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Consent to ECT: patients' experiences in an Irish ECT clinic

AIMS AND METHOD
The aim of this study was to examine the subjective experience of the procedure for obtaining consent for electroconvulsive therapy (ECT) in an Irish setting. A total of 89 consecutively treated patients were sent a postal survey at an average of 17 weeks after ECT treatment.

RESULTS
This survey revealed low rates of perceived coercion in relation to consenting to ECT. Overall, there were high rates of satisfaction with the consenting procedure in terms of information and staff support.

CLINICAL IMPLICATIONS
In an accredited clinic, the consenting procedure can be conducted in an environment free of coercion, resulting in higher levels of patient satisfaction than previously reported.

The issue of consent to electroconvulsive therapy (ECT) is a contentious one. This factor, along with uncertainty regarding memory impairment, was at the core of the concerns of the National Institute for Clinical Excellence (NICE) in their 2003 review. The resulting guidelines have been criticised by the Royal College of Psychiatrists (Royal College of Psychiatrists, 2005) as inappropriately limiting practice and access to an effective treatment.

The procedure to obtain consent for ECT, as recommended by NICE (2003), consists of:

(a) involving the individual's advocate and/or carer where possible;
(b) providing full and appropriate information in a suitable format and language to enable an informed discussion;
(c) explaining and discussing the general risks of ECT, risks specific to the individual, enhanced risks for individuals in specific groups and potential benefits to the individual;
(d) not pressurising or coercing the individual into consenting to the treatment;
(e) reminding the individual that they have the right to withdraw consent at any time.

The Service User Research Enterprise (Rose *et al*, 2005) conducted a systematic review of patients' views of information, consent and perceived coercion. They report that 'approximately half of those who receive ECT feel that they are given insufficient information about the procedure and approximately a third perceive themselves to have been coerced into having the treatment'. Unlike their review of patient satisfaction rates with ECT, there was 'no apparent polarisation between clinical and patient-led research on the question of information' or levels of perceived coercion. These findings are clearly a major cause for concern for ECT practitioners. The reported lack of improvement over time in the perceived levels of information received by patients, despite publication of Royal College of Psychiatrists' (2005) revised guidelines for ECT and several other initiatives in the area, is disappointing.

In Ireland there have been recent developments in mental health legislation. Under the Mental Health Act (Ireland) 2001, the Mental Health Commission is obliged to make rules providing for the use of ECT. The Act, which came into full force on 1 November 2006, lays out the procedure to be followed in the administration of ECT when the patient is unwilling or unable to give consent. The rules governing the use of ECT have recently been made available (Mental Health Commission, 2006) and follow international norms comparable to the ECT Accreditation Service (ECTAS) guidelines (Caird *et al*, 2004). Capacity to consent to treatment is assumed unless there is evidence to the contrary. The Mental Health Commission requires that a written record is kept of the assessment of competence, and written consent kept for each treatment session. The Commission also states that there must be no coercion used when obtaining consent and patients must be made aware that they can have access to an advocate of their choosing and that adequate information is provided. If treatment needs to be given involuntarily, a specific form needs to be completed and a second consultant needs to approve the treatment. The rules also deal with standards in relation to the administration of ECT.

The following study was undertaken to gather data in relation to subjective experiences of the consent process leading up to ECT in Ireland.

Method

This study was conducted at St Patrick's Hospital, Dublin, a 300-bed psychiatric facility. The ECT department has been approved with excellence by ECTAS (Caird *et al*, 2004).

A postal questionnaire, consisting of 16 questions relating to issues of adequate information and consent, was developed as part of a study into subjective attitudes and experiences of ECT. Over a 7-month period, 89 consecutively treated patients were sent the questionnaire. Five of these patients were detained under the relevant mental health legislation. The Research Ethics Committee, St Patrick's Hospital, gave ethical approval for the study.

The patients surveyed were prescribed ECT in the months prior to the department receiving accreditation

Table 1. Survey responses of 51 patients undergoing ECT

Question	Response, *n* (%)		
	No	Yes	Unsure
Were you given the patient information sheet about ECT?	6 (12)	34 (68)	10 (20)
Did you understand the reason for considering ECT?	5 (10)	37 (74)	8 (16)[1]
Did you understand the side-effects of the treatment?	9 (18)	26 (52)	15 (30)[1]
Did you understand what ECT was likely to do?	7 (14.3)	25 (51)	17 (34.7)
Did the clinic staff check that you still agreed to have ECT before your treatment?	12 (25.5)	20 (42.6)	15 (31.9)
Were other options discussed with you?	21 (43)	19 (39)	9 (18)
Was sufficient time given for you to make a decision and time to discuss ECT with your family?	10 (20)	35 (70)	5 (10)
Did you have adequate time to discuss ECT with your doctor?	6 (12)	40 (80)	4 (8)
Did you say to your doctor that you agreed to have ECT?	2 (4)	43 (86)	5 (10)
Did you have the opportunity to discuss the decision to proceed with ECT with the nursing staff?	12 (24)	28 (56)	10 (20)
Overall, did you feel that you had enough information to make an informed decision?	10 (20)	40 (80)	
Did you feel coerced or forced into having ECT?	44 (92)	2 (4)	2 (4)[1]
Were the team responsive to any concerns you may have had?	4 (8)	36 (75)	8 (17)[1]
Did you sign a form to show that you agreed to have ECT?	3 (6.5)	31 (67.4)	12 (26.1)
Was the information leaflet helpful in explaining what happens in the ECT suite?	6 (13.6)	29 (65.9)	9 (20.5)[1]
Did the staff in the ECT suite explain what would happen to you when you were there?	8 (17)	39 (83)	

ECT, Electroconvulsive therapy.

[1] Response option was 'partly' instead of 'unsure'.

(with excellence) from ECTAS in 2004, but while the department was implementing changes to ensure compliance with ECTAS standards.

Results

Two mailings resulted in 51 responses (57% response rate). Issues of subjective experience and memory impairment have been reported previously (Rush *et al*, 2007).

The ages of the participants ranged from 20 to 82, with a mean of 53.4 years. The group was made up of 17 male and 33 female patients (34% and 66% respectively). Of these, 16 (33%) were undergoing their first course of ECT. Two patients were treated under the Mental Treatment Act 1945. The average length of time since completion of treatment was 17 weeks. There were no statistical differences in terms of age, gender or diagnosis between responders and the group as a whole.

The results of the survey are presented in Table 1.

Discussion

Our findings are at odds with previous studies. We found far higher rates of satisfaction with the information provided to the patients. In all, 80% of patients reported that they had enough information to make an informed choice. This is significantly higher than the 50% reported by Rose *et al* (2005). Several factors might account for this discrepancy, not least of which is the process of accreditation available through ECTAS. The inclusion of papers from the 1980s may also reduce the relevance of the systematic review for more contemporary service settings. Further research is required to examine the subjective experiences of patients since the introduction of the NICE guidelines and ECTAS.

The most dramatic difference between our study and previous ones relates to the subjective experience of coercion. Ninety-two percent of our patients denied feeling coerced into treatment. This is in marked contrast to the findings of Rose *et al* (2005), who indicated that up to one-third of patients felt coerced into treatment. Both of the patients in the present study who felt coerced into treatment were voluntary patients. Interestingly, the two patients treated while detained involuntarily reported that they were not coerced into treatment. This is surprising but we would hope that standard consent procedures are followed regardless of the individual's status under the Mental Treatment Act 1945. However, further work is required to clarify this, along with an exploration of the effect that the new legislation has had on the subjective experiences of patients.

The low rates of discussions regarding alternative treatments (43% reported that these were not discussed) may relate to the fact that most referrals to the department were for treatment-resistant depression and other options had already been considered and tried prior to ECT. However, 66 (74%) of patients understood the reasons for prescribing the treatment to them.

Another area of concern is that only less than half of patients reported that staff in the clinic checked that they still agreed to have ECT. Since this study has been completed the department has included this on the written documentation as a necessary item prior to ECT and we plan to include it in a future departmental audit.

These findings have increased our awareness of the need for continuous quality improvement to complement quality assurance.

The relationship between this vulnerable population and the staff appears to be good, which again would not be expected given the data reported elsewhere. A majority (80%) indicated that they had adequate time with their doctor to discuss the decision and that 75% of teams were responsive to their concerns (along with 17% partly responsive). Eighty-six per cent of patients reported that they recalled saying to their doctor that they agreed to have ECT. The majority of patients had adequate time to discuss the treatment options with their families. Patient satisfaction with ECT suite staff was also high.

The low rate of response may introduce bias into our findings but the lack of differences noted between the group at baseline and responders is reassuring. Our findings suggest that in accredited clinics the experiences of patients, in terms of the consent procedure, need not be a negative one. Improving the level of information and ensuring an environment free of coercion are not unattainable aims and, if ECT is to continue to be used, these goals must be met.

We aim to repeat this study to assess the effect of the introduction of a stimulus dosing prescription policy and the Mental Health Act 2001 on patient's perceptions of their treatment.

Conclusions

With the development of services, higher rates of patient satisfaction with ECT can be obtained. We agree with Rose *et al* (2005) that coercion is inappropriate and would invalidate consent. However, as shown above, ECT treatment is not necessarily associated with poor consent procedures and can be provided in a modern, accredited service in a manner that is consistent with legal and ethical principles.

Declaration of interest

None.

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Assessment of mental capacity: who can do it?

AIMS AND METHODS

To determine the point prevalence of mental incapacity and the 'Bournewood gap' in general adult and old age mental health in-patients. The correlation of mental capacity assessment between doctors and nurses was investigated. Data were gathered on one census day for all general adult and old age psychiatric in-patients at three hospital sites.

RESULTS

Half the sample lacked capacity and one third fell into the 'Bournewood gap'. The capacity assessment by nurses and doctors correlated highly (κ=0.719, P=0.0001).

CLINICAL IMPLICATIONS

'Bournewood gap' patients should have their needs assessed in order to identify and protect their rights. Appropriately trained mental health nursing staff can undertake this assessment.

Mental capacity is a legal concept related to the ability to enter into a valid contract. It is gained on entering adulthood and is presumed to be present throughout life unless demonstrated to be permanently or temporarily lost. To treat a capable patient without consent could be potentially an assault. In England and Wales, the Mental Capacity Act 2005 provides a statutory framework to protect vulnerable people who are not able to make their own decisions. The Act is underpinned by five key principles:

- a presumption of capacity
- the right for individuals to be supported to make their own decisions