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Trainees' forum

Guidelines for out-patient electroconvulsive therapy

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Psychiatry is much more community based than ten years ago. Despite this there is little specific research published on out-patient electroconvulsive therapy (ECT) and there is a lack of well-defined guidelines for its administration.

A recent audit at Coney Hill Hospital studied the use of ECT. In 1990–1991, 153 patients received a total of 188 courses of ECT (courses being separated by at least 21 days). Out-patients (defined as non-resident hospital patients) formed 31% of those receiving ECT. Comparison between the in-patient and out-patient groups showed that the out-patient group had a higher percentage of women (79%:67%) and a higher percentage of over 65s (32%:24%). There was no difference in the mean number of treatments per course (5.7) received by the two groups.

The relatively high proportion of the elderly receiving ECT has been reported previously. Pippard & Ellam (1981) found in their overall survey of ECT that 37% of courses were given to people aged 60 years and over. Similarly, the high percentage of women receiving ECT has also been reported. Jaffe *et al* (1990) studied a group of 32 out-patients receiving ECT of whom 69% were women. In general, however, out-patient ECT has received little attention in the literature. The following guidelines for administration of out-patient ECT are based on current practice at Coney Hill Hospital.

Guidelines

Selection of patients

Patients present from a number of sources – out-patient clinic, day hospital or following direct referral from general practitioner, community psychiatric nurse or other community worker. Psychiatric assessment is performed by a consultant psychiatrist or other senior psychiatrist. Physical assessment is performed by a junior doctor. To be suitable for out-patient ECT the patient must:

have a psychiatric disorder requiring treatment with ECT. By far the most common diagnosis is depression. Those with suicidal ideation, frank psychosis or inadequate fluid intake are generally unsuitable for out-patient treatment

be physically fit, either ASAI – a normal physically healthy person or ASAII – a patient with a mild systemic disease process which does not limit the patient's activities in any way (Ament, 1963). This excludes those with uncontrolled hypertension, i.e. diastolic blood pressure over 110, diabetic patients dependent on insulin or oral hypoglycaemic agents, patients with uncontrolled epilepsy, and morbidly obese patients. Depending upon the local policy, the patient may require certain investigations such as full blood count, urea and electrolytes, chest x-ray, or electrocardiogram. In cases of doubt, the patient is discussed with an anaesthetist

have suitable home circumstances. These include living (or being able to stay) within one hour's drive of the hospital, having a responsible adult to escort them home and stay with them until fully recovered, and possessing suitable home facilities such as access to a telephone. On no account is the patient allowed to drive himself home.

Preparation of the patient for ECT

The psychiatrist prescribing ECT fully explains the nature of the procedure, its benefits, risks and side effects. This verbal explanation is backed up with written information and instructions. Real consent, as required by English Law, is obtained and documented on the standard ECT form along with other relevant information, e.g. a record of physical findings, current medication and the results of any investigations performed. The patient is told to present, having fasted overnight, to the ECT suite at the hospital on the required days.

Administration of ECT

The patient presents to the ECT suite at the hospital in the morning where ECT is given in accordance with national guidelines (Freeman *et al*, 1989). Out-patients are treated prior to in-patients. During the

recovery period the patient is observed. Once pulse and blood pressure have returned to normal and the patient is conscious and is fit to go home, he/she is escorted to his transport by the staff. He/she is then escorted home by the responsible adult. Instructions are given to contact the GP or duty doctor at the hospital should any problems occur. The total time spent in the ECT suite rarely exceeds three hours. Patients have a maximum of three treatments per week.

Regular review

The patient is reviewed after every treatment by the psychiatrist prescribing ECT and a decision is made whether the course of ECT is to continue. Any changes in the patient's physical health or medication are noted on the ECT form and brought to the anaesthetist's attention.

Comments

Jaffe *et al* (1990) found out-patient ECT to be safe for the long-term management of recurrent depressive illness in the elderly. In their study of 32 out-patients (with a mean age of 68 years), 69% of the patients responded favourably to ECT. A low rehospitalisation rate of 9% demonstrated the efficiency of the treatment. In California, Kramer (1990) found that a course of out-patient ECT was 62% cheaper than comparable course of in-patient ECT. Thus it would appear that out-patient ECT is an effective, safe and cost-efficient form of treatment. As long as the patient is physically fit, age is not a contraindication to out-patient ECT.

In *Electro-convulsive Therapy*, the Department of Health (1991) has published statistics on ECT in England for the year ending 31 March 1990. These show that most ECT was given to in-patients. Of the 178 districts using ECT, 30 gave it exclusively to in-patients. There was wide variation in practice between the districts with regard to out-patient ECT. Across the country as a whole, out-patients received 15.4% of all ECT treatment. The statistics also showed that some districts give up to 86% or even 91% of their ECT to out-patients. It is also shown that the overall use of ECT has declined by 6.2% since 1985. During that time the proportions of in-patients and out-patients receiving ECT have remained constant.

Direct comparison between the Department of Health and Coney Hill statistics is not possible. This is because the Coney Hill figures refer to the number of out-patients receiving ECT whereas the Department of Health figures reflect the number of ECT treatments given to out-patients. Nevertheless, 31% of patients treated with ECT at Coney Hill are out-patients. This is double the Department of Health figure of 15.4% of ECT treatments being given to out-patients. With the planned closure of the hospital in 1994, the number of in-patient beds will be decreased. It is likely, therefore, that the proportion of out-patients receiving ECT will increase. With these guidelines it is hoped to establish an effective, safe and efficient out-patient ECT service.

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Erratum

The article 'Patients repeatedly admitted to psychiatric wards' by M. Evans, D. Rice and C. Routh which appeared in the trainees' forum section in the *Psychiatric Bulletin*, March 1992, **16**, 157–158 was mistakenly reprinted in the original articles section in the June issue of the *Psychiatric Bulletin*, **16**, 327–328.