients receiving E.C.T. may vary according to the local anaesthetic policy, the most recent guidance concurs on its recommendations in many respects:

- each outpatient should have a friend or relative with whom to go home, both in case there are unforeseen effects from the anaesthetic and also because of the risk of suicide (133).
- "outpatients . . . should not be allowed to return home until they have fully recovered from the 'hangover' effects of the general anaesthetic. Ideally, outpatients should be accompanied home by a friend or relative and in no circumstances should they be allowed to drive themselves home in a motor vehicle." (Freeman (ed.), 1995: 119).
- "Furthermore, they should be advised to avoid alcohol . . . Where an outpatient arrives unaccompanied, it is the responsibility of the clinical nurse manager to ensure that the patient is not allowed to leave until fully recovered" (Freeman (ed.), 1995: 116).
- "outpatients should not drive themselves home, or return home unescorted, and certainly not before they are fully recovered from the effect of the anaesthetic. This may be up to four hours after treatment. For hospitals spread over a wide geographical area, those patients being treated from outside the immediate hospital should be treated as outpatients." (Royal College of Nursing, 1997: 3).
- "It is recommended that outpatients have a relative or friend who can accompany them and who can stay with them following treatment for a period of at least 18 hours." (Clinical Resource and Audit Group, 1997a: 23).

Particular care is required when providing E.C.T. to outpatients and the available guidance should be carefully followed (26).

This caution should also be applied to inpatients, many of whom are not detained under the Mental Health Act, but who still require supervision after they have had E.C.T. due to the possible effects of the treatment on their memory and of the general anaesthetic. The risks for inpatients might be seen in some ways as being at least as great as for outpatients, especially where they may be more ill and/or not detained under the Mental Health Act. Post-E.C.T. supportive observation is an area little considered to date.

2.4.8 E.C.T. and drugs.

Only a little research has been undertaken to identify the interactions between E.C.T. and different drugs, their safety and the outcomes they produce for patients (61) (86). The Royal College of Psychiatrists' E.C.T. Handbook concludes that:

- The majority of patients receiving E.C.T. will be taking concomitant medication.
- Psychotropic and anaesthetic drugs have a significant effect on both seizure threshold and seizure duration during electro-convulsive therapy.
- Drugs which reduce the duration of seizure by increasing the seizure threshold may be associated with treatment failure.
- Alternatively, a larger number of E.C.T. treatments may have to be administered to achieve the desired therapeutic effect. This situation should be avoided as it increases the risk to the patient receiving E.C.T.
- Despite the obvious importance of this area, few clinical studies have been undertaken. Most of the research has been done in animals, and particularly rats.
- Although this work has highlighted some important areas for further research, such studies should be treated with caution.

- The effects of psychotropic and anaesthetic drugs on the efficacy and safety of E.C.T. are neglected areas of research. There is an urgent need to undertake clinical research; this has the best chance of being successful if a collaborative approach is adopted between psychiatrists and anaesthetists." (Freeman (ed.), 1995: 55).

One study highlighted two cases in which older women, both with heart disease, taking tricyclic antidepressants and on longer than usual courses of E.C.T. died from heart attacks during their course of treatment. This raises "the question of whether in such 'at risk' patients E.C.T. and tricyclics should be given together." (Freeman and Kendell, 1980: 16).

2.5 Training of Clinical Staff.

It is clearly recommended that there should be a named consultant responsible for the supervision of the E.C.T. service and for ensuring that it meets the standards required by the Royal College of Psychiatrists. This includes: developing local protocols and procedures; (continuous) audit; supervision of the training of junior staff; and liaison with anaesthetic colleagues. (26).

The traditional British system is to delegate responsibility for administering E.C.T. to junior doctors on rotation. "This means that as many as 10 different doctors may be on the E.C.T. roster at any one time, that there will be a high turnover of doctors as they move on rotation to other hospitals and that a high proportion of administering doctors will be on their first or second job." (Duffett and Lelliott, 1997: 564). The situation in England and Wales contrasts with that in the United States, where the American Psychiatric Association requires that doctors are specifically accredited before they are allowed to give E.C.T.

There are concerns about the standards of training and practice in the administration of E.C.T. One survey of 115 doctors below consultant level showed that there is no consistent method of training in E.C.T. Some who used E.C.T. had not even been taught how to do so. Many had no guidelines and consultant supervision was rare. (75)

A survey of junior doctors in 53 E.C.T. clinics across East Anglia, North-East Thames and Wales (undertaken as part of the Royal College's third audit of E.C.T. in 1996) highlighted that "the training in E.C.T. appeared to be of variable quality and one-half [of the respondents] had not been supervised by an experienced psychiatrist on the first occasion they administered E.C.T. Responses to exam-type questions revealed that 45% lacked knowledge about one or more basic issues related to effective administration of E.C.T." (Duffett and Lelliott, 1997: 563). The majority of doctors on E.C.T. rosters would have been in their first year of specialist psychiatry training. The authors found that "the junior doctors in the only two clinics which were genuinely consultant-led had significantly greater knowledge (these clinics were also the only two judged exemplary on the overall rating). Unfortunately, these clinics were the exception." (Duffett and Lelliott, 1997: 564).

The need for significant developments in the area of training (specific to administration) is illustrated by an example from the Queen Elizabeth II Hospital of the East Hertfordshire N.H.S. Trust for a visit by a second opinion appointed doctor in February 1996. In order to fulfil the requirements of the Mental Health Act, the doctor signed a Form 39 using a hospital secretary as a person "professionally concerned" with the patient's treatment. A locum consultant subsequently questioned the validity of the form, which was withdrawn by the Mental Health Act Commission and a further S.O.A.D. visit arranged (105).

This area of major deficiency has only just begun to be addressed. For example, in 1997, the Mental Health Act Commission reported that it had held seminars for second opinion appointed doctors in Nottingham, Bristol and Chester on The E.C.T. Handbook of the Royal College of Psychiatrists (105).

In response to continued public criticism of E.C.T., the Royal College of Psychiatrists took a greater interest in training and established a Special Committee on E.C.T. to establish practice guidelines. The weight it gave to training may be reflected in the length of the chapter on training and supervision in its E.C.T. Handbook: half a page (61).

The Royal College's Special Committee on E.C.T. also produced an "Official Video Teaching Pack", with by a teaching manual, which addresses specific deficiencies previously reported in the administration of E.C.T. in Britain. It pays particular attention to training junior doctors and criticises the traditional method of junior doctors teaching each other. The video has, however, been criticised for being "potentially misleading" with some concepts "presented in a limited way that is more likely to confuse than clarify." 80 To use the video, it is argued that a person would need considerable clinical experience and supplementary reading.

A role of the Royal College is "to inspect the facilities available for the administration of E.C.T. and ask searching questions about the training of the junior doctors administering the treatment in the course of its three to four yearly cycle of inspection of psychiatric training programmes around the country. If serious shortcomings are detected, as they are from time to time, the College informs both the Trust and the Postgraduate Dean concerned that it will withdraw educational approval from the Trust in question if the requisite changes are not introduced." (Kendell, 1997).

The apparent frustration of the Royal College was illustrated in the explicit warning that "Failure to provide E.C.T. in accordance with [the College's] guidelines may result in withdrawal of approved training status of the provider unit concerned" (Thompson, 1997). The psychiatric profession has begun to recognise that E.C.T. may become legislated against because of its misuse.

The authors of 1996 survey for the Royal College of Psychiatrists commented that their audit "demonstrates that, despite the College's recent initiatives to improve practice and 17 years of audit, E.C.T. is still often being delivered by inadequately trained personnel." They conclude that, unless the traditional British system of delegating responsibility of E.C.T. administration is

changed, "it will remain difficult to assure the quality of training and supervision in E.C.T. or to introduce a comprehensive national accreditation scheme, similar to that of the [American Psychiatric Association]." (Duffett and Lelliott, 1997: 564).

This move towards accreditation in England and Wales was strengthened by the ten-minute rule bill introduced into the House of Commons on 3 December, 1997, by John Gunnell, M.P. for Morley and Rothwell, which sought to ensure that E.C.T. is administered only by specially accredited doctors using up-to-date machines in clinics with statutory approval (Hansard, 3 December, 1997: 393; Electro-Convulsive Therapy (Restrictions on Use) Bill, 1997).

There are at present no training or competency standards for nurses practising in E.C.T. clinics, a situation that should be remedied at the earliest opportunity (26).

2.6 Variations in use and practice.

Over 100,000 E.C.T. treatments per year are given nationally, although it should be noted that, when the Department of Health collected statistics on the use of E.C.T. until 1991, some hospitals did not report all treatments (124). There are wide variations in its use between regions, hospitals and psychiatrists. Rates of use vary from 126 treatments per 100,000 people in Oxford to 420 per 100,000 in South Glamorgan (30). There are even greater differences between hospitals. There are also wide variations in the use of E.C.T. between individual psychiatrists. A study in one region showed that 15% of consultants were responsible for 40% of the treatments given (67).

A 1981 report sponsored by the Royal College of Psychiatrists showed wide variations in E.C.T. techniques, indications and practice. The report concluded that one third of the units examined failed to deliver adequate care (125). The Editor of The Lancet castigated the British psychiatric profession: "Every British psychiatrist should read this report and feel ashamed and worried about the state of British psychiatry. If E.C.T. 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 failed to supervise and monitor its use adequately. It is not E.C.T. which has brought psychiatry into disrepute. Psychiatry has done just that for E.C.T." (Anon, 1981: 1208).

Apparently little attention was paid to the recommendations of the 1981 report (125), although there was encouragement for improvements in E.C.T. machines (123). An audit of E.C.T. in two N.H.S. regions of England found, however, some improvement in practice (124).

Despite some improvements in practice since the 1991 audit, a third audit undertaken for the Royal College of Psychiatrists of the administration of E.C.T. in 53 clinics in East Anglia, North-East Thames and Wales rated only 16 as good or exemplary, 26 as deficient in some areas of practice and 11 as poor. In summary, the audit produced these results:

- Supervision and training: although all services now have a named consultant psychiatrist responsible for the E.C.T. clinic and training, there is still room for improvement. It was apparent that members who had attended the College's E.C.T. training courses were providing services to a higher standard.
- E.C.T. equipment: there has been a considerable improvement since the audit in 1991 and the majority of E.C.T. machines have now been replaced with more technically advanced equipment.
- Anaesthetic practice: as compared to 1991, there was an improvement in anaesthetic practice.
- E.C.T. clinic rooms: compared with 1991, some clinics had been relocated to better facilities and none were found to be substantially worse." (141).

2.7 How Does E.C.T. Work?

There are a range of theories about how E.C.T. works. There is, however, little or no evidence or agreement in this area. The following examples illustrate that the process remains unknown or unclear:

- repeated seizures alter chemical messages in the brain (61);
- it possibly affects neurotransmitters in complicated and so far unexplained ways (25);
- it works "because the abnormality of brain function responsible for endogenous depression is unknown, it must be obvious from the outset that a direct answer to the question 'how does E.C.T. work?' is not possible at the present time" (Grahame-Smith, 1988);
- it works by changing brain chemistry, "but comparing this favourably with the current generation of pharmacologically specific drugs would be similar to the assumption that a broken television could be mended as readily with a sledgehammer as with a screwdriver: you might jog the right bit" (Green, 1992);
- "post-traumatic euphoria" similar to the effects that follow head and brain injuries, such as amnesia, denial, euphoria, apathy, mood swings, helplessness and submissiveness (17);

- through brain damage indicated by impaired mental function and changes in brain waves (56) (113).

These differing theories suggest that research has so far failed to identify the processes caused by E.C.T. and that any explanations are, at best, educated guesses.

2.8 Effectiveness of E.C.T.

2.8.1 Clinical Research.

Many clinical research projects undertaken by doctors conclude that E.C.T. is effective for the treatment of depressive illness. It is, however, important to note that studies tend to measure outcomes in terms of symptom reduction rather than quality of life and social functioning (114).

The Royal College of Psychiatrists states that "E.C.T. may be the treatment of choice for depressive illness" (Freeman (ed.), 1995: 17). It has been stated that E.C.T. can be used as an alternative to neuroleptic drugs (antipsychotic drugs) (61). Some state that patients who have had E.C.T. rather than medications experience greater clinical improvement and are also more likely to be alive at follow-up over the following one to ten years (122), although others suggest higher longer-term mortality and readmission after E.C.T. (116).

One study found that "both bilateral and unilateral E.C.T. are highly effective treatments for depression and are significantly superior to simulated E.C.T. There was also evidence that patients receiving bilateral E.C.T. recovered more rapidly than those receiving unilateral E.C.T. and required significantly fewer treatments." (Gregory et al., 1985: 520). Another study concluded that, for inpatients thoroughly treated with medication trials, the response to E.C.T. may only be as high as 50%, whereas for those where the response rate may be as high as 90% (130).

One early clinical trial compared the effectiveness of E.C.T., Imipramine, Phenelzine (a monoamine oxidase inhibitor) and a placebo on 250 patients aged 40-69 with depressive illness. This found that on a short-term (four weeks) and long-term (six months) basis, both E.C.T. and Imipramine "increased the frequency of recovery over and above the spontaneous rate shown by patients on the placebo". E.C.T. was reported as specially effective in men and the drug in women. The report concluded that "Imipramine showed a slower action than E.C.T., but its use certainly reduced the total number of patients for whom E.C.T. was finally regarded as necessary." (Clinical Psychiatry Committee, Medical Research Council, 1965: 886).

Several clinical trials have compared real and simulated E.C.T. One study compared one group of patients with depressive psychosis who received six brief pulse unilateral shocks under conventional anaesthesia and muscle relaxation with another group who underwent the same procedure without receiving shocks. The results of this led to the conclusion that the E.C.T. pre-treatment procedure has an important therapeutic effect, and cast doubt on the predominant view of the medical profession of the effectiveness of E.C.T. in general and of brief pulse unilateral E.C.T. in particular (91).

E.C.T. is not effective and should not be used to treat: violent or offending behaviour; diabetes or obsessive-compulsive disorders (61). It is also considered that "E.C.T. should not be used in the treatment of anxiety and post-traumatic stress disorder unless there is a co-existing depressive illness requiring E.C.T. in its own right" (Hyde, 1997: 2), although it might be said that someone looking for such coexistence is likely to find it.

2.8.2 Duration of Effect.

The natural history of most depressive illnesses is that they improve over time, but the length of time may be considerable. The consequences of a long-debilitating illness on the patient, their relatives and carers and their social situation are considerable. The question is whether they are any less for a person if they have E.C.T.

A wide variety of research appears to support the view that the therapeutic effects of E.C.T. are rapid and only short-term. Comparative trials found that those people getting real E.C.T. showed a swifter improvement in their symptoms than those who got simulated E.C.T. One study concluded that "the therapeutic effects of electrically induced convulsions in depression were of lesser magnitude and were more transient than has sometimes been claimed." (Johnstone et al., 1980: 1317). Researchers have concluded that:

comparative trials between real and simulated E.C.T. showed significant difference between the two groups after two weeks, less after four weeks, and none at three or six months. (13) (71) (84);

"E.C.T. does not influence long-term survival. These findings combined with a close examination of the literature do not support the commonly held belief that E.C.T. exerts long-range protective effects against suicide." (Milstein et al, 1986);

two trials found that patients with schizophrenia who had E.C.T. improved significantly better than those who did not both after six treatments and at the end of treatment 157 and in the first eight weeks 1, but there was little or no difference from 12-16 weeks or at six months 1;

patients with manic states who had E.C.T. "improved more during the first eight weeks than did patients who

were treated with lithium carbonate [but] clinical ratings after eight weeks showed no significant differences." (Small et al., 1988: 727);

later research on the long-term prognosis of depressed patients found that "index E.C.T. treatment predicted high longer-term mortality and readmission risks" (O'Leary and Lee, 1996: 423).

Many psychiatrists view E.C.T. as "a short-term solution for long-term problems" with no proven value (31). Even the Royal College of Psychiatrists recognises that E.C.T. may relieve only the symptoms of depression, while (dubiously) claiming that depression may produce domestic or work problems (rather than be caused by them). It argues that the survivor "will be able to deal with these other problems more effectively" if symptoms are relieved. (Royal College of Psychiatrists, 1995b: 3). There is, however, no evidence for this, as no research has ever been undertaken on it.

The conclusion that E.C.T. has only a short-term beneficial effect is supported by the 1995 national survey of survivors. Many said that it had given temporary relief from distress, but that this returned fairly soon afterwards. They felt that E.C.T. offered no "cure" (163).

There is a high relapse rate in the first four months after E.C.T. A follow-up of older survivors after E.C.T. found that a quarter were readmitted to hospital within six months and about 70% relapsed during the course of the 14-month study period (101). "Continuation" or "maintenance" E.C.T. is often recommended in such cases. This means that E.C.T. is given over many months, mainly to obtain short-term, rapid improvement rather than long-term relapse free survival. This might be seen as being based on the assumption that someone who has depression will have recurring episodes. It is, however, an area that is under-researched, with no reliable randomised control trials having been undertaken, although it is argued that it is safe and effective, especially for patients who relapse very quickly after a course of E.C.T. and where other treatments are ineffective (26). Nevertheless, the Royal College of Psychiatrists states that "continuation" E.C.T. should be considered when:

- (1)the index episode of illness responded well to E.C.T.;
- (2)there is early relapse despite adequate continuation drug treatment, or an inability to tolerate continuation drug treatment;
- (3)the patient's attitude and circumstances are conducive to safe administration." (Freeman (ed.), 1995: 71).

2.8.3 E.C.T. and Suicide.

E.C.T. is often justified because of the more rapid change that it can create. It is argued by some that it avoids the risk of suicide or starvation (with a danger of kidney failure) that exists if severe depression runs its course.

E.C.T. can sometimes prevent death when a person is severely depressed and in a critical state through no longer eating or drinking. There is, however, little or no evidence that E.C.T. prevents suicide. In its Biennial Report for 1991-93, the Mental Health Act Commission reports that "the most frequent single indication for [E.C.T.] is that the patient is refusing to eat or drink as a result of their depressive illness. The reports of the appointed doctor frequently indicate that in their view the treatment in these circumstances is 'life-saving'" (Mental Health Act Commission, 1993: 39). The Commission notes, however, that it has no means to systematically collect data on the outcome of treatment.

One paper often cited as supporting the view that E.C.T. does prevent suicide actually concludes that: "In the present study, treatment was not shown to affect the suicide rate" (7). Later, these same authors demonstrated that patients who were treated with E.C.T. made significantly fewer suicide attempts over a 6-month follow-up period than did patients who did not receive E.C.T. (7.) Likewise, a later study found that "Patients who committed suicide were more apt to have received E.C.T. than those who died from other causes, but this difference was not significant . . . E.C.T. does not influence long-term survival. These findings combined with a close examination of the literature do not support the commonly held belief that E.C.T. exerts long-range protective effects against suicide." (Milstein et al, 1986).

2.8.4 Survivors' Views.

There has been relatively little work done on establishing survivors' views of E.C.T. It seems clear, however, that there is a polarisation of views among people who have had E.C.T. about how helpful it has been for them.

One study to seek the views of survivors involved a series of interviews with 166 people who had E.C.T. in the 1970s. It should, however, be noted that this was done by psychiatrists in a psychiatric hospital. The authors got the impression that those with strong views expressed them, but that it was less certain whether others were more distressed by E.C.T. than they were prepared to say. They concluded that most survivors "did not find the treatment unduly upsetting or frightening, nor was it a painful or unpleasant experience. Most felt it helped them and hardly any felt it had made them worse." (Freeman and Kendall, 1980: 16). Many complained, however, about permanent memory loss, especially around the time of treatment.

A national survey of survivors in 1995 found that 13.6% described their experience as "very helpful", 16.5% "helpful", 13.6% said it had made "no difference", 16.5% "not helpful" and 35.1% "damaging". 60.9% of women and 46.4% of men described E.C.T. as "damaging or "not helpful" (163). This may be linked to the fact that women were less likely to receive an explanation of the treatment and more likely to be treated compulsorily.

The survey also concluded that survivors who had had E.C.T. voluntarily found it less damaging and more helpful than those receiving it compulsorily. 62% of those threatened with E.C.T. found it "damaging", while this was true for 27.3% of those for whom E.C.T. was not used as a threat. Only 3.6% of those threatened with E.C.T. said it was "very helpful" compared to 17.7% of those who had not been threatened.

Of the women who did not consent, 50% described their treatment as "damaging" and only 8.6% as 'very helpful'. By contrast, of those women who consented, 33.7% found it "damaging" and 16.5% 'very helpful'. There was an even greater contrast amongst men. While 20% of the total who had had E.C.T. described it as "very helpful", this figure was only 2.3% for those treated compulsorily. 21.2% of the men who had E.C.T. voluntarily described it as "damaging", but this figure rose to 51.2% for those treated against their will. (163)

Likewise, whether an explanation is given before E.C.T. appears to affect survivors' perception of the treatment's effectiveness. 30.4% of those who got an explanation described E.C.T. as "very helpful" compared to only 8.5% of those who did not. Those getting an explanation were also less likely to describe E.C.T. as "damaging": 11.6% compared to 44.8% who did not get an explanation. (163)

Diagnosis also appears to affect survivors' views on E.C.T. In the survey, half of those diagnosed as having manic depression, 35.2% diagnosed with schizophrenia and 24.6% diagnosed with depression described their experience of E.C.T. as "damaging". (163)

One major study found that 43% of survivors said E.C.T. had been helpful, and 37% unhelpful (134). This contrasts with the view of the Royal College of Psychiatrists that "over 8 out of 10 of depressed patients who receive E.C.T. respond well" (Royal College of Psychiatrists, 1995b: 3).

2.8.5 Who does E.C.T. work for?

There are no symptoms or clinical features proven as criteria to decide who will benefit from E.C.T. The E.C.T. Handbook states, however, that:

- The best predictor of a good response to E.C.T. is the number of the typical features of depressive illness
- E.C.T. may be particularly effective in depressive illness with psychotic features.
- Depressed patients who have not responded to antidepressant drug treatment may recover if treated subsequently by E.C.T.
- Continuation antidepressant drug treatment is essential after successful E.C.T." (Freeman (ed.), 1995: 4).

It is also stated that "two particular symptoms, retardation and depressive delusions, respond well to E.C.T. and there is good evidence that patients with depressive delusions are more likely to fail to respond to antidepressant drugs." (Clinical Resource and Audit Group, 1997a: 3).

Various studies have been undertaken to look at predicting the outcome of E.C.T. for different patients. It is significant that the most recent work indicates that psychotic features and psychomotor disturbance (rather than the severity of depression) are best correlated with a good response for E.C.T. (76) (122).

A review of two randomised control trials found that "patients who were neither retarded nor deluded did not benefit significantly from real as opposed to simulated E.C.T." (Buchan et al., 1992: 355). Likewise, another study found that using any of the categories of "retarded/non retarded", "agitated/not agitated" or "psychotic/non-psychotic" did not predict a good response to E.C.T. (148).

A third clinical trial concluded that patients with manic states who underwent E.C.T. "improved more during the first eight weeks than did patients who were treated with lithium carbonate [but] clinical ratings after eight weeks showed no significant differences between the lithium carbonate- and E.C.T.-treated patients. Likewise, the two groups had comparable rates of relapse, recurrence, and rehospitalisation during the follow-up period." (Small et al., 1988: 727). The Royal College of Psychiatrists' E.C.T. Handbook states that:

- E.C.T. may in occasional circumstances be the treatment of choice for severely manic patients.
- E.C.T. may be a safe alternative to high-dose neuroleptics, with the advantage of a faster therapeutic response.
- E.C.T. should be considered in less disturbed manic patients with slow or inadequate response to medication.
- The clinical state of the patient may mean that E.C.T. has to be delivered on the ward rather than in an E.C.T. suite." (Freeman (ed.), 1995: 6).

Similarly, in assessing the effect of E.C.T. on people with schizophrenia, two different trials found that patients receiving E.C.T.

improved significantly better than those who did not for about eight weeks, but there was little or no difference after that (1) (157). "[T]he superiority of real E.C.T. was not confirmed at the end of six months" (Abraham and Kulhara, 1987: 152).

The Royal College of Psychiatrists' E.C.T. Handbook states that:

- E.C.T. is not recommended for Type II schizophrenic patients; the exception is when marked depressive symptoms arise in the context of a Type II syndrome.
- The practical usefulness of E.C.T. in Type I schizophrenic patients is limited to patients:
 - (a) who are unable to tolerate a dose of a neuroleptic equivalent to 500 mg. chlorpromazine daily;
 - (b) who are responding poorly to a dose of neuroleptic equivalent to 500 mg. chlorpromazine daily;
 - (c) where the maximum rate of symptomatic response is required;
 - (d) specific subgroups [acute catatonic states; schizoaffective states; acute drug-induced schizophreniform disorders; acute paranoid syndromes; patients with neuroleptic malignant syndrome].
- E.C.T. may reduce antisocial behaviour which occurs as a response to underlying Type I psychotic symptoms when antipsychotic medication alone fails to alleviate psychotic symptoms." (Freeman (ed.), 1995: 9).

One study concluded that E.C.T. is safe and effective for the treatment of affective and catatonic disorders in patients with multiple illnesses (Rohland et al., 1993). Another severely qualifies this by stating it is effective "if the specific medical risks are carefully evaluated in each case, and appropriate modifications of technique are used to reduce the risk of potential complications." (Zwil and Pelchat, 1994).

The Royal College of Psychiatrists' E.C.T. Handbook states that:

- E.C.T. is an effective form of treatment in catatonic states, and may be life-saving in cases of lethal catatonia.
- E.C.T. may have a potentially life-saving role in the treatment of cases where the differential diagnosis of [neuroleptic malignant syndrome] and [lethal catatonia] is unclear." (Freeman (ed.), 1995: 11).

One study concluded that E.C.T. not only helps the depression often associated with Parkinson's Disease but it also helps the movement disorder as well. This only looked, however, at seven patients all of whom manifested delirium as a consequence of the E.C.T., and one of whom experienced no improvement in either the depression or the Parkinson's symptoms (55). The Royal College of Psychiatrists' E.C.T. Handbook states that:

- E.C.T. has a short-term anti-Parkinsonian effect.
- The place of maintenance E.C.T. in Parkinson's Disease has not been established." (Freeman (ed.), 1995: 12).

E.C.T. is not normally used to control epilepsy and related disorders, as drug treatments are now considered more appropriate. The Royal College of Psychiatrists' E.C.T. Handbook states that:

- E.C.T. is very effective at terminating the acute mental state disturbances associated with spontaneous seizures which appear to have a direct relationship to the underlying seizure disorder, e.g. fugue, twilight, and post-ictal confusional states. One or a small number of E.C.T. treatments may suffice.
- E.C.T. is effective in the treatment of other more chronic mental state disturbances which are encountered in epileptic patients, e.g., schizophreniform and affective psychoses. Spontaneous epilepsy is neither a contraindication nor a specific reason for using E.C.T. to treat a coexistent mental state disorder in an epileptic patient.
- E.C.T. is a powerful anticonvulsant treatment, but the anticonvulsant effect is dependent on ongoing E.C.T. applications. Given the efficacy of contemporary anti-epileptic drugs, E.C.T. is only likely to be considered as a viable anti-convulsant treatment option in desperate cases where conventional drug treatment has failed." (Freeman (ed.), 1995: 15-16).

2.8.6 E.C.T. and Alternatives.

The national survey of survivors by the United Kingdom Advocacy Network (163) concluded that most psychiatrists effectively see the prescription of drugs as the only alternative to E.C.T. Of the respondents, 76.3% had been prescribed drugs, only 15.2% received counselling or psychotherapy, and 17.8% were offered no other treatment at all. These latter figures were even lower for people under 30. Many respondents felt that "talking treatments" should have been made available to them as their illnesses had an emotional, psychological or spiritual dimension. They felt that little or no consideration was given to why they were feeling so depressed. (163)

One study confirmed that many depressive illnesses may be improved, even without physical treatments, by using intensive nursing and medical care (84). The evidence cited above suggests that, in the medium- and long-terms, E.C.T. is no more (and maybe even less) effective than other treatments. It appears to address only short-term symptoms and not the underlying causes of a patient's condition.

Complementary to this is the view of many who oppose E.C.T. who argue that it does not allow more natural ways of combatting depression, such as:

- grieving
- building up self-confidence
- developing coping skills
- finding more positive patterns of thought and behaviour
- discovering ways out of oppressive situations
- being listened to (30).

It is argued that this approach "does not address the issue of mental illness and depression as a biological process. It does not explore the complex inter-relationship between genetic, biological, psychological and sociological processes that must be considered when planning treatment with a particular person. The list tends to confuse depression with grief and responses to stress." (Hyde, 1997: 5).

This raises the contrast - and conflict - between medical and non-medical models of depression, its causes and treatment. There is perhaps a good case for a more holistic model that accounts for all the facets of an individual.

Mind argues that the relative effectiveness of different treatments needs more research, especially when access to psychological services and "talking treatments", which aim to understand and empower people, remains limited. This situation is particularly underlined by the fact that, although older people (especially women) are at a high risk of depression and receive more E.C.T. than younger people, few counselling and psychology services target them, even though there is a body of knowledge and expertise for it.

2.9 Risks and Side Effects of E.C.T.

2.9.1 Effects of E.C.T.

E.C.T. is recognised to cause a range of effects in patients. These include:

cardiovascular effects (such as bradycardia; hypotension; tachycardia; hypertension; dysrhythmias; myocardial oxygen consumption);

cerebral effects (such as cerebral oxygen consumption, cerebral blood flow and intracranial pressure);

increased intraocular pressure; and

increased intragastric pressure.

Parasympathetic stimulation occurs almost immediately.

2.9.2 Contraindications for E.C.T.

In considering giving E.C.T. to patients who are physically ill, the Royal College of Psychiatrists recommends in its E.C.T. Handbook that:

- all coexisting medical conditions should be assessed and, where possible, treated before E.C.T.;
- the balance between risks and benefits must always be weighed;
- as far as possible, patients and their families should be involved in discussions about the treatment, its risks and benefits;
- E.C.T. is not a treatment in itself for [stroke, dementing illnesses or cardiovascular disease]." (Freeman (ed.), 1995: 28).

The contraindications for E.C.T. are quite controversial in the literature. It is also notable that psychiatrists' views about absolute

or partial contraindications diverge significantly (10). Doctors should gauge each patient on an individual basis and decide on the relative merit of E.C.T. against the risks to them. For some psychiatrists, absolute contraindications are:

- recent myocardial infarction;
- recent cerebrovascular accident; and
- intracranial mass or lesion.

The Royal College of Psychiatrists' Committee on E.C.T. considered, however, that there are no absolute contraindications to E.C.T. (61), but that it is desirable to wait three months following a myocardial infarction or cerebrovascular accident unless the benefits of E.C.T. are likely to outweigh the risks. It is also considered that E.C.T. can be considered in the presence of intracranial mass or lesion under some circumstances and with precautions (79).

Relative contraindications (those for which particular caution must be taken before a decision is taken to use E.C.T.) are:

- angina pectoris; congestive heart failure;
- severe pulmonary disease; severe osteoporosis;
- major bone fractures; glaucoma;
- retinal detachment; thrombophlebitis;
- pregnancy.

E.C.T. presents much higher risks for a person with heart disease due to both the use of anaesthetic and the application of an electric current to cause a seizure. Risks are, however, also posed to these patients by the use of antidepressants (172).

Through a survey of old-age psychiatrists, it was found, however, that not one of 15 conditions was considered never inappropriate for E.C.T. treatment (10).

2.9.3 Side Effects of E.C.T.

The immediate side effects of E.C.T. commonly include:

- amnesia
- drowsiness
- confusion
- disorientation
- apathy
- physical weakness
- headaches
- nausea
- dizziness.

For older people, there is a particular risk of heart problems, falls and strokes (31). The Royal College of Psychiatrists specifically states that "special precautions may be needed to guard against memory impairment or confusion (for example, longer gaps between each treatment)" (Freeman (ed.), 1995: 17).

Other side effects reported by survivors include: weight loss; weight gain; lack of concentration; loss of confidence, dignity and self-esteem; fear of hospitals and psychiatry; anger and aggression; psychological trauma; loss of self and soul; anxiety; body spasms; brain damage; nightmares and speech difficulties (163). Damage to the teeth, tongue, eyes and cutaneous structures (including burns where the electrodes have been located) are not unheard of.

"It is hoped that the new generation of modern E.C.T. machines will be less likely to cause problems with memory and cognitive function as the dose of E.C.T. given can be more accurately tailored to the needs of the individual. Brief-pulse E.C.T. is less likely to cause cognitive impairment than the old-fashioned sinusoidal wave treatment." (Hyde, 1997: 3). It will be important to monitor whether less patients complain of long-term memory impairment as newer E.C.T. machines are brought into use, although unclear who will undertake this task as it has rarely if ever been done in the past.

2.9.4 Memory Loss.

The Royal College of Psychiatrists states that "E.C.T. does not have any long-term effects on your memory or your intelligence." (Royal College of Psychiatrists, 1995b: 4). Its E.C.T. Handbook says, in contrast, that "some patients may, however, be left with discreet memory gaps for specific autobiographical events, the explanation for which is unclear." (Freeman (ed.), 1995).

Memory loss is the most commonly reported side effect of E.C.T. It lasts at least a few weeks. Some survivors have, however, reported memory loss many years after E.C.T. Research has shown that this is different from poor memory caused by depression itself (2). One study found 60-70% of survivors had memory complaints six to nine months after bilateral E.C.T. (153). Another found that 55% of survivors felt that they had not regained their normal memory function three years after E.C.T. The researchers' conclusion was that there existed some actual permanent memory gap as a result of E.C.T., even for those denying such an effect (152). A further study found that, unlike a control group, every survivor who had had E.C.T. showed a number of instances of amnesia which persisted over time (82). Even official figures, where they are kept, find memory loss as the most often reported complication. For example, in California between 1989 and 1994, 19.7% of all patients reported memory loss lasting longer than three months. This constituted 93.6% of all reported complications.

Through interviews in a separate project, 30 per cent of survivors felt that their memory had been permanently affected (64), a report supported by further research of survivors who complained about enduring unwanted effects of E.C.T. which found that they did have areas of impaired cognitive function, not all of which could be explained by other variables such as the levels of depression and medication (65). The two explanations given for this were either that E.C.T. does cause some lasting impairment of memory in a proportion of survivors, or that the self-selected group interviewed had worse memories than average and mistakenly attributed this to their past treatment. A third possibility - that those survivors who achieved average scores on the memory tests may have had better than average memories before E.C.T. and that they too may have been damaged by the treatment - was not considered.

The risk of memory impairment also varies according to the technique used to give E.C.T. (2) (89). It appears that bilateral E.C.T. causes more severe memory loss than unilateral E.C.T., at least in the short term (167), although some argue that the latter causes more severe damage to the part of the brain next to which the electrodes are placed (85). The Royal College of Psychiatrists' E.C.T. Handbook recommends that:

- unilateral E.C.T. should be used where: speed of response is less important; there has been a previous good response to unilateral E.C.T.; and minimising memory impairment is particularly important;
- bilateral E.C.T. should be used where: speed and completeness of response have priority; unilateral E.C.T. has failed; previous bilateral E.C.T. has produced a good response without undue short-term memory impairment; and determining cerebral dominance is difficult (61).

It has been found, however, that most clinics never use unilateral E.C.T., some occasionally, and only a small number on a frequent basis (124).

Likewise, sine wave E.C.T. appears to cause more damage than brief-pulse E.C.T. A Department of Health working group in the 1980s concluded that the use of sine wave equipment appeared to arise only from convenience and could not be recommended. Nevertheless, a decade later, six out of 35 clinics in East Anglia were still using sine wave machines, and also bilateral electrode placement (124).

At the present time, there are no indicators based on solid research that can predict even reasonably accurately who will experience longer-term memory loss after E.C.T.

2.9.5 Emotional and Psychological Effects of E.C.T.

The emotional and psychological impact of E.C.T. is often underestimated or ignored. It is perhaps easier for clinical staff to recall those patients who have asked or benefited from E.C.T. than those who experienced it as an assault or a nightmare.

For those survivors who do feel damaged by E.C.T., the effects can be devastating. While some survivors report the beneficial effects of E.C.T. for them, others have commented on E.C.T.: "like dying, every time", "the nightmare of E.C.T.", "the fear of having it will remain with me for the rest of my life." (Cobb, 1994: 3). Some survivors find that the loss of power that E.C.T. represents, with its invasive nature, can underline their feelings of guilt and worthlessness. It can even reinforce their resolve for suicide.

The Royal College of Nursing's E.C.T. - Guidance for Nurses (137) addresses the importance of "psychological preparation for treatment". It recognises that "E.C.T. understandably induces anxiety in a great number of those receiving the treatment. In addition some may find the experience of short-term memory loss after treatment disturbing." The Guidance identifies a range of measures that can be taken to reduce anxiety associated with E.C.T. and also the levels of memory impairment experienced after treatment:

"Management of Anxiety.

- Ensuring that the patient is fully informed and that concerns surrounding the treatment are addressed and questions answered.
- The use of anxiety management techniques.
- Ensuring as short a wait as possible in the treatment waiting room.
- The escorting nurse to be known to the patient, preferably the patient's named nurse.

- Offering reassurance and support.

Management of Cognitive Side-Effects of E.C.T.

The factors affecting memory loss are well understood: these are:

- Time.
- The nature of the event.
- The mental set at the time of perception.
- The mental set at the time of assessment.

Information which is more likely to be retained is:

- That which the client consciously attempts to retain.
- That which is familiar.
- That which is emotionally important.
- That which is not experienced or relayed too close to the time of treatment.

Care plans for the psychological effects of the treatment could include methods such as:

- A system of prompts to aid recall, either managed jointly between the named nurse and the patients, or by the patient alone.
- Encouraging the patient to consciously retain information that is important to them.
- Keeping events on the day of treatment to as regular a routine as is possible.
- Making relatives or significant others aware of the psychological effects and if possible involving them in the management of these.
- Whenever possible not relaying important information too close to the time of treatment.

It is important that the named nurse feeds back to the medical team patient responses to the treatment. In this way, adjustments in the administration of the treatment, such as the use of unilateral E.C.T. can be considered where individual are experiencing marked side effects. " (Royal College of Nursing, 1997: 2-3).

2.9.6 E.C.T. and Brain Damage.

Some researchers have argued that the process of E.C.T. causes structural damage to the brain (16) (56) (85). Other studies, using computerised axial tomography (C.A.T.) and magnetic resonance imaging (M.R.I.) scanning, post mortem data and animal electroshock studies (E.C.S.) conclude that E.C.T. does not cause changes to a person's brain structure (37).

2.9.7 Anaesthesia.

E.C.T. must be given with a general anaesthetic. There are thus the slight but not negligible risks of illness and even death associated with anaesthesia. This should be put in the context of the repetition of E.C.T. for most people 2-3 times a week.

2.9.8 E.C.T. and Death.

E.C.T. is not part of the remit of the National Confidential Enquiry into Perioperative Deaths, leaving little or no reliable evidence about what the relationship is between E.C.T. and death. Most existing clinical reports only relate deaths to E.C.T. where they occur very soon afterwards. Deaths are under-reported or are not linked to the administration of E.C.T. (16)

According to the Royal College of Psychiatrists, death within 24 hours of E.C.T. occurs in about one in 50 000 treatments, and is usually related to cardiovascular or pulmonary problems (E.C.T. is associated with hypertension and tachycardia)(140). (It should be noted, however, that this figure is given no source - although it appears to originate in California, which contrast with more comprehensive figures from Texas - and refers to deaths only in the College's E.C.T. Handbook (61). By contrast, others estimate the risk of death as 4.5 deaths per 100 000 treatments 112. Older people are at a higher risk than younger ones.

2.10 Consent to Treatment.

2.10.1 Rules and Guidance.

As the Royal College of Nursing's E.C.T. Guidance for Nurses underlines, there is a "need for a culture of openness, trust and maximum availability of information in which patients can arrive at fully informed decisions." (Royal College of Nursing, 1997: 4).

As with other invasive treatments, consent must be given for E.C.T. for all patients. This does not, however, necessarily mean the consent of the patient themselves: E.C.T. is give to a large number of people every year without their consent under sections 58 and 62 of the Mental Health Act 1983. The doctor should explain to the person what the treatment involves, why it is proposed for

them, and advise on any significant risks and alternatives. The patient must understand the nature, purpose and consequences of treatment and thus be aware of what they are consenting to for consent to be valid. The explanation should be given in language the person can understand (especially important for deaf people and people from black and minority ethnic communities), and supported by sufficient written information. Most patients can withhold or withdraw their consent if they wish, even before the first treatment has been given.

Coercion should never be used to persuade patients to have E.C.T. Consent should never be obtained under the threat of 'consent or be sectioned'. A refusal by a patient to have E.C.T. should not be used to jeopardise their right to alternative treatments. Initial consent should not be taken to mean agreement to a 'course' of E.C.T., as it can be withdrawn at any time, and so its continuation should be verified before each individual treatment (26).

The provision of written information does not alter the need for the implications of the treatment to be explained adequately to the patient before asking them to sign a consent form. Patients who need to want further information should be given it before being asked to give their consent. It is also important to discuss the treatment after it has been given in case memory loss has affected the patient's recollection. This may be especially important for outpatients receiving E.C.T., for whom there are model information sheets in addition to that provided for all E.C.T. patients (26) (61).

Consent for E.C.T. for patients under 16 years and adults with a learning disability requires particular care. This is a particularly complex legal area which calls for specialist advice. Some brief (but insufficient) guidance is available (61).

There is, however, a distinction to be made between voluntary patients and those detained under the Mental Health Act. The following applies directly only to detained patients.

Some guidance on information is contained in chapter 14 of the Mental Health Act Code of Practice. For consent to treatment, the Code states in section 14.13:

"Consent to treatment . The patient must be informed, in terms which he is likely to understand, of the nature, purpose and likely effects of the treatment proposed. (See Chapters 15 and 16). Patients must be advised of their rights to withdraw consent to treatment at any time before its completion and of the need for them to give fresh consent to treatment thereafter. If relevant a detained patient should be told how his refusal or withdrawal of consent can be over-ridden by the second opinion process operated by the Mental Health Act Commission and, where treatment has begun, of the doctor's power to continue it on an urgent basis if the discontinuance would cause serious suffering to the patient. (These explanations should be the responsibility of medical and nursing staff)." (Department of Health and Welsh Office, 1993: 51).

For consent and E.C.T., two specific sections of the Mental Health Act apply:

(a) Treatment requiring the patient's consent or a second opinion (section 58) -

the administration of medicine beyond three months and treatment by E.C.T. at any time. These safeguards apply to all patients liable to be detained except those detained under sections 4, 5(2), 5(4), 35, 135, 136 and 37(4), and also those conditionally discharged under sections 42(2), 73 and 74. All these patients can only be treated under common law.

(b) Urgent treatment (section 62) - in certain circumstances, the provisions of

sections 57 and 58 do not apply where urgent treatment is required. Any such decision is the responsibility of the patient's responsible medical officer (R.M.O.).

Under section 58 of the Act, the Code of Practice states that:

"16.9 When E.C.T. is proposed, valid consent should always be sought by the patient's R.M.O.:

(a) if the patient consents the R.M.O. or the Second Opinion Appointed Doctor (S.O.A.D.) should complete form 38 and include on the form the proposed maximum number of applications of E.C.T. Such information should be included in the patient's treatment plan;

(b) if the patient's valid consent is not forthcoming, the R.M.O. (in the event that he wishes to proceed with the treatment) must comply with the requirements of section 58, which should be initiated as soon as possible.

16.10 Whenever practicable, staff should give a patient treated by E.C.T. a

leaflet which helps him to understand and remember, both during and after the course of E.C.T., the advice given about its nature, purpose and likely effects. This may help to ensure that a valid consent is in force." (Department of Health and Welsh Office, 1993: 62).

Where a S.O.A.D. is sought from the Mental Health Act Commission via the Mental Health Act administrators, they should visit the patient and judge whether, "having regard to the likelihood of its alleviating or preventing a deterioration of [the patient's] condition, the treatment should be given. This must be done after consultation with the R.M.O. and two others professionally concerned with the patient's care - one a nurse and the other neither a doctor nor a nurse.

Viscount Colville of Culrose (the first Chairman of the Mental Health Act Commission) outlined the role of the S.O.A.D. In the House of Lords, he said "I should say [the appointed doctor does not provide] a second opinion in the recognised technical or medical sense because we do not wish the doctor who comes to advise to substitute his own opinion for that of the consultant who is directly responsible, but merely to say whether or not he thinks that in the condition the patient is in the line of medication proposed and the plan of treatment are as a whole in accordance with good practice." Thus, unlike the common use of the term "second opinion", which is about a doctor concluding what they would do in the particular circumstances of a case, the second opinion required of a S.O.A.D. is whether the R.M.O.'s treatment proposal falls within the mainstream of psychiatric practice. The term can therefore be very misleading, and can raise the question of how much of a safeguard the S.O.A.D. system is for patients.

Having seen the patient, consulted with staff, and reached a judgement, the S.O.A.D. should complete a Form 39 if they agree to the treatment proceeding. On this, they must state the maximum number of treatments a patient can receive and also to state a time period within which it should be given. The Mental Health Act Commission suggests that it is good practice to regard the certificate of authorisation from a S.O.A.D. as lapsed where there has been a break of more than three weeks in a course of E.C.T. treatment. In these circumstances, the Commission suggested that a further second opinion is sought if the patient is not able to give valid consent under the terms of Section 58 (103).

In England and Wales, between July 1995 and April 1997, just over one-third of all referrals for a second opinion under the Mental Health Act 1983 were for E.C.T., with a small proportion for treatment plans involving both medication and E.C.T. There were significant variations, according to the gender and ethnicity of patients, in the types and frequency of treatments for which referrals were made. Men and women were referred in roughly equal numbers, but men more often for medication and women more often for E.C.T. (105).

2.10.2 Information and Explanations.

Mind suggests to people or their relatives to ask the doctor the following questions if E.C.T. is recommended:

What is the reason for suggesting E.C.T.?
Are there any long-term effects?
What are the risks associated with E.C.T.? How could E.C.T. help me?
Has every alternative treatment, such as drug treatment or talking treatments such as cognitive therapy been tried?
What treatment will be offered in addition to and after E.C.T.?
Is bilateral or unilateral E.C.T. planned?
How great is the risk of physical deterioration or suicide?
How many treatments will I have? At what dosage? Is this the recommended dosage for someone of my age and sex? (112).

The Royal College of Psychiatrists specifically states that "people who are being asked to consent to E.C.T. should be informed of any likely adverse effects of treatment" (Freeman (ed.), 1995: 70). In one survey, however, only 14% of survivors who had had E.C.T. had been given any information about it, and only 9% could remember being told about any adverse effects (134). In a consultation with older women, Mind found that no woman was told of the risks of E.C.T., while some women were informed and others not about the purpose of treatment, what it involves and the right to refuse (31).

It is especially important to highlight that many patients who are given E.C.T. are very severely ill at that time of treatment. Having a depressive illness can influence a person's perception of events and their ability to think, ask questions and concentrate. One study of survivors' experiences and attitudes towards E.C.T. found that many who had been involved in a previous study and got detailed explanations of E.C.T. claimed that they had never been given one. It was concluded that "it might . . . be beneficial to patients to give them a *second* explanation of the treatment after they have completed the course and are symptomatically improved." (Freeman and Kendall, 1980: 16).

It is unclear how many people are given sufficient information (including about risks, alternatives and rights) to make an informed choice. One study found that less than 25% of those over 65 knew that electrodes were used in E.C.T. or that an electric current was passed through the brain (100). Certainly, only a small minority have direct access to independent advocacy when they might need it. This is particularly so for older people, for whom there is only a very small number of independent advocacy services (such as that run by Brighton and Hove Mind). The value of independent advocacy is beginning to be recognised: "The patient

should be asked if they wish to meet with an advocate and what role they wish an advocate to play." (Clinical Resource and Audit Group, 1997a: 10).

Whether an explanation is given before E.C.T. appears to affect survivors' perception of the treatment's effectiveness. In the 1995 national survey of survivors, 30.4% of those who got an explanation described E.C.T. as "very helpful" compared to only 8.5% of those who did not. Those getting an explanation were also less likely to describe E.C.T. as "damaging": 11.6% compared to 44.8% who did not get an explanation. (163)

2.10.3 Validity of Consent.

The validity of consent may be questionable in many cases. In one study, almost half of the survivors thought that they could not refuse E.C.T. Some 45% of survivors knew that it was possible to refuse but often said that it was futile to do so as they would eventually get it anyway (100). Many survivors report that their experience is an emphasis on gaining their compliance rather than their informed consent 31.

Many respondents to a national survey of survivors said that they were given no choice but to consent to E.C.T. and so in effect their treatment was not strictly voluntary. They said that this was due to:

- fear of being sectioned
- desperation to leave the psychiatric unit
- avoiding drugs
- ignorance of rights
- incapability of challenging staff
- threats of having children put into care
- threats of having E.C.T. compulsorily if not voluntarily (more than a quarter of respondents were threatened with E.C.T. as a means of making them comply. (163)

Issues raised by survivors and their organisations in Scotland around consent have been summarised as follows and elicited a series of recommendations:

"(i)patients who feel they were coerced into having E.C.T. against their wishes;

(ii)patients who feel that insufficient explanation was given to them about the treatment;

(iii)patients who feel that alternative treatments were not fully explained or explored;

(iv)patients who fear that their strong desire not to have E.C.T. would be eroded by their severe depression and they would be unable to refuse E.C.T. if they became depressed again;

(v)patients who fear that they might not be given E.C.T. quickly enough and might not be able to explain this to a doctor who was reluctant to give E.C.T." (Clinical Resource and Audit Group, 1997a: 28).

The importance of the nurse's role in consent is emphasised in the Royal College of Nursing's E.C.T. - Guidance for Nurses (137). This states that:

"Before treatment the doctor should provide the patient with information about the treatment, unwanted side effects and any alternatives.

The importance of the nurse's role in obtaining informed consent should not be underestimated. The patient's named nurse should ideally be present when consent for treatment is obtained. It may also fall upon the nurse to provide further or repeated information in order to maintain informed consent, or alternatively to enable an informed refusal or withdrawal of consent. Clear explanations should be provided for the following:

- The right to withdraw consent at any time.
- Possible side effects of the treatment.
- The process of administering the treatment.
- Fasting prior to treatment.
- Pre- and post-treatment observations."

2.10.4 E.C.T. Without Consent.

Across England and Wales, approximately 2 000 people per year are given E.C.T. without their consent. The number of requests for a second opinion appointed doctor (S.O.A.D.) are reported by the Mental Health Act Commission as:

Period	Number of Requests
1985-87	3,362
1988-89	4,454
1989-91	4,144
1991-3	4,001
1993-95	4,607

These figures do not include people given E.C.T. without consent "in an emergency" under section 62 of the Mental Health Act for detained patients or under the common law for informal patients.

In its patient fact sheet, the Royal College of Psychiatrists states that patients who get E.C.T. without their consent are people who are seriously ill - for example, people who are suicidal, starving themselves, or who believe that they are too wicked to be treated. With the agreement of an independent psychiatrist (after the latter's consultation with the persons' doctor, a nurse and another professional who is not a doctor or a nurse), E.C.T. can be given to patients under the Mental Health Act 1983 if they are considered incapable of giving informed consent (or are capable but refusing consent) and the treatment is seen as necessary by the doctors. There is no information compiled to show whether or not the use of E.C.T. without consent varies between psychiatrists.

The 1995 national survey of survivors concluded that those who had had E.C.T. voluntarily found it less damaging and more helpful than those receiving it compulsorily. 62% of those threatened with E.C.T. found it "damaging", while this was true for 27.3% of those for whom E.C.T. was not used as a threat. Only 3.6% of those threatened with E.C.T. said it was "very helpful" compared to 17.7% of those who had not been threatened. (163)

Of the women who did not consent, 50% described their treatment as "damaging" and only 8.6% as 'very helpful'. By contrast, of those women who consented, 33.7% found it "damaging" and 16.5% 'very helpful'. There was an even greater contrast amongst men. While 20% of the total who had had E.C.T. described it as "very helpful", this figure was only 2.3% for those treated compulsorily. 21.2% of the men who had E.C.T. voluntarily described it as "damaging", but this figure rose to 51.2% for those treated against their will. (163)

This continuing concern about this issue was reflected in a ten-minute rule bill introduced into the House of Commons on 3 December, 1997, by John Gunnell, M.P. for Morley and Rothwell, which sought to ensure that E.C.T. is not administered without a patient's consent unless the patient requires urgent treatment (Hansard, 3 December, 1997: 393).

2.10.5 Variations in consent.

In one national survey of survivors, 71.7% said that they had had no explanation of E.C.T. at all. 29.9% of men and 20.3% of women got an explanation. Of those who got an explanation, 86.3% said that they understood it. (163)

A review of official records showed that of all the people who get E.C.T. without their consent, just over half are women over 50 (about 1 000 women per year), and 36% are women over 65 53. This finding is supported by the 1995 survey of survivors by the United Kingdom Advocacy Network, in which 38.7% of women were given E.C.T. compulsorily compared to 32% of men, regardless of diagnosis (163).

Older people and women are the least aware of their rights. This may be even worse for people in these groups who have a sensory impairment or are from black and minority ethnic communities. In one study, only 27% of people over 65 years knew they could refuse, compared with 71% of those under 65 (100).

There is also a contrast for consent to treatment in terms of diagnoses. The survey of survivors by the United Kingdom Advocacy Network in 1995 found that those diagnosed with schizophrenia were more likely, at 47.3%, to be given E.C.T. compulsorily than those with depression (27%) or manic depression (32.6%) (163).

3. Electro-Convulsive Therapy in Salford.

3.1 Background.

Mental health services in Salford are run by the Mental Health Services of Salford N.H.S. Trust, which runs both local services for Salford people and specialist services for people in North West England and the United Kingdom.

At the time of the project, E.C.T. suites were in use at Meadowbrook / Glendale (the main adult acute unit and acute unit for older people in Salford) and at Prestwich Hospital (the site of several specialist regional and national services).

To establish a basic knowledge of the use of E.C.T. in Salford, the Project Team addressed a range of initial and subsequent questions to the Trust. To support this research, two Project Team members and the C.H.C. Chief Officer made a visit to the E.C.T. Suite at Prestwich Hospital on Friday 22 November, 1996. They met with Mr. Les Hardy (Clinical Support Services Manager at the Mental Health Services of Salford N.H.S. Trust), Dr. Chetty (Consultant Anaesthetist at the Salford Royal Hospitals N.H.S. Trust) and Dr. Rosenberg.

Four members of the Project Team and the C.H.C. Chief Officer subsequently met with Dr. Gillian Moss (Consultant in the Psychiatry of Later Life) and Mr. Hardy on Friday 24 January, 1997, at the Ellesmere Unit, which is located on the site of Hope Hospital (the local teaching general hospital). At the time of the meeting at Ellesmere, the new E.C.T. Suite at Meadowbrook was not completed or in operation.

Two members of the Project Team and the C.H.C. Chief Officer visited the new E.C.T. Suite at Meadowbrook on 27 October, 1997, and were escorted by Ms. Avril Harding (Clinical Manager).

In the discussions, it was noted that the Trust did at one time have an E.C.T. Committee that met regularly, but that this was no longer the case.

3.2 Visits.

Following the discussion on 22 November, 1996, the visiting team were shown around the E.C.T. Suite at Prestwich Hospital. A range of things were noted:

The large, impersonal waiting room contained a number of cupboards, as well as chairs. There were some magazines, and also posters and leaflets about complaints and the C.H.C.

Patients are taken into the E.C.T. Suite one at a time, placed on a trolley and then taken through a curtain into the treatment area, with their head first.

The treatment area includes resuscitation equipment. Patients are given Diprivan anaesthetic and a muscle relaxant. A pulse oximeter is used.

There were several old posters on the wall of the treatment area - "Giving E.C.T. (Royal College of Psychiatrists, June 1985), a list of standard equipment, and a poster on cardio-pulmonary resuscitation.

The windows of the E.C.T. Suite enable people to see out but not in.

From the treatment area, patients are moved into the large recovery room, where they are moved by stages as they recover.

Patients end in a seating area, where tea, coffee and toast are available.

The E.C.T. Suite at Prestwich was brought out of use during 1997 when the new E.C.T. Suite at Meadowbrook was opened. A small visiting team was shown the new facilities on 27 October, 1997. These were located on the ground floor of the unit. A range of things were noted:

Of the patients now given E.C.T. at Meadowbrook, the vast majority were Salford residents, with 80-90% being inpatients.

The overall environment of the facilities was of a higher standard, although no less clinical than previous ones.

The waiting and recovery rooms were one and the same, although less imposing and cluttered than that at Prestwich.

The waiting / recovery room was divided from the treatment and recovery areas by a corridor which was used as a thoroughfare by staff.

The treatment area contained a lot of goods and equipment, although it was reported that shelving had been ordered for this.

New anaesthetic equipment had been obtained and was in use.

An Ectonus Series 5 E.C.T. machine was still in use. A new machine had been identified and ordered which would do brain traces and allow the voltage used to be age-related.

If required, the emergency resuscitation team would be called from the Heart Care Unit at Hope Hospital, adjacent to the unit, from which two doctors would be met at reception. Although full resuscitation facilities were in the E.C.T. Suite, the drugs required were held upstairs in Meadowbrook. There was no clearly available information for staff about the contact for the emergency resuscitation team.

3.3 The Use of E.C.T.

It took the Trust considerable effort to provide basic information about the use of E.C.T. It took several months to locate information about the use of E.C.T. at Meadowbrook / Glendale (previously The Lancastrian Unit) in 1988-1991 and in 1995, and could not give anything other than a crude analysis of the information it did have. This may, in part, have been due to the fact that the Lancastrian Unit remained part of Hope Hospital when the Mental Health Unit was established, thus splitting the organisation of psychiatry in the 1980s, with some based at Hope Hospital and another separate service at Prestwich Hospital.

During the visit to the E.C.T. Suite at Prestwich Hospital on 22 November, 1996, it was noted that recording of E.C.T. patients is kept only in A4 ruled feint books. No information technology is used. This makes it extremely difficult to monitor, audit or report on E.C.T. The Trust information system made it extremely difficult to document E.C.T.

3.3.1 Historical use:

The following figures show the historical use of E.C.T. within the Mental Health Services of Salford. It should be noted that Meadowbrook only came into being in 1991 (Glendale several years later). E.C.T. was previously given at The Lancastrian Unit at Hope Hospital.

Year	Meadowbrook/Glendale/Lancastrian Unit	Prestwich Hospital	Total
1986	609	895	1,504
1987	889	1,212	2,101
1988	511	1,023	1,534
1989	413	962	1,375
1990	287	825	1,112
1991	808	895	1,703
1992	723	646	1,369
1993	532	426	958
1994	395	364	759
1995	361	291	652
1996	78	456	524

There are no clear reasons for the variations over time in E.C.T. use. The Trust, however, reported that "in the past, the figures for E.C.T. were artificially inflated by individuals on the long stay wards being reviewed and diagnosed as having long-standing untreated affective disorders. Many of them required prolonged treatment with E.C.T. to relieve their long-standing illnesses. It was then possible to discharge a number of these patients from hospital. These changes in the number of patients being treated are a response to increasingly active earlier treatment for patients leading to a steady reduction in the number of patients receiving inpatient treatment from Salford. Many patients, particularly in the older age groups, now benefit from prophylaxis with lithium and/or carbamazepine which is closely monitored by a Domiciliary Drug Treatment Clinic. Theoretically this should reduce the relapse rate and consequently the need for E.C.T." (Hyde, 1997: 6).

The Project Team was informed by consultants that in the Trust:

Many fewer patients now get E.C.T. because depression tends to be picked up earlier and more patients can tolerate the new antidepressants. The Elderly Service has expanded over the past 15 years from one consultant to three. This allows a better quality of maintenance of patients.

The declining or more appropriate use of E.C.T. is also due to the better training of psychiatrists. "The present generation of psychiatrists working in Salford have received excellent training compared to the last generation of 'asylum psychiatrists' and may well have a more realistic case load with consequent ability to spend more time with individual patients." (Hyde, 1997: 7).

According to responses to a survey in September 1997 by Psychology Politics Resistance as part of its North West Right to Refuse Electroshock Campaign, the use of E.C.T. within the Mental Health Services of Salford N.H.S. Trust compares with other N.H.S. trusts in Greater Manchester as follows:

Trust	Number of patients per year receiving E.C.T.	Number of patients per year receiving E.C.T. while detained under the Mental Health Act
Mental Health Services of Salford (9/96 - 9/97)	48	14
North Manchester Healthcare (8/96 - 9/97)	56	3
Royal Oldham Hospital and Community Services (1/96 - 12/96)	56	14
South Manchester University Hospitals (Withington Hospital) (no dates given)	58	18
Trafford Healthcare (no dates given)	73	24

Source: *Psychology Politics Resistance - correspondence from N.H.S. trusts.*

3.4 What conditions is E.C.T. used to treat?

The Project Team was informed by consultants that, in the Trust:

E.C.T. is used according to diagnosis, mainly for depression and rarely for conditions such as catatonic schizophrenia. It is used not necessarily always as a last resort, but when depression is very severe or that other treatments have produced negative results in the past for individual patients. In addition, some patients cannot tolerate antidepressants (although this is now less so with new drugs).

Most patients do not get E.C.T. because they respond themselves or with alternative treatments.

3.5 Who is given E.C.T.?

3.5.1 E.C.T. and gender.

The Project Team was informed by consultants in the Trust that the major indication for E.C.T. is depression and that this is more common in women than men. Dr. Moss said that this (together with the fact that women tend to live longer) accounted for the fact that women are more likely to receive E.C.T.

By gender, E.C.T. was given to patients within the Trust as follows:

	1994		1995		1996	
Age Group	Male	Female	Male	Female	Male	Female
Under 65	11	15	11	26	6	17
Over 65	14	37	17	28	8	26
Total	25	52	28	54	14	43
Percentage	32.5	67.5	34.1	65.9	24.6	75.4

On average over the three years, 69.6% of all patients who were given E.C.T. were female and only 30.4% male. This gender difference varied only slightly between the over-65 and under-65 groups.

According to responses to a survey in September 1997 by Psychology Politics Resistance as part of its North West Right to Refuse Electroshock Campaign, the use of E.C.T. by gender within the Mental Health Services of Salford N.H.S. Trust compares with other N.H.S. trusts in Greater Manchester as follows:

Trust	Female	Male
Mental Health Services of Salford (9/96 - 9/97)	67%	33%
North Manchester Healthcare (8/96 - 9/97)	67%	33%
Royal Oldham Hospital and Community Services (1/96 - 12/96)	62.5%	37.5%
South Manchester University Hospitals (Withington Hospital) (no dates given)	60%	40%
Trafford Healthcare (no dates given)	49.3%	50.7%

Source: *Psychology Politics Resistance - correspondence from N.H.S. trusts.*

3.5.2 E.C.T. and age.

The Project Team was informed by consultants that the major indication for E.C.T. is depression and that this develops with age. Dr. Moss said that this accounted for the fact that older people are more likely to receive E.C.T.

The Trust reported that "it would be difficult and inordinately time consuming to break the patients down into age bands as this information is not one of the items that is kept in the E.C.T. recording book. It seems . . . sensible to arrange for this for the future."

By age, E.C.T. was given to patients within the Trust as follows:

	1994		1995		1996	
Age Group	Under 65	Over 65	Under 65	Over 65	Under 65	Over 65
Male	11	14	11	17	6	8
Female	15	37	26	28	17	26
Total	26	51	37	45	23	34
Percentage	33.8	66.2	45.1	54.9	40.4	59.6

On average over the three years, 60.2% of all patients who were given E.C.T. were over 65 years and 39.8% under 65. This age difference varied only slightly between male and female patients.

According to responses to a survey in September 1997 by Psychology Politics Resistance as part of its North West Right to Refuse Electroshock Campaign, the use of E.C.T. by age within the Mental Health Services of Salford N.H.S. Trust compares with other N.H.S. trusts in Greater Manchester as follows:

Trust		Proportion of ECT patients by age
Mental Health Services of Salford (9/96-9/97)	under 16	0%
	16-60	50%
	over 60	50%
North Manchester Healthcare (8/96-9/97)	under 16	0%
	16-60	60%
	over 60	40%
Royal Oldham Hospital (1/96-12/96)	under 16	0%
	16-65	64.3%
	over 65	35.7%
South Manchester University (no dates given)	under 16	0%
	17-64	86%
	over 65	14%
Trafford Healthcare (no dates given)	under 16	0%
	6-60	43.8%
	over 60	56.2%

3.5.3 E.C.T. and people under 18 years old.

There was no evidence or report of E.C.T. being given to a young person under 18 years of age in Salford in the recent past.

3.5.4 Use by home district:

In regard to the home district of patients, assuming that some patients getting E.C.T. in the Mental Health Services of Salford come from outside the City, and that a few Salford people may be getting E.C.T. elsewhere, the figures from the Trust suggest a rate of use of approximately 250 - 280 treatments per 100 000 population. This is in the mid-range for reported rates of use across England and Wales.

During the visit to the E.C.T. Suite at Meadowbrook on 27 October, 1997, it was reported that of the patients then being given E.C.T., the vast majority were Salford residents

3.5.5 E.C.T. and ethnicity.

The Trust replied: "the recording of the use of E.C.T. by ethnicity and home district is again something that is not recorded. It would be possible to back track home districts to each patient by name by looking at their notes, but this would be an extremely time consuming exercise. As you are aware, ethnicity has only been recorded in the N.H.S. since April 1995 and again is something which is not recorded currently for E.C.T. I will arrange for this to be recorded in the future."

Later, however, the Trust reported that "the Afro-Caribbean and Asian population within Salford at present is very small and the ethnic groups who are represented in significant numbers, for example, the large Jewish community in Higher Broughton, are not regarded as ethnic groups at all within the official N.H.S. categories. At present, information collected is appropriate for the tasks of the Trust. Other information is of course available in the patient's notes." (Hyde, 1997: 7).

Reliable information on the ethnicity of the population of Salford is, in fact, limited. Its accuracy is also questionable due to under-reporting, especially among black and minority ethnic communities (for example, the Census form was produced in English only).

The 1991 Census and a later 1993 profile by Salford Community Health Council, Salford Family Health Services Authority and Salford Health Authority 144 reported the ethnic group of the Salford's residents as:

Ethnic Group		1991 Census	1993 Profile
	% of residents	Number (estimate)	Number (estimate)
White	97.8	215,613	225,740
Black Caribbean	0.1	220	50
Black African	0.1	220	110
Black other	0.2	441	-
Indian	0.4	882	1,250
Pakistani	0.3	661	800
Bangladeshi	0.1	220	250
Chinese	0.3	661	750
Other Asian	0.1	220	-
Other	0.5	1,102	1,050
Total	100	220,463	230,000

Table 3: Salford population by ethnicity (117,144)

Clearly, these figures do not reflect "white minorities", such as people of Irish, Jewish and East European descent. They make up a significant proportion of the total population.

According to responses to a survey in September 1997 by Psychology Politics Resistance as part of its North West Right to Refuse Electroshock Campaign, the use of E.C.T. by ethnicity within the Mental Health Services of Salford N.H.S. Trust compares with other N.H.S. trusts in Greater Manchester as follows:

Trust	% of ECT patients White	% of ECT patients Ethnic Minority
Mental Health Services of Salford (9/96 - 9/97)	97.9%	2.1%
North Manchester Healthcare (8/96 - 9/97)	91.0%	9.0%
Royal Oldham Hospital and Community Services (1/96 - 12/96)	94.6%	5.4%
South Manchester University Hospitals (Withington Hospital) (no dates given)	95.0%	5.0%
Trafford Healthcare (no dates given)	98.6%	1.4%

Source: Psychology Politics Resistance - correspondence from N.H.S. trusts.

3.6 Administration of E.C.T.

3.6.1 Good practice and guidelines.

The C.H.C. requested the clinical and non-clinical criteria and guidelines used within the Trust for E.C.T. The response from the Trust was that "it is difficult to give clinical and non-clinical guidelines for the use of E.C.T., as E.C.T. is given as a medical treatment on the clinical judgement of the prescriber and it is therefore a clinical decision in each case."

It was also reported by the Trust that "there are no specifications on standards of guidelines about E.C.T. contained in contracts held by the Trust with purchasers." Thus, it can be concluded that no guidelines are in operation for the use of E.C.T., with judgements left to individual clinicians.

There are written guidelines from the Anaesthetics Department." The anaesthetic guidelines of January 1990 were updated in November 1996, during the course of the Project. Both versions are attached at Appendix One. The Project Team was told that these were still the only guidelines for E.C.T.

This response made no reference to the procedure for E.C.T. developed by the Mental Health Unit of Salford Health Authority (which became the Mental Health Services of Salford N.H.S. Trust) in 1993, nor its updated version, Procedure:

Electro-Convulsive Therapy (E.C.T.) (July 1996 - review date July 2000) (see Appendix Three).

It was not until the Project Team specifically asked about this documents it was either provided or referred to. While the procedure had been updated (albeit significantly later than the review date set on the original versions), the lack of reference to it in any of the discussions or correspondence with the Trust raises a question about staff awareness and implementation of it.

3.6.2 Equipment.

Dr. Moss stated that the E.C.T. machines within the Trust are "obsolete and unsatisfactory" and that it does not have any "modern" machines.

The Trust informed the C.H.C. that the following E.C.T. machines were in use at Prestwich Hospital as at February 1997, and were to be moved to Meadowbrook when the E.C.T. facilities transferred there later in 1997:

Ectonus Series 5-regular machine

Ectron CCX-reserve

Duopulse (2c/
-used only if both other machines fail.

Ectonus (2c/

It should be noted that the Ectonus Series 5 machine had been superseded by the Ectonus Series 5A. The Duopulse E.C.T. machine has long been superseded by a more modern device.

During the visit to the Prestwich E.C.T. Suite on 22 November, 1996, the Project Team were told that staff wanted a new E.C.T. machine that could also measure E.E.G. This may be significant, as E.E.G.-based seizure times are estimated to be 10 - 40 % longer than seizure times by observation of muscle activity (using the Cuff Technique to control for the muscle relaxant) (59) (98).

When the C.H.C. visited the E.C.T. Suite at Meadowbrook on 27 October, 1997, the Ectonus Series 5 E.C.T. machine was still in use. Staff involved in the administration of E.C.T. considered that a new machine capable of providing E.C.G. monitoring was required. The short list included a Mecta SR1, a Mecta SR2 or a Thymatron DGX, although on 29 October, 1997, the Vickers Company stopped sales of the Mecta machines and terminated their contracts with the makers, as they were found to be possibly dangerous (48). Following demonstrations and using guidance from the Royal College of Psychiatrists, a new machine had been identified and ordered which would do brain traces and allow the voltage used to be age-related.

The servicing of E.C.T. machines is also a concern of many. According to responses to a survey in September 1997 by Psychology Politics Resistance as part of its North West Right to Refuse Electroshock Campaign, the servicing of E.C.T. machines within the Mental Health Services of Salford N.H.S. Trust compares with other N.H.S. trusts in Greater Manchester as follows:

Trust	Servicing period for E.C.T. machines
Mental Health Services of Salford	One year
North Manchester Healthcare Six months	Six months
Royal Oldham Hospital and Community Services	
South Manchester University Hospitals (Withington Hospital)	"Regularly in line with the manufacturers' recommendations".
Trafford Healthcare	One year

Source: Psychology Politics Resistance - correspondence from N.H.S. trusts.

3.6.3 Frequency and number of treatments.

The Project Team was told by consultants that in the Trust, although fewer patients now get E.C.T., those that do probably receive a similar number of treatments and for similar lengths of time to patients in past years.

While no direct information was provided by the Trust, use of the figures provided produces the following average number of treatments per patient:

Year	Total number of treatments	Total number of patients	Average treatments per patient
1994	759	77	9.86
1995	652	82	7.95
1996	524	57	9.19

Allowance may have to be made for the small number of patients who received more than one course of treatment during any year. It is, however, unclear whether this distinction is made when data is collected and whether such information is readily available.

3.6.4 Anaesthesia.

The C.H.C. requested the clinical and non-clinical criteria and guidelines used within the Trust for E.C.T. The response from the Trust was that "it is difficult to give clinical and non-clinical guidelines for the use of E.C.T., as E.C.T. is given as a medical treatment on the clinical judgement of the prescriber and it is therefore a clinical decision in each case."

There are written guidelines from the Anaesthetics Department." The anaesthetic guidelines of January 1990 were updated in November 1996, during the course of the Project. Both versions are attached at Appendix One. The Project Team was told that these were still the only guidelines for E.C.T.

The guidelines for anaesthesia for E.C.T. in the Mental Health Services of Salford N.H.S. Trust varied significantly from those used for day surgery in the Salford Royal Hospitals N.H.S. Trust, even though the anaesthetists in both cases are employed by the Salford Royal Hospitals. [See Appendix One].

Only post-fellowship or consultant anaesthetists were allowed to be involved in E.C.T.

Anaesthesia varies according to the patient's condition.

3.7 Training of Clinical Staff.

3.7.1 Training of staff:

Discussions with clinical staff in the Trust highlighted that:

At the time of the C.H.C.'s first review, doctors (except anaesthetists) got no specific or formal training in E.C.T. This situation began to change after the relocation of the service from Prestwich to Meadowbrook.

While the E.C.T. service was at Prestwich (1996-1997), E.C.T. was administered almost entirely by Dr. Rosenberg with assistance from trainees in Old Age Psychiatry who were all experienced in the administration of E.C.T. Specific training was not provided to junior doctors as they were not required to administer E.C.T." (Hyde, 1997: 7).

From April 1997, "trainee psychiatrists based at Meadowbrook [had] been involved in the administration of E.C.T. and were all offered individual training in the use of the E.C.T. box. They were experienced trainees having worked in other hospitals and had been trained in administering E.C.T., and none have taken up this invitation." (Hyde, 1997: 7-8).

From 1 August, 1997, all junior doctors on the rotation were required to complete a log book defining the experience they had, as well as to develop a learning contract within the first month of their attachment with the Trust. Both of these documents should be reviewed by the Postgraduate Dean's Department in reviewing their training. These were intended to act as checks to ensure that doctors administering E.C.T. received the appropriate training 79.

On the C.H.C.'s visit to Meadowbrook on 27 October, 1997, it was reported that were still junior doctors applying E.C.T. who had not been trained in its use, although assurances were given that all doctors would be trained on the use of the new machine when it was obtained and that this training would be repeated by a consultant psychiatrist every six months when new junior doctors arrived.

There were two regular nursing staff at the Prestwich E.C.T. Suite, both of whom were registered mental nurses (R.M.N.s).

3.8 Variations in use and practice.

The use of E.C.T. by consultant was as follows:

In the under-65 services:

Consultant						
Meadowbrook	1994		1995		1996	
	Male	Female	Male	Female	Male	Female
Dr. Black	0	2	0	2	0	1
Dr. Callender	1	0	1	2	0	0
Dr. Colgan	0	4	0	5	1	4
Dr. Kelly	3	5	1	0	-	-
Dr. Soni	2	1	3	5	1	0
Dr. Stone	2	3	1	5	0	0
Prestwich						
Dr. Black	0	0	1	0	0	0
Dr. Campbell	1	0	0	0	-	-
Dr. Colgan	0	0	1	1	0	4
Dr. Davison	-	-	-	-	0	1
Dr. Holloway	1	0	0	2	0	0
Dr. McGloughlin	-	-	-	-	0	1
Dr. Monteiro	1	0	1	0	0	0
Dr. Soni	0	0	2	2	3	5
Dr. Stone	0	0	0	2	0	1
Dr. Wilson	-	-	-	-	1	0
Totals	11	15	11	26	6	17

In the over-65 services:

Consultant	1994		1995		1996	
Meadowbrook						
Dr. Moss	0	2	6	5	0	0
Dr. Stout	6	10	5	9	4	8
Prestwich						
Dr. Atkins	-	-	-	-	0	2
Dr. Davenport	0	1	0	2	0	1
Dr. James	0	1	0	0	0	0
Dr. Jolley	0	1	0	0	0	0
Dr. Moss	1	1	3	1	0	4
Dr. Stout	7	21	3	11	4	11
Totals	14	37	17	28	8	26

These figures make interesting reading, not least in the variations both for individual consultants year-on-year, but also between consultants. The reasons for these variations are unclear and warrant further investigation.

Discussions with consultants within the Trust highlighted that:

There is no information held by the Trust on the variations in use of E.C.T. between consultants and hospitals, although some of this may be due to differing clinical judgements.

There was no work known by them in England and Wales to allow comparison of E.C.T. provision in different N.H.S. trusts, or any work similar to that being undertaken in Scotland.

3.9 Effectiveness of E.C.T.

3.9.1 Clinical Audit and Research.

Within the Trust, clinical audit had been undertaken in regard to E.C.T., but this was only a single audit in 1992 about its administration rather than outcomes. The Project Team was told by consultants in the Trust that:

the recent reorganisation of the Elderly Service had left things somewhat disorganised, but it was felt that a suggestion should be put to Salford and Trafford Health Authority to seek an audit of E.C.T.

Although the Salford Case Register records information on research and audit, this appears irrelevant in the case of E.C.T., as so little research and audit has actually been undertaken.

3.9.2 Duration of Effect.

The Project Team was told by consultants in the Trust that:

Psychiatrists would look for a quick difference as a result of E.C.T. - an effect after two weeks. It would be difficult to check the effectiveness for patients having E.C.T. against those who do not.

The relapse rate of patients is fairly high, perhaps 60% within two years. E.C.T. should therefore always be followed up with maintenance treatment.

The Project Team was informed that "Psychiatrists in Salford do not prescribe E.C.T. expecting that this will reduce the rate of relapse. Psychiatrists in Salford do not prescribe E.C.T. to prevent long-term relapse. The Royal College of Psychiatrists' Committee on E.C.T. emphasise that it is essential that maintenance of the treatment with medication should be instituted after a course of E.C.T. to reduce the risk of relapse. This may be with antidepressants, lithium, carbamazepine or a combination." (Hyde, 1997: 5).

3.9.3 Survivors' Views.

No work had ever previously been done in Salford to assess patients', survivors' or relatives' views about E.C.T. and its use.

3.9.4 Who does E.C.T. work for?

On criteria to determine the effectiveness of E.C.T., the Project Team was told by consultants in the Trust that a major factor they used to decide how effective E.C.T. is likely to be for any patient is the presence of delusion and also biological symptoms. Both can, of course, be seen as matters of judgement rather than objective fact.

A depressive delusion involves a person believing that they are worthless, unlovable and not deserving of care or attention. In such a psychological state, there is no logical reason to continue to live, and the person will believe that everyone is better off without them. A delusion is a belief that cannot be questioned.

Biological symptoms are those which suggest a depressive illness that is not a response to grief, a lack of self-confidence or a lack of coping skills, but one that is related to biochemical and pathological changes in the brain and body.

3.9.5 E.C.T. and Alternatives.

The Project Team was informed by consultants that in the Trust the alternatives to E.C.T. used are mainly antidepressants. There was no mention of psychological services, "talking treatments" or other alternatives. This was despite the presence in the Mental Health Services of Salford of both a Psychotherapy Department and also a large, highly-trained Psychology Department that offers cognitive therapy and various other treatments that can be used to treat depression, either with or without physical treatments.

It was, however, reported that "In considering alternative treatments to E.C.T., it should be noted that patients treated with E.C.T. are normally too ill to be accessible to psychological treatments. These are available and will be considered where appropriate either when someone who has been severely depressed has improved or for an individual with a less severe depressive illness for whom E.C.T. would not be considered. Many individuals with depressive illnesses have a biologically determined illness and are not necessarily in need of psychological treatment." (Hyde, 1997: 8).

The C.H.C. was later informed that "When contemplating E.C.T. in Salford, we consider not only alternative pharmacological treatments but the availability of both eclectic psychological treatments, and specific psychological treatments of cognitive behavioural therapy and psychodynamic therapy. The majority of people receiving E.C.T. are not amenable at that time to psychological treatments." (Hyde, 1997: 5).

3.10 Risks and Side Effects of E.C.T.

3.10.1 Risk assessment for E.C.T.

The Project Team was told by consultants in the Trust:

On a patient's first referral, an anaesthetist makes an assessment, including investigations. E.C.T. is only allowed if the anaesthetist is satisfied it is safe to do so. The final decision on whether a patient can be given E.C.T. is that of the anaesthetist, who takes into account the consultant's view.

Older people are at a higher risk, especially if they have heart disease. If a patient's physical health is borderline, the anaesthetist will check with the consultant psychiatrist about the decision to give E.C.T. (although this does not happen often). Problems with heart conditions, falls and strokes (even in older people) are few.

There is no evidence that E.C.T. has ever been given in a coronary care unit or intensive care unit in Salford 79.

3.10.2 Side Effects of E.C.T.

The Project Team was told by consultants that in the Trust, there was currently no mechanism in place for monitoring the side effects of E.C.T., including memory loss. Dr. Moss felt that differences were individual to patients. This should be an important area for further research to be undertaken.

3.10.3 Anaesthesia.

The anaesthetists used by the Mental Health Services of Salford N.H.S. Trust are employed by the Salford Royal Hospitals N.H.S. Trust. The service involves four E.C.T. consultant anaesthetist sessions. During the period of the project, the source funding for these was an unresolved issue, with sessions being cancelled and discharges being delayed. A service level agreement was drafted to improve the situation, although this had extra funding implications.

The Project Team was told by consultants that:

No day case surgery is undertaken on patients over 75 years in the Salford Royal Hospitals N.H.S. Trust, but E.C.T. is undertaken on patients older than this in the Mental Health Trust. Greater monitoring of E.C.T. patients may be required.

Repeated anaesthesia has no cumulative effect, as only has a short-term effect. Repeated anaesthesia does, however, increase the level of risk.

3.10.4 E.C.T. and Death.

The Project Team was told by consultants that death and serious injury due to E.C.T. are very rare. There had been no instances in the Trust in at least the previous 18 months. In the past there had been two or three deaths, but these were of people who would probably have died any way.

3.11 Consent to Treatment.

3.11.1 Rules and Guidance.

The local guidance on consent within the Mental Health Services of Salford N.H.S. Trust in force at the time of the Project was:

Procedure: Consent to Treatment (March 1995) - review date October 1999: see Appendix Two; and

Quality Statement: Consent to Treatment (Mental Health Act 1983) (February 1994) - review date February 1999: see Appendix Four.

It was not until the Project Team specifically asked about these documents that they referred to by the Trust. While the procedure and quality statement had been updated (albeit significantly later than the review dates set on the original versions), the lack of reference to them in any of the discussions or correspondence with the Trust raises a question about staff awareness and implementation of them.

On the question of consent, the Mental Health Act 1983 and the Mental Health Act Code of Practice provides the essential framework. Many statements from these are reproduced in the Trust's procedure guidance and quality statement.

If a patient is able and willing to give consent to E.C.T. and anaesthesia, they are then asked to sign a standard N.H.S. consent form, which is countersigned by the R.M.O. The Trust actually provided the C.H.C. with a consent form specific for E.C.T. [Appendix Three]. This identifies that the E.C.T. treatment has been explained. The form should be checked by the medical staff giving the E.C.T. and anaesthetic and by the nursing staff. Treatment should not be given without a valid consent form being provided.

The treatment course is reviewed weekly by the R.M.O. and the multi-disciplinary team. Competence to give or refuse consent is not formally assessed prior to each individual session. Consent is, however, reaffirmed by the patient at each treatment by his/her confirmation to the named nurse or nurse in charge prior to each treatment that they will be attending for that treatment and not by mere assent or being there.

While some patients' capacity to consent may vary over time, their right to refuse treatment should always be observed. Any attempts at persuasion should involve only discussion and reason without undue pressure. If a patient does refuse E.C.T., alternative treatments should be continued, along with an explanation of the associated benefits and risks.

If a patient refuses to give consent or their consent is clinically judged to be not valid, the R.M.O. has to make a clinical judgement as to whether to carry on with the treatment under the Mental Health Act, in line with the Code of Practice. In the case of patients who are given E.C.T. without their consent, the authority of a Second Opinion Appointed Doctor (S.O.A.D.) from the Mental Health Act Commission to do this must be recorded on a Form 39. This should accompany the patient. Without it, the patient should not be given any treatment. E.C.T. staff also have a responsibility to check the number of treatments the patient is given against the specified number authorised by the S.O.A.D.

During Mental Health Act training, staff are taught about the withdrawal of consent. This can be done not only by a patients saying that they do not want the treatment, but also by action, such as refusing to get on a trolley or not putting their arm out for the anaesthetic. To give treatment in these circumstances (unless the Mental Health Act is fulfilled) would be illegal.

3.11.2 Information and Explanations.

In 1996, the Trust reported that "there is no written information given to patients regarding E.C.T. E.C.T. is individually discussed with each client by the doctor prescribing it. It is also backed up with discussions by nursing staff and also by E.C.T. staff when then patient first comes for treatment."

Clinical staff also told the Project Team that information for patients and the obtaining of consent to treatment was not standardised within the Trust.

During discussions with clinical staff in the Trust, the Project Team was told that no written information is given to patients about E.C.T. At present, the only explanation for E.C.T. was verbal. All information is given verbally, and is thus dependent on staff, their communication skills and the way in which the information is presented. A new form and set of criteria were required. It was noted that the Royal College of Psychiatrists had produced videos illustrating "ideal interviews".

At the time of the visit to the E.C.T. Suite at Meadowbrook on 27 October, 1997, the C.H.C. team was told that patients should be given the Royal College of Psychiatrists' leaflet by ward staff, although this was probably more likely to be on request than automatic.

This situation was in contrast to that when Salford C.H.C. enquired about this in 1994, when it was provided with a copy of the Royal College of Psychiatrists E.C.T. (Electroconvulsive Therapy) A Factsheet for You and Your Family dated 12 July, 1993, and marked for the Meadowbrook Department of Psychiatry of the Mental Health Services of Salford.

The Trust indicated that the information as suggested by Mind "would be very useful for patients or their relatives to ask about E.C.T. These reports of survivors and the comments about validity of consent make disturbing reading and should be read by doctors prescribing E.C.T. . . . We will explore with the staff administering E.C.T. the development of a small pamphlet addressing these questions and providing some written information." (Hyde, 1997: 6).

3.11.3 Validity of Consent.

The process of obtaining valid consent from a patient is based on the clinical judgement of their responsible medical officer (R.M.O.). If they and the clinical team consider that a course of E.C.T. treatments would be beneficial, this should be discussed with the patient and, where appropriate, their relatives. Under the Patient's Charter, patients should be given a full explanation, including about the benefits, risks and alternatives. Nursing staff can have an important role in this process. The Trust is expected by the local Health Authority to audit and report on performance against this standard.

The Trust includes obtaining valid consent as an integral part of its Mental Health Act training updates.

The Project Team was informed by Trust staff that there is no independent advocacy available to patients who are offered or given E.C.T.

3.11.4 E.C.T. Without Consent.

The Project Team was told by Trust staff that treatment without consent is monitored by the Mental Health Act Commission, including against the Mental Health Act Code of Practice.

4. Patients', Users and Survivors' Views in Salford.

4.1 Background.

The Project Team tried several different approaches to obtaining the views of survivors of E.C.T. from the start of the Project. These included press releases, articles in local press and media (including voluntary sector and mental health publications), and direct letters and mailings to mental health user groups and carers' organisations. These yielded, however, only two people, both of whom were coopted onto the Project Team.

The Project Team felt it vital that every effort was made to obtain the views of people who had had E.C.T. in Salford. It therefore met with Survivors in Salford, the only city-wide organisation of mental health service users to discuss possible ways forward. From this discussion, it was agreed to hold a workshop and to invite survivors, users and carers to come to give their views. This was a format that had been used successfully by Survivors in Salford before on other mental health issues.

4.2 Planning and Publicity.

The workshop was promoted and publicised through the press and media (including articles in local newspapers and interviews on B.B.C. local radio), and through the distribution of 1 500 flyers targeted at survivors through user groups, carers' groups, community psychiatric nurses, health centres, social workers, support workers, drop-ins and libraries. The mailing list for *Marooned?*, the mental health magazine for Salford, and the Salford Council for Voluntary Service Directory of Local Information were used to assist with distribution. The flyers included information about lunch and the reimbursement of travel expenses.

4.3 Letters and Telephone Calls.

As well as participants on the day, the publicity for the workshop also attracted a range of letters and telephone calls from E.C.T. survivors to Salford Community Health Council (C.H.C.). These included:

A survivor who had had two courses of E.C.T. in 1997 for manic depression. They considered that it had saved their life, but was worried about the side effects.

A survivor who had had several courses of E.C.T. at Prestwich Hospital over 16 years, the first after being diagnosed schizophrenic. After the first courses of treatment, it had taken two years to recover. Later, when the person decided not to have E.C.T., it took them eight years to reach the same level. "I think you recover quicker with E.C.T. and it cuts the amount of time you are suffering".

A survivor who had recently had E.C.T. at Meadowbrook, reportedly for continuous earache, and who withdrew their consent after a small number of treatments. They described the experience as "awful" and as "a quick conveyor belt process". "Came out of Meadowbrook worse than when I went in. Just a handful of anti-depressants and hope these kept me quiet. Sorry, against E.C.T."

A survivor who had had over 100 E.C.T. treatments at both Prestwich Hospital and Meadowbrook. They reported that, for them, three or four "bouts" helped and that the treatment was followed by a headache, but no memory loss. They said that E.C.T. "lifts a cloud from you and lets the sunlight through".

A survivor who estimated that they had had at least 150 E.C.T. treatments. They reported short-term memory loss, especially for the first 6-7 days after treatment, but that this improves over time. They wrote that "I think it's a small obstacle, compared with not having my sanity . . . If they banned E.C.T. I'd be terrified for the rest of my life."

A son whose mother had had five or six E.C.T. treatments about ten years before while in her eighties for post-influenzal depression, and then again after two and four years. He said that, after each course of treatment, she was "right as rain". His mother was now in good health, very sprightly for her age and with a good memory.

A survivor who had E.C.T. nine years before after a nervous breakdown. This had consisted of only one treatment, due to her husband stopping further treatment, as she had had a fit while going for the second. She now had permanent epilepsy, even though there were no family history of this. She believed that the epilepsy was caused by the E.C.T.

A survivor who had had course of seven E.C.T. treatments. She complained of having vivid and alarming dreams since E.C.T., a poor memory, difficulty in thinking, and problems with both sleeping and cooking.

4.4 The E.C.T. Workshop.

The workshop was held on Wednesday 22 October, 1997, at the Banqueting Suite at Buile Hill Park in Salford. This is a central venue often used for meetings of mental health survivors, which is well away from any hospitals and mental health facilities.

A full lunch was provided at the workshop. Travel expenses reimbursed to all those who wished to claim. Funding for the event was shared between the Mental Health Services of Salford N.H.S. Trust, Salford C.H.C. and Survivors in Salford. Information

stalls about Salford C.H.C. and E.C.T. Anonymous were also on show throughout the day.

The workshop attracted 33 participants. It was jointly chaired by Ken Stokes, Vice-Chairperson of Salford Community Health Council and a member of the Project Team, and by Pat Garrett, the Chair of Survivors in Salford. The morning session was for users, survivors, relatives and carers only. This was to allow them to express their views freely and without any fear or pressure of doing this with health professionals present.

4.4.1 The E.C.T. Workshop - Morning Session.

Ken and Pat welcomed everyone to the event, explained the role of both organisations and the purpose of the event, and stressed the need for everyone to listen to each others' views and respect each other's confidentiality.

Chris Dabbs, the Chief Officer of Salford C.H.C., then gave a brief presentation on the aims and objectives of the Project and the issues that had been highlighted to date. He was followed by Pat Butterfield and Andrew Bithell from E.C.T. Anonymous, a national support and pressure group for all E.C.T. survivors and their helpers. They gave their own views on E.C.T. and its use in the United Kingdom. The audience then asked a range of questions about E.C.T. and the Project.

Four discussion groups were then formed. Facilitation and the taking of notes were undertaken by a Member and officers of the C.H.C., members of Survivors in Salford and members of E.C.T. Anonymous. Each group was given a "prompt sheet" - a list of the issues thrown up by the Project Team's work to date - to help and inform their discussions.

Each group was asked to identify three issues that they wished to highlight to the representatives of the Mental Health Services of Salford N.H.S. Trust during the afternoon session. These were:

Change the law to give all patients a right to choose or refuse E.C.T.

All patients should have access to an advocate when offered E.C.T. and during a course of E.C.T.

All alternatives, especially talking treatments, should be offered before E.C.T. is considered.

Better long-term monitoring of patients after E.C.T. and long-term research into its effectiveness and side effects.

Concerns about E.C.T. particularly being given to older people and women - was there discrimination involved?

Health professionals to listen to patients and survivors more, both as individuals and as groups.

Better and more information for patients and relatives about E.C.T., with the maximum possible time being given to consider it before making a decision about whether to have E.C.T. This information should include views from psychiatrists and survivors, giving views both supporting and opposing E.C.T.

Greater distinction between physical and mental illness - some people reported being given E.C.T. for conditions that were physical and not mental.

To use only the most recent, up-to-date equipment for E.C.T., with this being tested and maintained on a frequent and regular basis.

A vegetarian lunch was served. During the lunch interval, survivors' poetry was performed by Survivors' Poetry Manchester,

4.4.2 The E.C.T. Workshop - Afternoon Session.

Dr. Steve Colgan and Ms. Avril Harding from the Mental Health Services of Salford N.H.S. Trust arrived at the start of the afternoon session. Chris Dabbs from the C.H.C. then presented the main issues highlighted by the discussion groups.

The question and answer session elicited the following responses from Dr. Colgan and Ms. Harding:

Most patients who are given E.C.T. without their consent are actually not able to give or withhold their consent.

There is a tension between seeking an absolute right to refuse E.C.T. and situations where the patient's judgement is impaired and they are suicidal.

The debate on the right to refuse E.C.T. needs wider moral and ethical discussion of the competing views.

Many patients at Meadowbrook were not aware of the independent advocacy service provided there by the Salford Mental Health Services Citizen's Advice Bureau. This service is not available to patients in the Elderly Service.

The main general risk with E.C.T. is that associated with repeated general anaesthesia.

E.C.T. is more commonly used in older people as they tend to respond well to E.C.T. and find drugs more noxious than younger people.

There is a need to listen more to and take more account of the views of patients.

Patients and carers should have as much information as they want about E.C.T. The Trust was developing a new leaflet on E.C.T.

The very high concurrence rate between the views of responsible medical officers (R.M.O.) and second opinion appointed doctors (S.O.A.D.) was because they were trained to the same standard.

The Trust recognises that there are still problems. It wants to continue to discuss the local service with survivors and carers in order to help make improvements.

The Trust was currently commissioning new E.C.T. equipment for the new E.C.T. Suite at Meadowbrook. Older E.C.T. were still being used, but were not considered dangerous and were maintained regularly and had not broken down since the new E.C.T. Suite had opened.

The period of time given to decide whether to give or withhold consent varies according to circumstances, but is as long as safe and possible.

It is recognised that one side effect of E.C.T. can be memory loss (at least in the short term). Long-term memory loss is rare and difficult to determine.

Compared to other alternative treatments, E.C.T. is better researched.

E.C.T. practice has improved over time, including in regard to machinery, anaesthetics, privacy and dignity.

5. Conclusions.

A. E.C.T. and Its Use in England and Wales.

5.1 E.C.T. and its use.

1. E.C.T. is perhaps the most controversial treatment currently used by the medical profession. Many patients, survivors, relatives, professionals and others have serious concerns about the use of electro-convulsive therapy. While some survivors report it as helpful or lifesaving to them, many others see it as a damaging and threatening tool of psychiatric oppression.
2. E.C.T. is used mainly to treat depressive disorders, but also mania, schizophrenia and neuropsychiatric conditions. It is also reported as having been used for a variety of other conditions for which its use is not generally clinically indicated.
3. E.C.T. has cardiovascular, cerebral, intraocular and intragastric effects in patients.
4. There are a range of theories about how E.C.T. works. There is no firm evidence to demonstrate how the process operates.
5. Most patients receive E.C.T. two or three times per week as part of a course of treatments which usually number between two and 12. There is some evidence that E.C.T. given twice per week is as effective as E.C.T. three times per week and has less severe cognitive effects. A significant number of patients receive several courses of treatment over time.
6. About 22 000 people are given E.C.T. in England each year. This is a rate considerably higher than other countries in Europe, some parts of North America and the Far East.
7. Women are far more likely to be given E.C.T. than men, at a ratio of about 2:1.
8. Older people (especially those over 65) are more likely than younger people to get E.C.T., the average age of patients being somewhere in their fifties.
9. E.C.T. is rarely given to people under 18 years, with no evidence of its use for children under 12.
10. There is no reliable information about the use of E.C.T. in regard to the ethnicity of patients.

5.2 Effectiveness of E.C.T.

1. Clinical studies tend to concentrate on (short-term) symptom reduction rather than on the quality of life, physical health or social functioning of survivors.
2. There is very little good research on the long-term effectiveness or side-effects of E.C.T.
3. E.C.T. is demonstrably effective for a narrow range of severe psychiatric disorders in a limited number of diagnostic categories: delusional and severe endogenous depression and manic and certain schizophrenic syndromes.
4. Most clinical research concludes that E.C.T. is effective for the treatment of depressive illness and is preferable to drugs for some patients.
5. Clinicians generally hold that E.C.T. is particularly effective for patients with a higher number of typical features of depressive illness, especially where these include psychotic features. It is also reported that two particular symptoms - retardation and depressive delusions - respond well to E.C.T. and that patients without these symptoms do not benefit significantly from E.C.T.
6. E.C.T. is not effective in treating Type II (chronic) schizophrenia and has only a limited use in treating Type I (acute) schizophrenia in patients with specific indicators.
7. E.C.T. is effective in treating people with affective and catatonic disorders, but only where there is account taken of specific medical risks and appropriate modifications made.
8. There is little evidence for the use of E.C.T. in treating either Parkinson's Disease or epilepsy.
9. There are no symptoms or clinical features proven as criteria to determine who will benefit from E.C.T., although most recent work indicates that psychotic features and psychomotor disturbance (rather than the severity of depression) are best correlated with a good response for E.C.T.
10. E.C.T. can prevent death when a person is severely depressed and is in a critical state through no longer eating or drinking.
11. There is no good evidence to prove that E.C.T. prevents suicide or affects the suicide rate.
12. E.C.T. is not effective for violent or offending behaviour, diabetes, obsessive-compulsive disorders, anxiety, post-traumatic stress disorder, stroke, dementing illnesses or cardiovascular disease.
13. There has been relatively little work done to establish survivors' views on E.C.T. Some of the research that has been undertaken is of poor quality.
14. From the limited surveys undertaken, between 30% and 43% of survivors report E.C.T. as being helpful or life-saving to them. Between 37% and 51% of survivors found E.C.T. unhelpful or damaging. Factors which appear to increase the proportion of patients finding E.C.T. helpful are:
 - being treated voluntarily rather than compulsorily
 - being treated with one's consent rather than without consent
 - E.C.T. not being used as a threat
 - being given a full explanation before E.C.T.
 - diagnosis: more people diagnosed with depression report positive outcomes than people diagnosed with schizophrenia, more of whom in turn report positive outcomes than people diagnosed with manic conditions.
15. The beneficial effects of E.C.T. are rapid and only short-term (at most eight weeks).
16. There is a high relapse rate within the first four months after E.C.T., and an even higher rate in the longer term.
17. There is no high quality research to support the use of "continuation" or "maintenance" E.C.T.
18. E.C.T. has no positive long-term effect and does not positively influence long-term survival. Indeed, it has been argued that index E.C.T. treatment predicts high long-term mortality and readmission risks.

19. When effective, E.C.T. relieves only the symptoms of depression and is ineffective in treating depressive illness itself. There is no evidence that it helps patients to deal with their underlying problems more effectively.

20. There is very little good research on the effects of different medications on the efficacy and safety of E.C.T. for patients, although at least some drugs may reduce the effect of E.C.T.

5.3 Risks and side-effects of E.C.T.

1. Guidance very strongly advises against giving E.C.T. to patients who have had a recent myocardial infarction (heart attack), a recent cerebrovascular accident (stroke) or an intracranial mass or lesion (brain injury or tumour).

2. Relative contraindications for E.C.T. are: angina, congestive heart failure, severe pulmonary disease, severe osteoporosis, major bone fractures, glaucoma, retinal detachment, thrombophlebitis and pregnancy. Heart disease in particular produces much greater risks for patients having E.C.T. There are many other side effects reported by survivors.

3. The greatest risks of E.C.T. are probably those associated with the regularly repeated general anaesthesia which is given.

4. There are divided opinions on whether E.C.T. causes brain damage.

5. The research into the relationship between E.C.T. and deaths caused by it tends only to concentrate on very short-term time scales. The risk of death from E.C.T. ranges from 0.002% to 0.0045%, although it is argued that many deaths are not reported or not linked to the administration of E.C.T. The risk of death is higher in older people than younger ones.

6. The immediate side effects of E.C.T. commonly include: amnesia, drowsiness, confusion, disorientation, apathy, physical weakness, headaches, nausea and dizziness. For older people, there are particular risks of heart problems, falls and strokes.

7. Memory loss or impairment is the most commonly reported side effect of E.C.T. Most survivors experience some short-term memory impairment, while a significant proportion report longer-term or permanent memory loss. Many survivors report that clinical staff tend to be rather dismissive of these complaints.

8. The level of memory impairment varies, at least in part, according to E.C.T. technique, with bilateral E.C.T. appearing to cause more severe memory loss than unilateral E.C.T., although the latter may cause more severe damage to the patient's brain.

9. Sine wave E.C.T. appears to cause more damage to patients than brief-pulse E.C.T.

10. The emotional and psychological effects of E.C.T. are often underestimated or ignored.

11. The Royal College of Nursing's E.C.T. - Guidance for Nurses identifies a range of measures that can reduce the anxiety of patients before E.C.T. and the level of memory impairment afterwards, including: management of anxiety; management of cognitive side-effects of E.C.T.; the type of information more likely to be retained; and care planning.

5.4 E.C.T. and alternative treatments.

1. E.C.T. is not always used as a treatment of last resort before all other alternatives have been tried. This is, at least in part, due to the extreme severity of the condition of some patients.

2. In most cases, most psychiatrists see the prescription of drugs as the only real alternative to E.C.T. Relatively few patients (especially older people) are offered other (non-drug) therapies and many are offered no alternative at all.

3. There is little good research or evidence to demonstrate the relative effectiveness of E.C.T. and alternative treatments.

5.5 Rules, guidance and criteria for E.C.T.

1. The most widely accepted guidance for E.C.T. is The E.C.T. Handbook (including "checklists for good practice in E.C.T.") produced by the Royal College of Psychiatrists (61).

2. There is guidance for nurses in the Royal College of Nursing's E.C.T. Guidance for Nurses (137).

3. Guidance is also available in Electroconvulsive Therapy (E.C.T.). A Good Practice Statement and the accompanying summary for purchasers, produced by the Working Group on Mental Illness of the Clinical Resource and Audit Group at the Department of Health in The Scottish Office 26 27.
4. There are no accurate or accepted criteria to determine a person's threshold for the current involved in E.C.T.
5. The post-treatment care and observation of outpatients, but especially inpatients, has generally been given insufficient consideration.
6. There is no national specification for E.C.T. machines.

5.6 Quality of care and practice of E.C.T.

1. There are extremely wide variations in the use of E.C.T. between psychiatrists, hospitals and regions, without any apparently logical reasons for this.
2. Audits by the Royal College of Psychiatrists showed that one-third of units examined failed to deliver adequate care in 1981, and 21% in 1995. Despite some improvements in practice, only 30% of E.C.T. clinics were rated as good or exemplary in 1995.
3. The anaesthetic standards of care and practice used for E.C.T. are substantially inferior to those for other patients (such as those receiving day surgery) and commonly fall short of accepted national guidelines.
4. Despite several initiatives and audits by the Royal College of Psychiatrists since 1980, E.C.T. is still often being delivered by inadequately trained staff.

5.7 Training and supervision of clinical staff.

1. The Royal College of Psychiatrists recommends that each individual E.C.T. service should have a named consultant responsible for its supervision and for ensuring that it meets the standards set.
2. E.C.T. clinics that are genuinely consultant-led tend to achieve higher standards than others, but are the exception in Britain.
3. In Britain, most E.C.T. is administered by junior doctors on rotation. Many have had little or no training in E.C.T. and often administer it without consultant supervision. The training that is given is of variable quality.
4. The traditional British system of delegating responsibility to junior staff for the administration of E.C.T. effectively prevents accreditation and the assurance of high quality training and supervision.
5. There are no training or competency standards for nurses practising in E.C.T. clinics.

5.8 Consent, information and explanations.

1. The rights of patients to give or withhold consent to E.C.T. are essentially the same as that for other patients. Patient do not have an absolute legal right to refuse E.C.T.
2. Particular care is required in regard to consent to treatment for patients under 16 years or adults with a learning disability.
3. Initial consent does not imply agreement to a course of E.C.T. and should be verified before each treatment.
4. There are particular considerations needed for consent in regard to patients detained under the Mental Health Act 1983, both generally for any treatment and specifically for E.C.T., as detailed in the Mental Health Act Code of Practice.
5. Depressive illness can influence a person's perception of events and their ability to think, ask questions and concentrate.
6. There is anecdotal evidence that some patients consent to E.C.T. because of coercion or threat by clinical staff.
7. The validity of consent by many patients is questionable in terms of the quality and sufficiency of the information and explanations given, and their perception (real or otherwise) of whether they have a choice to accept or refuse E.C.T. or alternative treatments.
8. Sufficient information and explanations, including about any significant risks and alternative treatments, must be given to a patient (using languages and formats appropriate to their individual needs) before they can make an

informed decision about whether or not to give consent.

9. The quality and depth of information and explanations for patients is often poor and sometimes non-existent. Nearly all information for patients about E.C.T. is that written by professionals and does not incorporate survivors' views and experiences.

10. Many survivors report that they were never advised about any significant risks or alternative treatments before consenting to E.C.T.

11. Older people and women are less aware of their rights than younger people and men. This may be even worse for people with sensory impairments, people from black and ethnic minorities and people whose first language is not English.

12. Patients (whether or not detained under the Mental Health Act) have no legal right to be offered or to be given an independent second opinion where E.C.T. is considered as a treatment of choice.

13. Independent advocacy is rarely available or offered to patients before they are asked to consent to E.C.T. or indeed at any other time. This is especially so for older people.

14. Memory loss due to E.C.T. may affect the patient's recollection of information given beforehand. It is advised that this should be repeated at an appropriate time soon after the treatment has been given, at the end of a course of treatment and when they are symptomatically improved.

15. About 2 000 people per year in England and Wales are given E.C.T. without or against their consent. Many are considered not able to give or withhold their consent. These are people who are seriously ill and treated under the Mental Health Act following an opinion given by a second opinion appointed doctor. More than half are women over 50 years old. Compulsory treatment is twice as common for people diagnosed with schizophrenia than for those diagnosed with depression.

5.9 The monitoring of E.C.T. and its administration.

1. The Royal College of Psychiatrists has a role to inspect the facilities available for the administration of E.C.T. and ask searching questions about the training of junior doctors administering the treatment. If serious shortcomings are detected and are not rectified, the Royal College can withdraw educational approval from the N.H.S. trust or other provider in question.

2. The Royal College of Psychiatrists stated in 1997 that failure to provide E.C.T. in accordance with its guidelines may result in the withdrawal of approved training status of the N.H.S. trust or other provider concerned.

3. The Mental Health Act Commission has a responsibility to ensure that patients detained under the Mental Health Act 1983 meets the standards within the Act and the Mental Health Act Code of Practice. The Commission is considering ways in which to ensure that the recommendations in The E.C.T. Handbook of the Royal College of Psychiatrists are adopted.

4. While there has been considerable work done in Scotland to audit the use and administration of E.C.T. in Scotland (by the Clinical Resource and Audit Group for the Scottish Office 26 27), there is no comparable work in England, Wales or Northern Ireland.

B.E.C.T. and Its Use in the Mental Health Services of Salford.

5.10 E.C.T. and its use in Salford.

1. The use of E.C.T. in Salford peaked in 1987 and had significantly declined since then, although this change was exacerbated by the reduction and eventual closure of the large Regional Long-Stay Service.

2. Part of the reduction in the use of E.C.T. was also due to depression being identified earlier and also the introduction and use of more effective drugs for depressive and manic conditions.

3. The Mental Health Services of Salford N.H.S. Trust was treating fewer patients with E.C.T. than other N.H.S. trusts in Greater Manchester for which information was made available. A relatively high proportion of these patients were, however, treated while detained under the Mental Health Act.

4. While fewer patients now receive E.C.T., those that do receive a similar number of treatments for a similar length of time as in previous years.

5. The figures provided by the Trust suggest a rate of 250-280 E.C.T. treatments per 100 000 population. This is in the mid-range for reported rates across England and Wales.
6. There were clear variations in the use of E.C.T. for individual consultants year-on-year, but also between consultants. There was no information held by the Trust to compare these rates with consultants in other N.H.S. trusts.
7. Consultants in the Trust claim to prescribe E.C.T. according to diagnosis and mainly for depression and rarely for conditions such as catatonic schizophrenia.
8. Consultants in the Trust state that they use the presence of delusion and biological symptoms as the criteria to determine the likely effectiveness of E.C.T.
9. E.C.T. appears to be prescribed when depression is very severe, other treatments have previously produced negative results for individual patients, or for people who cannot tolerate antidepressants.
10. The vast majority of patients receiving E.C.T. in Salford are Salford residents.
11. An average of 69.6% of all E.C.T. patients in the Mental Health Services of Salford N.H.S. Trust were female and only 30.4% male. These proportions did not vary greatly for patients under 65 and those over 65. With the exception of one other N.H.S. trust, this difference was similar to other N.H.S. trusts in Greater Manchester for which information was made available.
12. The gender difference was reported as being due to more women experiencing depression and also living longer.
13. No detailed information about the age of E.C.T. patients was available. This was limited to whether patients were under 65 years or over 65 years.
14. There is no evidence of E.C.T. being given to anyone under 18 years of age in the recent past.
15. On average, 60.2% of all E.C.T. patients were over 65 years and 39.8% under 65. This age difference varied only slightly between male and female patients. With the exception of one other N.H.S. trust, this difference varied from other N.H.S. trusts in Greater Manchester for which information was made available, where a significantly higher proportion of patients getting E.C.T. were under 65.
16. The Trust reported that it did not record the ethnicity of patients receiving E.C.T., but a 1997 survey of N.H.S. trusts in Greater Manchester stated that 2.1% of patients receiving E.C.T. in the Trust were from an ethnic minority. This was a very low rate compared with other N.H.S. trusts in Greater Manchester (with one exception) where information was made available, and reflects the relative proportion of people from black and ethnic minorities within the Salford population.

5.11 Effectiveness of E.C.T. in Salford.

1. There has never been any research or clinical audit undertaken in Salford on the effectiveness of E.C.T. [It is intended during 1998/99 to undertake clinical audit of E.C.T. use in people under 65 years at Meadowbrook].

5.12 Risks and side-effects of E.C.T. in Salford.

1. There was no formal mechanism or process to assess the side-effects of E.C.T. on the patients who are given E.C.T.
2. There had been no deaths associated with E.C.T. in the recent past. There had been two or three deaths in previous years, but consultants reported that these patients would probably have died anyway.

5.13 E.C.T. and alternative treatments in Salford.

1. The only alternative treatments to E.C.T. mentioned by consultants were drugs (particularly antidepressants). There was no mention of psychological alternatives or "talking treatments", although the Trust later commented that these are considered but most people prescribed E.C.T. are not amenable to these at the time.

5.14 Rules, guidance and criteria for E.C.T. in Salford.

1. The only guidelines available for E.C.T. are the E.C.T. guidelines for anaesthesia and the Trust's procedure guidance for E.C.T. These were not referred to by the Trust until specifically asked about them by the C.H.C.
2. The anaesthetic guidelines for E.C.T. varied significantly from those used for day surgery in the Salford Royal Hospitals N.H.S. Trust. The difference did not appear to be completely due to the difference in treatments.

5.15 Quality of care and practice of E.C.T. in Salford.

3. It is very likely that some patients who are given E.C.T. would be refused day surgery in the acute hospital.
4. The E.C.T. machines in use at the time of the project were not the most up-to-date available, although a new one, capable of E.C.G. monitoring, E.E.G. traces and adjusting the voltage by age, was on order by the end of the project period.
5. The reserve E.C.T. machines available for use if the other machines fail are obsolete.
6. The Trust has its E.C.T. machines serviced on an annual basis. This is less than some other N.H.S. trusts in Greater Manchester, who have their machines serviced every six months.
7. The physical environment of the E.C.T. facilities within the Mental Health Services of Salford N.H.S. Trust improved as a result of the relocation of the E.C.T. Suite to Meadowbrook, although they were no less clinical. [The Trust is currently in discussion with the anaesthetic staff of Hope Hospital about potential alternative accommodation for the provision of E.C.T. services].

5.16 Training and supervision of clinical staff in Salford.

1. E.C.T. was administered in the Trust by junior doctors who had no specific or formal training in E.C.T. When offered training (which is not compulsory) in 1997, none of the trainee psychiatrists took it up.
2. All junior doctors on rotation were required from 1 August, 1997, to complete a log book defining the experience they had, as well as to develop a learning contract within the first month of their attachment with the Trust. These were intended to act as checks to ensure that doctors administering E.C.T. received the appropriate training.
3. The sessional time allocated to consultants is insufficient to allow adequate closer supervision of E.C.T. services.
4. There was no evidence shown that any nursing staff received or were required to have any specific training in E.C.T.

5.17 Consent, information and explanations in Salford.

1. The Trust has a written procedure for consent to treatment and a quality statement on consent to treatment under the Mental Health Act. Neither of these was referred to in discussions with the Trust until specifically raised by the Project Team.
2. There is a consent form specific to E.C.T., although this is relatively old and contains some complex language.
3. Consent is sought from patients before each individual treatment. The capacity to give or withhold consent is, however, only sought at the start of a course of treatment.
4. Consent issues are included in Mental Health Act training for Trust staff.
5. The Trust does not provide written information about E.C.T. to each patient offered it. This is probably mainly given only on request.
6. The only written information available for patients was the Royal College of Psychiatrists' fact sheet. Information on E.C.T. is not available in any other formats or languages.
7. Most information and explanation is given verbally, initially by the doctor prescribing it, with this being backed up by nursing staff and E.C.T. staff before the patient's first treatment.
8. While an independent advocacy service had been established by the Salford Mental Health Citizen's Advice Bureau at Meadowbrook in 1997, this was limited to patients under 65 and there appeared to be significantly limited patients awareness of it. It was not automatically offered to each patient offered E.C.T.

5.18 The monitoring of E.C.T. and its administration in Salford.

1. The Trust found it difficult to find some basic information about the use of E.C.T. This was partly due to the organisation of services in past years.
2. The information the Trust was able to provide about the use of E.C.T. was relatively crude. This was mainly because all such information was and continued to be recorded in written records, and also because some information about patients was not collected at all.
3. The monitoring and auditing of E.C.T. would be extremely difficult due to the methods used to record information.
4. Only one clinical audit had ever been undertaken on E.C.T. in the mental health services in Salford. This was in 1992 and only about an aspect of E.C.T. administration rather than outcomes.

5. There was no evidence of any research having ever been done on E.C.T. in the mental health services in Salford.
6. The Trust had no formal mechanisms in place to monitor the long-term effectiveness or the side-effects of E.C.T. on patients.
7. No previous work had ever been done in Salford to obtain patients' or survivors' views on E.C.T.

6. Recommendations.

6.1 Use of E.C.T.

1. E.C.T. should be used:

- only when the objective is to achieve rapid and short-term beneficial effects (for at most eight weeks)
- to treat the symptoms of only limited categories of delusional and severe endogenous depressive illness where the patient:
 - has a high number of typical features of depressive illness, but only when these include psychotic features and psychomotor disturbance, and
 - exhibits symptoms of retardation and/or depressive delusions or
 - is in a critical state through no longer eating or drinking, but only as a last resort when no other effective treatment is available that has not already been tried.
- to treat only limited categories of certain manic syndromes, but not as a first-line treatment unless the illness is genuinely life-threatening.
- to treat only limited categories of Type I (acute) schizophrenia in patients with specific indicators.
- to treat people with affective and catatonic disorders only when account has been taken of specific medical risks and appropriate modifications made.

2. Extreme caution should be used and all other alternatives attempted before considering E.C.T. where patients have any of the following: angina; congestive heart failure; severe pulmonary disease; severe osteoporosis; major bone fractures; glaucoma; retinal detachment; thrombophlebitis; and pregnancy (especially in the first trimester).

3. E.C.T. should **not** be used:

- where the objective is to achieve a long-term beneficial effect or to influence long-term survival
- to treat Type II (chronic) schizophrenia
- to treat either Parkinson's Disease or epilepsy
- to treat violent or offending behaviour, obsessive-compulsive disorders, anxiety, post-traumatic stress disorder, stroke, dementing illnesses, cardiovascular disease or diabetes.
- to try to prevent suicide.
- to treat patients who have had a recent myocardial infarction (heart attack), a recent cerebrovascular accident (stroke) or an intracranial mass or lesion (brain injury or tumour).

4. The Government should ban E.C.T. for children and young people under 18 years.

5. More careful consideration and guidance is required for the clinically effective use of E.C.T. for patients who are taking psychotropic and other drugs. The use of an increased number of E.C.T. treatments for patients taking psychotropic and other drugs should be avoided.

6.2 Administration of E.C.T.

1. E.C.T. should be used only in accordance with the guidance and recommendations within the Royal College of Psychiatrists' E.C.T. Handbook.

2. The choice of unilateral or bilateral E.C.T. should be made using the guidance and criteria within the Royal College of

Psychiatrists' E.C.T. Handbook.

3. Only brief-pulse E.C.T. should be used. The Department of Health should ban sine-wave E.C.T.
4. E.C.T. should not be given to patients more than an absolute maximum of twice per week.
5. Where possible, E.C.T. should be given to patients where this is voluntary, with the patient's informed consent after a full explanation of the treatment, its risks and alternatives, where it is not used (or is perceived as being used) as a threat.
6. Patients who are given "maintenance" or "continuation" E.C.T. should have their memory and cognitive function recorded on a monthly basis.
7. Non-drug ("talking") therapies as well as drug treatments should always be considered as possible alternatives to E.C.T. before it is suggested or prescribed.
8. All nurses involved in dealing with E.C.T. patients should use the measures identified in the Royal College of Nursing's E.C.T. - Guidance for Nurses (137) to reduce the anxiety of patients before E.C.T. and the level of memory impairment afterwards.

6.3 Training and supervision of clinical staff.

1. Each individual E.C.T. clinic should:
 - be genuinely consultant-led, with adequate sessional time allocated to consultants to supervise E.C.T. services
 - have a named consultant with clinical and administrative responsibility for its supervision and for ensuring that it meets the standards set
 - have a programme of initial and continued training for clinical staff in E.C.T. techniques.
2. No doctor should be allowed to administer E.C.T. unless they have had approved training and either are a consultant or have direct supervision of a consultant.
3. The Department of Health and the Royal College of Psychiatrists should establish a mandatory national accreditation scheme for doctors prescribing or administering E.C.T., with complementary accredited training courses.
4. The Department of Health, in consultation with appropriate nursing and user / survivor organisations, should establish at the earliest opportunity national training and competency standards for nursing practising in E.C.T. clinics. These should be developed from the guidance in the Royal College of Psychiatrists' E.C.T. Handbook (61) and the Royal College of Nursing's E.C.T. - Guidance for Nurses (137).

6.4 Rules, guidance and criteria for E.C.T.

1. E.C.T. should be given according to the good practice guidelines set out by the Royal College of Psychiatrists in The E.C.T. Handbook (61), and the accompanying Checklists for Good Practice in E.C.T. 139.
2. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in consultation with user / survivor organisations, should develop national guidance for all nurses involved in E.C.T. developed from that in:
 - the Royal College of Psychiatrists' E.C.T. Handbook (61)
 - the Royal College of Nursing's E.C.T. - Guidance for Nurses (137) and
 - Electroconvulsive Therapy (E.C.T.). A Good Practice Statement by the Working Group on Mental Illness of the Clinical Resource and Audit Group at the Department of Health in The Scottish Office 26.
3. All health authorities and other commissioning organisations should specify in their contracts or service level agreements for mental health services that:
 - E.C.T. should be only be administered in accordance with the most recent guidelines of the Royal College of Psychiatrists, and
 - as a minimum, E.C.T. should be undertaken to the same quality standards as apply to surgical procedures that are carried out under general anaesthetic in the nearest district general hospital.
4. The Department of Health, in consultation with appropriate professional and user / survivor organisations, should develop clear national guidance about the post-treatment care and observation of both outpatients and inpatients.

5. The Department of Health should set a national specification for E.C.T. machines, including standards for their maintenance and replacement.
6. All E.C.T. machines should be serviced at least every six months and be replaced after no more than five years.

6.5 Quality of care and practice of E.C.T.

1. Those E.C.T. clinics that fail to provide at least adequate care and treatment should be closed.
2. The Department of Health, together with the Royal College of Anaesthetists, should take action to raise the anaesthetic standards of care and practice for E.C.T. and the criteria used for E.C.T. to at least the same exacting level as is required for day surgery under general anaesthetic.

6.6 Consent, information and explanations.

1. The Department of Health, in consultation with appropriate professional and user / survivor organisations, should institute and develop statutory nationally agreed, evidence-based information on E.C.T., including about all significant risks and alternatives. This should be available and provided in a format and language appropriate to each patient where E.C.T. is being considered. It should include answers to the questions suggested by Mind and give equal weight to the views of both survivors and professionals.
2. Sufficient information and explanations, including about any significant risks and alternative treatments, should be given to a patient (using languages and formats appropriate to their individual needs) before they can make an informed decision about whether or not to give consent.
3. Information given to a patient before E.C.T. should always be repeated at an appropriate time soon after the treatment has been given, at the end of a course of treatment and when they are symptomatically improved.
4. Specific written information (or in another format appropriate to the patient) should be given to people receiving outpatient E.C.T. after their treatment about the precautions they should take for their own safety and well-being.
5. A patient's consent and their capacity to consent should be verified before each individual E.C.T. treatment, and not only at the start of a course of treatment.
6. Patient consent to E.C.T. should never be obtained by coercion or threat by clinical staff or others. Mechanisms to monitor and prevent this should be developed and implemented.
7. The Government should legislate so that E.C.T. cannot be administered without a patient's informed consent unless it is considered the only remaining way available to save their life.
8. The Government should legislate to give all patients (whether or not detained under the Mental Health Act) the legal right to be offered and to be given an independent second opinion where E.C.T. is considered as a treatment of choice.
9. Independent advocacy should always be available and explicitly offered to patients before they are asked to consent to E.C.T., and then both during and after a course of E.C.T.

6.7 The monitoring of E.C.T. and its administration.

1. Each E.C.T. clinic should routinely audit its standards of practice, use, indications for and outcomes of E.C.T.
2. The Department of Health should require all N.H.S. trusts and other providers to record and publicly report on the use of E.C.T., including the diagnosis, gender, age and ethnicity of patients. The Department of Health should collect and collate this information and publish a regular breakdown of all E.C.T. treatments by N.H.S. trust throughout the U.K., with an assessment of outcome.
3. The Department of Health should establish a national audit in England of electro-convulsive therapy. The remit of this audit should include: E.C.T. and its use; the effectiveness of E.C.T.; the risks and side-effects of E.C.T.; alternative treatments to E.C.T.; rules, guidance and criteria for E.C.T.; quality of care and practice of E.C.T.; training and supervision of clinical staff; consent, information and explanations; and the monitoring of E.C.T. and its administration. This audit should take full consideration of patients' and survivors' views, and have full patients and survivor involvement in the groups that undertake the audits.
4. The Royal College of Psychiatrists should immediately withdraw approved training status from every N.H.S. trust or other provider in question where they are not providing E.C.T. in accordance with its current guidelines.
5. The Mental Health Act Commission should incorporate the guidelines from The E.C.T. Handbook (61) of the Royal College of

Psychiatrists and the Royal College of Nursing's E.C.T. - Guidance for Nurses (137) into its monitoring of services provided to patients detained under the Mental Health Act.

6.8 Research.

1. The Department of Health should actively encourage the development of a high-quality E.C.T. research programme, similar to that already established in Scotland. This should focus on:

- establishing the basic mechanisms through which E.C.T. operates
- the reasons why women and older people are more likely to be given E.C.T., and how far these patterns are based on clinical grounds
- the reasons for the extremely wide variations in the use of E.C.T. between psychiatrists, hospitals and regions
- the reasons why many more people are given E.C.T. in the United Kingdom than in other countries in Europe, some parts of North America and the Far East
- the long-term effectiveness and side-effects of E.C.T. with regard to the quality of life or social functioning of survivors
- the relative effectiveness of E.C.T. and alternative treatments
- the effectiveness of "continuation" or "maintenance" E.C.T.
- establishing the criteria to determine each individual's threshold for the current involved in E.C.T.
- the effects of psychotropic and anaesthetic drugs on the efficacy and safety of E.C.T. and their interactions
- survivors' views on E.C.T.
- the level of coercion or threat in practice by clinical staff to obtain patient consent and to what extent coercions and threats are intended or perceived.

B.E.C.T. and its Use in the Mental Health Services of Salford.

6.9 Strategy for change in Salford.

1. The Trust should develop a strategy for change in the use and administration of E.C.T. This initiative should include the consultant psychiatrist responsible for the treatment service, survivors (with their representatives), a named manager and key nurses involved in the treatment process. This strategy should address each of the elements below.

6.10 Use of E.C.T. in Salford.

1. Consultant psychiatrists in the Trust should use the criteria identified in section 6.1 for prescribing E.C.T.
2. Medical staff in the Trust should give much greater consideration to non-drug ("talking") therapies (as well as drug treatments) as alternatives to E.C.T. before it is suggested or prescribed.

6.11 Training and supervision of clinical staff in Salford.

1. The Trust should ensure that its E.C.T. service is genuinely consultant-led by a named consultant with clinical and administrative responsibility for its supervision and for ensuring that it meets the standards set. [E.C.T. is now overviewed by the Trust's Drugs and Therapeutics Committee chaired by the Medical Director and reports to the Trust Board].
2. The Trust should allocate more sessional time to consultants to allow closer supervision of E.C.T. services. [The Trust altered its arrangements in 1997 to ensure that at least one consultant is in the building when E.C.T. is being administered and available to attend the E.C.T. suite].
3. The Trust should not permit any doctor to administer E.C.T. unless they either are a consultant or have direct supervision of a consultant, and have had approved training, and have demonstrated that they have achieved the appropriate level of competence.
4. The Trust should develop a programme of initial and continued training for clinical staff in E.C.T. techniques.
5. The Trust should require all nursing staff working in the E.C.T. clinic to have undergone appropriate approved E.C.T. training and demonstrated that they have achieved the appropriate level of competence.

6.12 Rules, guidance and criteria for E.C.T. in Salford.

1. The Trust should review and revise its guidance on E.C.T. to ensure that it accords with and incorporates all of the recommendations of The E.C.T. Handbook (61) of the Royal College of Psychiatrists, the Royal College of Nursing's E.C.T. - Guidance for Nurses (137) and Electroconvulsive Therapy (E.C.T.). A Good Practice Statement by the Working Group on Mental Illness of the Clinical Resource and Audit Group at the Department of Health in The Scottish Office 26.
2. Clinical staff prescribing and administering E.C.T. within the Trust should develop a clinical protocol for the use and administration of E.C.T. that incorporates each of the items in sections 6.1-6.4 above
3. The Trust, together with consultant anaesthetic staff from the Salford Royal Hospitals N.H.S. trust, should rewrite the anaesthetic guidelines for E.C.T. so that the criteria and standards of care are at least as high and exacting as those for day surgery under general anaesthetic in the Salford Royal Hospitals N.H.S. Trust. These should also take into account issues raised in section 6.1 above.
4. Salford and Trafford Health Authority and other commissioning organisations in Salford should specify in their contracts or service level agreements for mental health services that:

-E.C.T. should be only be administered in accordance with the most recent guidelines of the Royal College of Psychiatrists, and

-as a minimum, E.C.T. should be undertaken to the same quality standards as apply to surgical procedures that are carried out under general anaesthetic in the Salford Royal Hospitals N.H.S. Trust.

6.13 Quality of care and practice of E.C.T. in Salford.

1. The Trust should not allow any patient to be given E.C.T. who would be refused day surgery under the anaesthetic criteria for day surgery in the Salford Royal Hospitals N.H.S. Trust, unless it is the only remaining option likely to save their life.
2. The Trust should use only E.C.T. machines (including reserve machines) that meet the current national specification. All available machines should be capable of E.C.G. monitoring and E.E.G. traces.
3. The Trust should ensure that all its E.C.T. machines are serviced at least every six months and replaced after no more than five years.

6.14 Consent, information and explanations in Salford.

1. The Trust, in consultation with professionals and survivors, should develop a new source of evidence-based patient information on E.C.T., including about all significant risks and alternatives, to replace the Royal College of Psychiatrists' fact sheet. This should include answers to the questions suggested by Mind and give equal weight to the views of both survivors and professionals.
2. Clinical staff should automatically provide information on E.C.T. to each patient in a format and language appropriate to them where E.C.T. is being considered, to complement the verbal explanation and discussion with clinical staff, before the patient is asked to make an informed decision about whether or not to give consent.
3. Clinical staff should always repeat information given to a patient before E.C.T. at an appropriate time soon after the treatment has been given, at the end of a course of treatment and when they are symptomatically improved.
4. Clinical staff should give every outpatient specific written information (or in another format appropriate to the patient) after their treatment about the precautions they should take for their own safety and well-being.
5. Clinical staff should verify the capacity of each patient to give or withhold consent (as well as their consent itself) before each individual treatment, and not only at the start of a course of treatment.
6. The Trust should completely revise its consent form for E.C.T. to ensure that it can be fully understood by patients and addresses each criterion required to ensure informed consent. The model developed by the Salford Royal Hospitals N.H.S. Trust for surgery should be used within this process.
7. Where a patient's informed consent is in doubt, clinical staff should delay giving E.C.T. while advocacy, second opinions and alternative treatments are explored, unless E.C.T. is considered immediately necessary as the only life-saving treatment available.
8. The Trust, together with the Salford Mental Health Services Citizen's Advice Bureau, should ensure that independent advocacy is always available and explicitly offered to every patient before they are asked to consent to E.C.T., and then both during and after a course of E.C.T.

6.15 The monitoring of E.C.T. and its administration in Salford.

1. The Trust should record and regularly report in public on the use of E.C.T., including the diagnosis, gender, age and ethnicity of patients.
2. The Trust should establish formal mechanisms to assess and monitor the short-term and long-term side-effects of E.C.T. on patients.
3. The Trust should establish a programme of regular clinical audit for E.C.T., focusing on its administration, indications, side-effects, short-term and long-term effectiveness with particular regard to the quality of life and social functioning of survivors.

6.16 Research in Salford.

1. The Trust should urgently develop processes and mechanisms (including the use of information technology) to enable it to monitor the E.C.T. service and easily produce information about its use, the patients who receive it, and its effectiveness.
2. The Trust should hold regular reviews of E.C.T. to ensure that E.C.T. is only administered in accordance with the most recent guidelines of the Royal College of Psychiatrists.
3. The Trust should audit the use of E.C.T. and identify the appropriateness of its use and whether other more effective alternatives could have been used instead.

4. The Trust should investigate the reasons why:

- such a relatively high proportion of patients given E.C.T. within the Trust are detained under the Mental Health Act

- there are such wide variations in the use of E.C.T. for individual consultants year-on-year and between consultants.

- a significantly higher proportion of patients receiving E.C.T. are over 65 in the Trust than in other local N.H.S. trusts

Any variations that cannot be justified on clinical grounds should be addressed through appropriate action.

5. The Trust, together with the University of Manchester, should encourage high-quality research on the administration, use, effectiveness and survivors' views of E.C.T. the Trust, focusing on the issues in 6.8 above.

Appendices.

Appendix One.

Salford Health Authority Mental Health Unit - E.C.T. Guidelines for the preparation and care of patients undergoing E.C.T.

- 1) Prior to the prescription and commencement of E.C.T. the following must be undertaken as indicated:

- a) HB-all patients

- sickle cell test if indicated

- U & Es-if on lithium / diuretics / I.V.I.s

- Urine-routine urinalysis including glucose

- E.C.G.-men over 40 years of age

- women over 45 years of age

- also any patient who is hypertensive or has a history of heart disease

- C.X.R.-only if chest symptoms or previous history of respiratory disease.

- b) A full physical examination must be undertaken unless one has been recorded in the preceding 4 weeks.

- 2) When attending for treatment

- a) Signed consent form pinned to front cover of notes and current medication sheets must accompany patient.
- b) Identity bracelets must be worn.
- c) Nurses who do escort duty to E.C.T. must know patient.
- d) Wards sending more than 3 patients are required to send a minimum of 2 staff.

3) Out-Patients who live alone should be kept in hospital overnight following treatment. If a responsible person is at home then the patient may go home after lunch.

If these guidelines are not adhered to, E.C.T. will not be given.

January 1990.

Mental Health Services of Salford N.H.S. Trust - E.C.T. Guidelines.

1) PRIOR TO COMMENCING E.C.T.:

- a) A full physical examination must be undertaken, and the findings recorded on the E.C.T. chart.
- b) The following investigations must be performed, as appropriate, and the results clearly visible in the patient's notes.
 - FBC: All patients
 - Sickle Test: If indicated on the basis of ethnic origin
 - U & E/IF on diuretics, Lithium, I.V.I.s, Potassium supplements
 - Glucose: All diabetics
 - Urinalysis: All patients
 - E.C.G.: All patients over 45 years of age; Any patient who is hypertensive, diabetic or has a history of heart disease
 - C.X.R.: Only if history of respiratory disease, or on-going chest symptoms

2) WHEN ATTENDING FOR TREATMENT:

- a) A signed consent form, or up-to-date Section form, should be in the front of the patient's notes.
- b) The current medication sheet must accompany the patient.
- c) Identity bracelets should be worn by all patients.
- d) Nurses escorting patients to E.C.T. should ideally know them, or at the very least, have been given some background information about the patient's condition or any recent changes in condition, treatment, or pre-medication that is relevant to the anaesthetic and E.C.T.
- e) Wards sending more than 3 patients are required to send a minimum of 2 staff.

3) OUT-PATIENTS:

Current anaesthetic recommendations stress the importance of adequate supervision of any patient having any anaesthetic on a day-case basis, however minor the procedure.

Those patients who DO NOT LIVE ALONE require a responsible adult to accompany them home, after lunch, and subsequently take responsibility for them at home.

Those patients WHO DO LIVE ALONE should be kept in hospital overnight following treatment.

4) INTER-HOSPITAL TRANSFERS:

Patients transferred between Hope and Prestwich for E.C.T. must be accompanied by at least one qualified member of staff.

In the interest of patient safety, if these guidelines are not adhered to, then E.C.T. will not be given.

November 1996.

Salford Royal Hospitals N.H.S. Trust.

Criteria for Day Surgery.

Guidelines for Referral of Patients Requiring General or Regional Anaesthesia.

NON-MEDICAL FACTORS.

1. Distance between Hospital and home no more than 60 minutes travelling time.
2. Access to transportation. Public transport should not be used.
3. Patients should have telephone communication with the Hospital.

4. No patient should be alone at night after the operation.

MEDICAL FACTORS.

1. Age. No patient over 75 years.
2. Length of operation. Surgical procedures should be capable of completion within 90 minutes of start of general anaesthetic, but this is not a hard and fast rule.
3. Physical status. All patients should be A.S.A. Grades I or II - rarely III.
A.S.A. I-A normal healthy patient.
A.S.A. II-A patient with mild to moderate systemic disease caused by the condition to be treated surgically or by any other disease.
A.S.A. III-Severe systemic disease or disturbance from any cause.
Patients with Grade III who might be considered suitable for day surgery anaesthesia are those with chronic arthritic disease or chronic haemolytic disease.
Occasionally some apparently Grade I patients are not suitable - e.g. those with: -
 1. Sickle cell disease.
 2. Malignant hyperpyrexia.
 3. Porphyria.

MORE DETAILED CONTRA-INDICATIONS TO DAY SURGERY ANAESTHESIA. CARDIOVASCULAR DISEASE.

1. Myocardial infarction within the preceding six months.
2. Hypertension. B.P. above 175/100 mm Hg.
Resting pulse rates below 50/mm and above 100/mm require further investigation.
3. Cerebro-vascular insufficiency.
4. Cardiac failure.
5. Heart block other than type I.

RESPIRATORY DISEASE.

1. Severe bronchitis and emphysema.
2. Severe asthma.
3. Severe bronchiectasis.
4. Acute respiratory infections.

MUSCULO-SKELETAL CONDITIONS.

1. Conditions causing reduction in vital capacity, e.g. kyphoscoliosis.
2. Conditions making endotracheal intubation difficult, e.g.:
 - a)ankylosis of temporal mandibular joints.
 - b)Congenital defects of head, neck and jaws.
 - c)Ankylosing spondylitis.

NERVOUS SYSTEM.

1. Motor neurone disease.
2. Muscular dystrophies and myotonic disorders.
3. Severe epilepsy.

HAEMATOLOGY.

1. Coagulation defects.
2. Severe haemolytic anaemias.
3. Anti-coagulant therapy.

ENDOCRINE.

1. Unstable diabetics on insulin or oral hypoglycaemic agents.
2. Obesity, i.e. greater than 20% above ideal weight for age and sex.

PREGNANCY.

Appendix Two.

Salford Health Authority Mental Health Unit.

Procedure Guidance Notes on the Mental Health Act 1983. Subject:Consent to Treatment.

Code:PGN CONS

Date Published:December 1992.

Review Date:December 1994.

This guidance has been prepared as reference information for staff within the Mental Health Unit.

Introduction.

1. Detailed information has been prepared on this subject in the "Quality statements, guidelines and procedure folder" under "Consent to treatment [Mental Health Act 1983]".

2. To aid staff identify the correct procedure, flow charts and appropriate forms have been attached: -

Consent to treatment after the first 3 months - flow chart attached - Appendix 1.

Consent to treatment at review of treatment - flow chart attached - Appendix 2.

Certificate of consent to treatment - Form 38 [when patient consents].

Certificate of second opinion - Form 39 [when patient does not consent].

Annex AMHAC 1 form
[completed by R.M.O., when appropriate, on renewal of section and forwarded to Mental Health Act Commission].

Section 62 - urgent treatment
[when patient urgently requires medication or E.C.T.].

Mental Health Services of Salford. An N.H.S. Trust.

Procedure.

Subject:Consent to Treatment.

Code:PGN.CONS

Date Published:March 1995.

Review Date:October 1999.

This guidance has been prepared as reference information for staff within the Mental Health Unit.

Introduction.

1. Detailed information has been prepared on this subject in the "Quality Statements, Guidelines and Procedure Folder" under "Consent to treatment (Mental Health Act 1983)".

2. To aid staff identify the correct procedure, flow charts and appropriate forms have been attached: -

Consent to treatment after the first 3 months - flow chart attached - Appendix 1.

Consent to treatment at review of treatment - flow chart attached - Appendix 2.

Certificate of consent to treatment - Form 38 [when patient consents].

Certificate of second opinion - Form 39 [when patient does not consent].

Annex AMHAC 1 form (completed by R.M.O., when appropriate, on renewal of section and forwarded to Mental Health Act Commission).

Section 62 - urgent treatment (when patient urgently requires medication or E.C.T.).

Appendix Three.

PRESTWICH / HOPE HOSPITAL, MANCHESTER.

E.C.T. Consent (Patient).

I hereby consent to undergo the administration of E.C.T., the nature and effect of which have been explained to me by Dr.

I also consent to the administration of an anaesthetic for this purpose.
No assurance has been given to me that the treatment will be administered by any particular practitioner.

(Date)(Signed)
(Patient)

I confirm that I have explained to the patient the nature and effect of this treatment.

(Date)(Signed)
(Medical Officer)

Date
Treatment No and Type
Brietal Sodium
Atropine
Anectine
Comments include duration of fit, Cuff method if used, etc.
Initials of both doctors

..... HOSPITAL UNIT No. _____

FULL NAME (BLOCK LETTERS)
Mr. / Mrs. / Miss

WARD OR ADDRESS

(A)ESSENTIAL FACTS:-

(1)DATE OF BIRTH:.....

(2)LEGAL STATUS.....

IF SECTION HAS FORM 38 BEEN COMPLETED. YES/NO
HAS FORM 39 BEEN COMPLETED. YES/NO

(3)ANY ALLERGIES, OR PREVIOUS DRUG/ECT ADVERSE REACTIONS (SPECIFY)

(4)PRIMARY DIAGNOSIS.....

SECONDARY DIAGNOSIS

(B)ESSENTIAL PHYSICAL FACTS:-

(1)IS PATIENT RIGHT OR LEFT HANDED

IS PATIENT RIGHT OR LEFT FOOTED

IS IT ESSENTIAL FOR PATIENT TO HAVE BILATERAL ECT?.....
(NEW POLICY: UNILATERAL UNLESS REQUESTED OTHERWISE).

(2)CVS:BP

OTHER ABNORMALITIES.....

RS:STATE ABNORMALITIES.....

SPINE: STATE ABNORMALITIES.....

(3)WEIGHT (in Kg).....

RECENT HAEMOGLOBIN LEVEL

RECENT ELECTROLITE LEVELS (if abnormal)

(4)E.C.G. RESULT

(5)CURRENT MEDICATION (DAY PATIENT. OUTPATIENT ONLY).

SIGNATUREDATE

Appendix Four.

Salford Health Authority Mental Health Unit.

Procedure Guidance Notes on the Mental Health Act 1983.

Subject:Electro Convulsive Therapy

Code:PGN ECT

Date Published:December 1992.

Review Date:December 1994.

This guidance has been prepared as reference information for staff within the Mental Health Unit.

Informal Patients

1. Informal patients who consent to E.C.T. sign the local consent to Electrotherapy / Anaesthetic form.

Detained Patients

2. If the patient is Compulsorily detained (other than a short term detention, i.e. Sections 4, 5(2), 5(4), 136) under the Mental Health Act 1983, a current copy of one of the following forms must be present and should be seen by the Doctor before E.C.T. commences.

FORM 38-Consent to treatment

FORM 39-Certificate of Second Opinion

Section 62-Urgent Treatment.

3. Consent to treatment regulations do not apply to short-term sections and such patients should be treated as for informal patients, i.e. can only have E.C.T. if valid consent is given and they sign the appropriate form as above (1).

4. Flow chart attached - Appendix 1.

Mental Health Services of Salford. An N.H.S. Trust.

Procedure.

Subject:Electro Convulsive Therapy (E.C.T.)

Code:PGN.ECT

Date Published:July 1996.

Review Date:July 2000.

guidance has been prepared as reference information for staff within the Mental Health Unit.

Informal Patients

1. Informal patients who consent to E.C.T. sign the local consent to Electrotherapy / Anaesthetic form.

Detained Patients

2. If the patient is compulsorily detained (other than a short term detention, i.e. Sections 4, 5(2), 5(4), 136) under the Mental Health Act 1983, a current copy of one of the following forms must be present and should be seen by the Doctor before E.C.T. commences.

FORM 38-Consent to treatment

FORM 39-Certificate of Second Opinion

Section 62-Urgent Treatment.

3. Consent to treatment regulations do not apply to short-term sections and such patients should be treated as for informal patients, i.e. can only have E.C.T. if valid consent is given and they sign the appropriate form as above (1).

4. Flow chart attached - Appendix 1.

Appendix Five.

Mental Health Services of Salford - Quality Statement.

Subject:Consent to Treatment (Mental Health Act 1983)

Code:CTT.QST

Date Published:February 1994

Review Date:February 1999

Which deals with consent to treatment. The majority of the information arises directly from the M.H.A. Code of Practice.

1. Part IV of the Act provides specific statutory authority for forms of medical treatment for mental disorder to be given to most patients liable to be detained without their consent in certain circumstances and with certain safeguards. It also provides specific safeguards. Patients liable to be detained are those who are detained or have been granted leave of absence (Section 17). It also provides specific safeguards to all patients when treatments are proposed that give rise to special concern.

2. Its provisions can be summarised as follows:

- a) *Treatments requiring the Patient's Consent and a Second Opinion (Section 57)* Psycho-surgery and the surgical implantation of hormones for the suppression of male sexual drive (exceptionally these safeguards apply to all patients).
- b) *Treatments requiring the Patient's Consent or a Second Opinion (Section 58)* The administration of medicine beyond three months, and treatment by E.C.T. at any time. These safeguards apply to all patients liable to be detained except those detained under S4, S5 (2) or (4), S35, S135, S136 and S37 (4); also patients conditionally discharged under S42 (2) and S73 and S74. All these patients can only be treated under common law.
- c) *Treatments that do not require the Patient's Consent (Section 63)* All medical treatments for mental disorder given by or under the direction of the patient's responsible medical officer and which are not referred to in Section 57 or 58 (this provision applies to the same patients as S58).
- d) *Urgent Treatment (Section 62)* In certain circumstances the provisions of Section 57 and 58 do not apply where urgent treatment is required.

3. Detained status itself does not imply inability to give consent. For all treatments proposed for a detained patient and which may be lawfully given under the Act, it is necessary first to seek the patient's agreement. It is the personal responsibility of the patient's R.M.O. to ensure that the patient's valid consent has been sought and the interview at which such consent was sought should be properly recorded.

Validity of Consent.

4. The responsible medical officer must determine whether the patient is willing to take the medication and whether his consent is valid, i.e. whether he is "capable of understanding the nature, purpose and likely effects of the treatment."
5. If the patient consents validly, the responsible medical officer records this on form 38.
6. If he refuses, or there is doubt about the validity of his/her consent, then a second opinion must be obtained from a doctor appointed for that purpose by the Mental Health Act Commission.
7. Electro Convulsive Therapy always requires either the patient's consent or a second opinion, even where the treatment is given in the first 12 weeks of detention.

Renewal of Consent.

8. The patient's consent, certified on form 38, does not expire. No formal renewals or review are required, but the patient's consent should be reviewed from time to time. Good practice would be for form 38 to be completed at the renewal of each section.
9. The patient is free to withdraw his consent at any time.
10. In the case of patients subject to a form 39, formal reviews of treatment are required. These are recorded on the Mental Health Act Commission's form "Review of Treatment", (Section 61 Mental Health Act).
11. For unrestricted patients, these reviews should occur at each section renewal.
12. For restricted patients, they should occur at the end of the first six months of the order if the treatment under the form 39 began before that time, and then on each occasion when a statutory report to the Secretary of State falls due.

Treatments Requiring Consent or a Second Opinion (Section 58).

13. Treatments requiring patient's informed consent or a second opinion currently specified by the Act are E.C.T. treatment and drug treatment of more than three months duration. This applies to patients detained under Sections 2 and 3 and by Court Treatment Orders.
14. Where the patient consents, the responsible medical officer or a medical practitioner appointed by the Commission (Second Opinion Appointed Doctor) will certify that informed consent has been given (form 38).
15. Where the patient does not consent, a second opinion appointed doctor will be requested by the responsible medical officer via Medical Records. On arrival the S.O.A.D. will consult with the R.M.O. and two persons professionally concerned with the patient, one a nurse and the other neither a doctor or a nurse and complete form 38 (if the patient now consents) or a form 39.
16. Once signed, forms 38 and 39 are lodged with other papers relating to the patient's compulsory detention, in the Medical Records Office. Two photocopies must be made, one to be kept with the patient's prescription sheet and the other to be retained with the photocopied section papers.

Medication Before Three Months.

17. This period starts on the occasion when medication for mental disorder was first administered by any means. The patient's responsible medical officer must ensure that the patient's valid consent is sought prior to the administration of any medication. If such consent is not forthcoming or is withdrawn during this period, the responsible medical officer must consider if he wishes to proceed in the absence of consent, consider alternative treatments or give no further treatment.

Medication After Three Months (Section 58).

18. At the end of the three month period referred to above, the patient's responsible medical officer should personally seek the patient's consent to continuing medication and such consent should be sought for any subsequent administration of medication. If the patient consents the responsible medical officer must certify accordingly (form 38). The responsible medical officer should indicate on the certificate the drugs proposed, by the classes described in the British National Formulary (indicating the dosages if they are above the B.N.F. advisory maximum limits) and the method of their administration. If the patient's consent is not forthcoming the responsible medical officer must comply with the safeguard requirements of Section 58 (although for urgent treatment Section 62 may apply).

The Three Month Rule.

19. The three month period gives time for the doctor to create a treatment programme suitable for the patient's need. Although the patient can be treated in the absence of consent during this period, no such treatment should be given in the absence of an attempt to obtain valid consent. The three month period is not affected by renewal of the detention order, withdrawal of consent, leave or change in or discontinuance of the treatment. A fresh period will only begin if there is a break in the patient's liability for detention.

20. If medication is likely to be continued beyond the three month period the need for consent or a second opinion should be foreseen in good time. The responsible medical officer should satisfy himself at all times that the consent remains valid.

Responsibility for Checking.

21. The Medical Records Department will remind the responsible medical officer to review consent when renewing sections and provide review of treatment forms at the appropriate times for patients subject to second opinions.

22. The responsible medical officer and medical staff will check the twelve week date on the prescription sheet and any existing forms 38 and 39.

Administering Drugs.

23. It is the responsibility of the doctor or nurse to check the prescription sheet and any attached documentation to ensure they have authority to administer the treatment.

Withdrawal of Consent.

24. The patient subject to the provisions of Part IV of the Act may withdraw consent at any time. Fresh consent or the implementing of Section 58 procedures is then required before further treatment can be carried out or re-instated. Where the patient withdraws consent he should receive a clear explanation (recorded in the patient's records) of:

*the likely consequences of not receiving the treatment.

*(where applicable) that a second medical opinion under Part IV of the Act may or will be sought in order to authorise treatment in the continuing absence of the patient's consent.

*(where applicable) the doctor's power to begin or continue treatment under Section 62 until a second medical opinion has been obtained.

Treatments Not Requiring Patient's Consent (Section 63).

25. Apart from treatment specifically mentioned in Sections 57 and 58, other forms of medical treatment for the mental disorder from which the patient is suffering (so long as they are given by or under the direction of the patient's responsible medical officer) may be given without the patient's consent being required (although it should always be sought). Section 63 covers a wide range of therapeutic activities involving a variety of professional staff and includes in particular psychological and social therapies. (See Section 145 of the Mental Health Act 1983 for a definition of medical treatment).

Urgent Treatment.

26. Any decision to treat a patient urgently under Section 62 is a responsibility of the patient's responsible medical officer who should bear in mind the following considerations:

a) Treatment can only be given where it is immediately necessary to achieve one of the objects set out in Section 62 and it is not possible to comply with the safeguards of Part 4 of the Act. It is insufficient for the proposed treatment to be simply "necessary" or "beneficial".

b) In certain circumstances "hazardous" or "irreversible" treatment cannot be administered under this section even if it is immediately necessary. The patient's responsible medical officer is responsible for deciding whether treatment falls into either of the categories, having regard to mainstream medical opinion.

c) Urgent treatment given under section 62 can only continue for as long as it is immediately necessary to achieve the statutory objective(s).

d) Before deciding to give treatment under Section 62 the patient's responsible medical officer should wherever

possible discuss the proposed urgent treatment with others involved with the patient's care.

The Responsible Medical Officer.

27. Treatment under Section 62 of the Mental Health Act 1983 can only be given under the direction of the patient's (responsible medical officer) consultant.

Special Forms.

28. Any treatment under Section 62 of the Mental Health Act 1983 is recorded on a special form which is available from the Medical Records Office.

29. The form is completed and signed by the patient's consultant and returned to the Medical Records Office.

Second Opinion.

30. Each treatment of E.C.T. or medication administered under Section 62 of the Mental Health Act 1983 must be recorded on a separate form.

31. If it is intended to continue the use of E.C.T. or medication a request for a second opinion doctor is made at the same time the first treatment is given.

Complying with Provisions of the Mental Health Act.

32. Any system for ensuring compliance with the Consent to Treatment Provisions of the Mental Health Act must ensure that:

- a) The date of the first dose of psychotropic medication is noted.
 - b) The question of consent is considered about ten weeks from that date.
 - c) Once a form 38 or form 39 has been completed all prescriptions fall within the plan of treatment described in it
- OR
- d) If a prescription that is not covered by the existing form 38 or 39 is required then a new form 38 or 39 is prepared.
 - e) The review of treatment for patients subjected to form 39 are carried out.

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