De l’expérience à la création d’unité

Dr C. Daudet

DU ECT

19/05/2011

Une procédure à faible risque (Applegate, 1997)

- Mortalité
- 1/10 000 patients ou 1/80 000 ECT
- Pour une unité ECT qui traite 80 patients/ans et fait 1000 séances = 1 décès tous les 125 ans

- Morbidité
- 1 accident pour 1 300/1 400 ECT
- Pour une unité ECT qui traite 80 patients/ans et fait 1000 séances = 1 accidents tous les 2 ans

Est-ce vraiment efficace?

- Efficacité de l'ECT dans la dépression
- UK ECT Review Group
  - Revue systématique Cochrane
    - www.cochrane.org
- The Lancet, 2003; 361: 799-808

- ECT vs. sham ECT (placebo)
  - 9 études, 256 sujets
- ECT vs. médicaments
  - 18 études, 1144 sujets

Rémission après ECT

- CORE (Consortium for Research in ECT)
- 394 patients
- HDRS initial: 34
- Durée épisode 11 mois
- ***Rémission: 86 %***
- ***Si car. Psych.: 95%***

Moy.: 7,3 séances

- CUC (Columbia University Consortium)
- 290 patients
- HDRS initial: 34
- Durée épisode 7 mois
- ***Rémission: 55 %***
- Moy. 10,5 séances

Fink, JAMA, 2007

L'ECT dans le Monde (ECT/100 000 hab.)

	1999	2000	2002	2003	2004	2006
Belgique		48		68		
Pays Bas	18					
Inde			114			
Danemark	305					
UKEcosse	130					
Australie					292	
Bretagne	108					
Aquitaine						178

Estimation des besoins

- a questionnaire survey of ECT practice in Australia, Chanpattana 2007
- taux d'ECT 2004: 292/100 000 hab (305/100 000 Dannemark, 1999, 350/100 000 Ecosse 1995)

- en 2006: en Gironde 3850 ECT (dont 1600 sur unité ECT) mais 5350 en Aquitaine
- soit 275/100 000 hb et 178/100 000 hb
- **Extrapolation: Gironde:** 6140 dont 3070 secteurs Perrens
- **Aquitaine** : 13 150 ECT

- prévalence dépression (vie): France 20%, Australie Nouvelle Zélande 12,6%

- Santé, part du PIB (OCDE 2004): France 11,1%, Australie 9,5%

Données Aquitaine 2006

Lieu	ETP IDE, AS	Med	Anesth	nb de J/sem	Patients/j
Perrens/Bordeaux	4	0,5	0,3	3	12
Mirambeau	1,5	0,5	0,5	5	3
Les Pins	1,5	0,3	0,3	3	12
Anouste	1,5	0,5	0,3	4	3,5
CH Bayonne	0,2	0,1	0,1	3	2
Cadillac	1,5	0,3	0,3	3	5
Maylis	1,5	0,3	0,3	2	6
Total	11,7	2,5	2,1	23	43,5

Actes /an	Obs
1600	Entretiens 2/3 +
657	pas d'entretien, d
1260	30% d'entretiens
500	1/3 entretien
200	unité d'un secteu
609	1/5 entretien, Lib
650	pas d'entretien, a
5476	

Dr H. Sackeim

- Estimation annuelle de patients recevant des ECT dans le monde

- 2 Millions !

« La vieille thérapeutique du futur » ? (H. Loo)

- ***Connaissances du XXe siècle*** (mémoire):
- Absence de déficit mnésique après 6 mois (Calev, 1993)
- Patients ECT = contrôles à distance (Devanand, 1991)
- Résolution en 72 jours de moy. (Freeman, 1980, Frith, 1983)
- Moindre incidence de l'ECT-UL (ANAES, 1997)
- À 6 mois, ECT-UL=ECT-BL (Daniel, 1985, Weiner, 1986)

Connaissances du XXe siècle (efficacité)

- ECT-UL proche du seuil = SHAM-ECT (Sackeim, 1991-1993)
- ECT-UL 2,5ST se rapproche de ECT-BL proche du seuil ou ECT-BL 2,5ST (ANAES, 1997)
- Mais ECT-UL toujours < ECT-BL pour Sackeim (1993)
- Discuté par Abrams (doses très supraliminaires) et Ottoson (courant sinusoïdal) (perte d'intérêt pour la mémoire?)
- Position d'Elia pour UL (Abrams,1989)

Au XXIe siècle

- ECT-UL 6ST = ECT-BL 2,5ST (80%) (Sackeim, 2000)
- ECT-UL 8ST = ECT-BL 1,5ST (McCall, 2002)
- Amnésie rétrograde impersonnelle > Amn. rétro. autobiographique (surtout pour BL/UL 2,5ST) (Lisanby, 2000)

Perspectives techniques : électrodes

- ***ECT-UL gauche*** en cas de troubles cognitifs ou de la parole sévères (Kellner, 1997)
- ***ECT bifrontale*** 1,5ST = ECT-BL (Bailine, 2000, Ranjkesh, 2005)
- ECT bifrontale = ECT-UL 5ST (Ranjkesh, 2005), = ECT-UL 6ST (Sienaert, 2006)
- Moins d'effets cognitifs, voire amélioration: (MMSE, mémoire verbale, attention, fns exécutives, AMI et subjective) (Sienaert, 2006)
- ***Frontale gauche - temporale droite***: 4 études de cas, 1 en ouvert (n=10) (Swartz 1994-2005)

Perspectives techniques : dosage

- Méthodes âge-dose (Abrams, 1989), demi âge-dose (Fink, 1996), titration (Sackeim, 1987), dosage fixe (Abrams, 1997)

- ***« Méthode de référence (benchmark) »*** (Swartz 2000-2002):
- 1ère séance: 3,5 à 5 fois l'âge du patient en mC, on relève le bpm max (151 moy.)
- Séances suivantes: paliers de 25-50 mC en + ou - selon différence de +/- 6 bpm

Perspectives techniques : paramètres

- Durée d'impulsion: brève (0,5-2 ms), ultra-brève (0,3 ms)
- Induction de convulsion 0,5>1 ms
- Courant ultra-bref:
- ***Sackeim (2004):***
- Score de mémoire: UL6ST-UB > BL2,5ST-UB > UL6ST > BL2,5ST
- HDRS: BL2,5ST-UB >> UL6ST = UL6ST >BL2,5ST
- ***Loo (2007):*** UL6ST-UB = UL3ST un peu - d'effets cognitifs
- UL6ST-UB < UL6ST mais bcp - d'effets cognitifs
- ***Sienaert (2006):*** UL6ST-UB = BF1,5ST-UB (rép. 80%) sans effet cognitif

Perspectives techniques : paramètres (2)

- Fréquence: 20 - 120 Hz
- Basses fréquences = induction + facile, +efficace?
- Hautes fréquences: stimulation en masse (crowding), intérêt? (période réfractaire pour > 70 Hz)

- Durée: 0,5 - 8 s
- Longue durée = induction + facile, efficacité?

- Tendance: impulsion brève et longue durée

S. Lisanby & M. Fink,

18th annual meeting of the association of convulsive therapy
4 mai 2008, Sibley's Memorial Hospital, Washington DC

Dr P.Sienaert - Louvain

Charles Perrens Hospital
Academic Psychiatry Service (Pr. H.Verdoux)
ECT Service

Psychiatrist : Dr. C. Daudet
Anesthesiologists : Dr. Gomez, Dr. Rappaport, Dr. Reinier
Head Nurse: G. Guay
Nurses :

THE LANCET, NOVEMBER 28, 1981

THE LANCET

ECT in Britain: a Shameful State of Affairs

LAST week the Royal College of Psychiatrists published what must be the most complete and thorough medical audit of a particular form of treatment that has ever been undertaken. As an account of the practice of a therapy widely used by British psychiatrists, *Electroconvulsive Treatment in Great Britain, 1980* is deeply disturbing.

The study, conducted by Dr J. PIPPARD and Dr L. ELLAM in 1979 and 1980, had four parts. First, letters were sent to all 3221 members of the Royal College of Psychiatrists, inquiring about their attitudes to and practice of ECT. Second, in a three-month prospective survey, both psychiatrists and hospitals were asked to keep a record of the ECT they actually used. Third, 614 randomly selected general practitioners were questioned about the effect of ECT on recently treated patients. Fourth—and the most revealing part of the study—the investigators visited one hundred ECT clinics and observed the circumstances and manner in which the treatment was given. PIPPARD and ELLAM estimate that in 1979 some 200 000 individual applications of ECT were given in 390 centres, all but 5000 in National Health Service hospitals. Across the country there was a 17-fold difference between the rates of the highest and lowest users of ECT as measured by the number of treatments per annum per 1000 of the population at risk. The Oxfordshire region was consistently the lowest user and North Yorkshire the highest. Nearly all general psychiatrists prescribe ECT and 90–98% expressed generally favourable attitudes to the treatment.

Despite the fact that over twenty studies indicate that unilateral ECT causes less confusion and memory disturbance than bilateral ECT and is no less effective, 80% of ECT clinics rarely or never use it, preferring bilateral electrode placement as a routine. The most disturbing findings come from the series of inspection visits to ECT clinics. 28% of these clinics have an obsolete treatment machine and in 48% the reserve

safety code for electro-medical apparatus.[2] 80% these obsolete machines delivered an untimed stim allowing electricity to pass across a patient's head fi long as the operator's finger pressed the treatm button. PIPPARD and ELLAM conclude that m patients were being treated with excessive amoun electrical energy likely to produce an increase in s effects such as memory disturbance without increa therapeutic efficacy. 40% of clinics did not main their ECT machine regularly. It was rare to fir consultant psychiatrist involved in the work of an E clinic and most treatment was given by untraine minimally trained junior doctors. 50% of junior had no or minimal training and 26% received st tuition but usually not until they had already gi ECT several times. Even where a consultant involved there was little evidence that he was m competent than his juniors.

The report describes clinics of various types quality and some of the accounts make chilling readi ECT is given in large open dormitory wards with r of patients lying on unscreened beds and with treatment and anaesthetic machines being transf from bed to bed. Patients waiting before and a treatment can see and hear treatment being given others. Even in some purpose-built clinics which w fully equipped with modern apparatus, standards w appallingly low. The investigators saw treatm sessions where few patients had a convulsion and wh this was not recognised by the medical st involved—or, if it was, they presumably thought unimportant. Nursing staff were noted to be bor apathetic, and hostile to ECT and rarely talked patients. In an attempt to summarise their findings t investigators made personal ratings on a scale of 0 t on six features of each clinic—premises, equipme anaesthetist, psychiatrist, nurses, and overall patie care. Only 16% of clinics rated 4 or 5 on all aspects care, indicating that the investigator was happy, reasonably so, about the standard of care and safety the clinic. A further 27% were thought to be general satisfactory. Less than half the clinics met t minimum criteria specified by the Royal College Psychiatrists.[3] In 30% standards were unsatisfacto and in 27% there were serious deficiencies such as lo standards of nursing care, obsolete apparatus, an unsuitable premises. Of the categories of personn rated, the psychiatrist came lowest. Only one-third psychiatrists were thought to be doing their job in satisfactory way, compared with 64% of nurses an 70% of anaesthetists. The picture painted is one ECT been given in many clinics in a degrading an frightening way with little consideration for patient feelings, by bored and uninterested staff, with obsolet

- SEAN Scottish ECT Accreditation Service
- ECTAS ECT Accreditation Service (England, Wales, Northern Ireland, Eire)

SEAN

- Scottish ECT Audit Network
- Dr Chris Freeman
- Dr James Hendry
- Dr Grace Fergusson
- Linda Cullen(Nurse)
- Robert Davidson (Project Worker)

Scotland

- Population 5.5 million
- 32 ECT clinics when started
- 27 clinics now

Scottish ECT Accreditation Network

Tuesday 18 May 2010

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Search SEAN
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Home

This site is designed to complement the work of SEAN enabling communication of the latest information on ECT (Electroconvulsive Therapy) in Scotland.

Over the last six years SEAN has taken a central role in ensuring that there is a continued process of clinical audit and monitoring of all NHS ECT sites in Scotland.

This audit has resulted in the publication of an ECT guide that can be viewed on this site and National Audit Reports which have now been published.

The value of the exercise has been reflected in the desire for it to continue. SEAN has now moved to a more sophisticated IT based method of ongoing live audit at each ECT site providing realtime feedback and quality control for the clinicians.

As the SEAN site expands it will be of interest to clinicians, managers, interest groups and individuals.

At present www.sean.org.uk includes publications on ECT to view for the patient or carer in the Public area, and for the clinician some references, audit and training materials in the Professional area. Both public and professional alike can benefit from all the areas including recent news and some useful Links.

Please use the Contacts page to pass us your thoughts and ideas onto the SEAN Management Team.

Printable View

Audit Standards

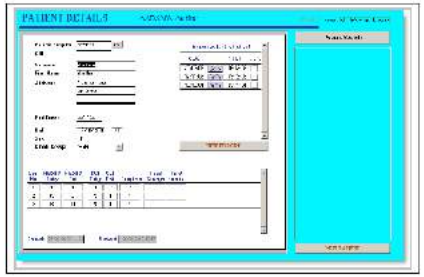
- 75% of patients should be 50% or more improved
- Collect data nationally
- Every clinic has PC, some stand alone, some linked to hospital data system
- Main outcome measure MADRAS

ECT DATABASE MARK 2 - SCREENS 12 SEPT 2006

7

OPENING SCREEN

PATIENT SCREEN

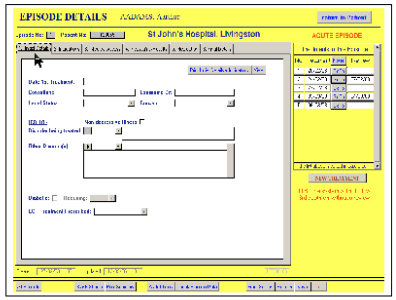


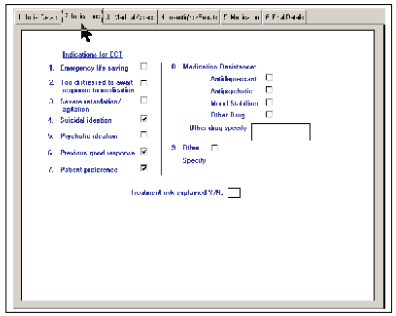
Audit

- Data sent centrally either email or disc
- Each clinic gets own data back and national data to compare
- Used to be anonymous now open

EPISODE SCREENS

(all pages have patient name etc at top)





Audit

- 5 cycles now, all met audit standard
- Have data on age, sex, drugs, anaesthetic agent, type and number of ECT as well as outcome

Accreditation

- All ECT teams meet twice yearly for network meeting
- Approx 100 people so 3+ from each clinic
- Annual visits from other members of network to inspect clinic
- Report goes to ECT team then to managers

Funding

- Initially from Government for two years
- Now each clinic pays approx. 2500 euros per year
- Covers network meetings, data handling, updates to data base, and inspections

Accreditation

- All clinics to high standard
- Now running for 7 years
- Two clinics closed down in first year, one NHS one private

Preparing for an ECTAS Visit

Royal College of Psychiatrists'
Research and Training Unit

(If you are a member, and would like to submit data, please click here)

Summary

The ECT Accreditation Service was launched in May 2003. Its purpose is to assure and improve the quality of the administration of ECT. ECTAS has the support of the Royal College of Nursing and the Royal College of Anaesthetists and the Healthcare Commission (HC) states: "ECTAS accreditation is one of the information sources the HC will use to direct its inspection activities in its core standards assessment of mental health services."

Benefits of joining ECTAS

- Allows achievements of clinic staff to be recognised
- Provides detailed advice and support about areas in need of improvement
- Helps prepare for external regulation for bodies such as the HC who recognise participation as part of their service evaluation
- Maintains a national network to improve communication between staff and clinics
- Provides opportunities to visit other clinics and share ideas and suggestions
- Email discussion group
- Twice-yearly Newsletter
- Quality assured service for service users

ECTAS also encourages clinicians and managers to:

- Focus on ECT service provision
- Continuously develop and revise current standards focusing on best practice
- Update documentation to meet current guidelines
- Update facilities and equipment according to regulations
- Encourage the clinic team to aspire to further develop services using audit, teaching and research

Current Members

- List of all ECTAS member clinics with accreditation status (as of February 2010)

Please use the links below to navigate the site:

- Costs and how to join
- The accreditation process
- ECTAS Online review tools
- Protocols
- Publications and Links
- Other useful downloads
- ECT Nurse Training
- Contact Staff

ECTAS

- 55 million population
- 160 clinics
- Used to be over 200

Aims and Objectives

- Accredit ECT Clinics
- Maintain National Network to support staff through:
  - A database of standards in the administration of ECT
  - ECTAS peer-review process
  - An email discussion group and Quarterly Newsletter
  - An Annual Members' Forum
- Self-regulating and self-funding network

Standards

- ECT Clinic and Facilities
- Staff and Training
- Assessment and Preparation
- Consent
- Anaesthetic Practice
- Administration of ECT
- Recovery, Monitoring and Follow up
- Special Precautions

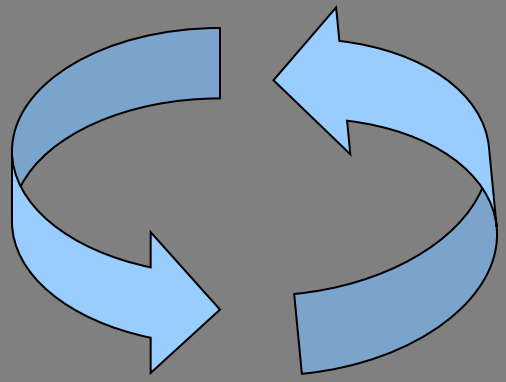
ECTAS standarts

Standard Classifications

- **Type 1**: Failure to meet these standards would result in a significant threat to patient safety or dignity and/or would breach the law
- **Type 2**: Standards that an accredited clinic would be expected to meet
- **Type 3**: Standards that it would be desirable for a clinic to meet

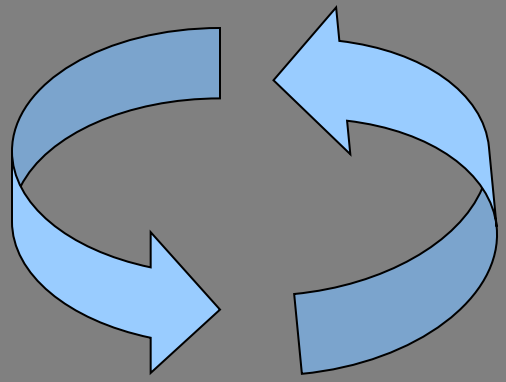
The Accreditation Process

First contact with ECTAS



The Accreditation Process

First contact with ECTAS

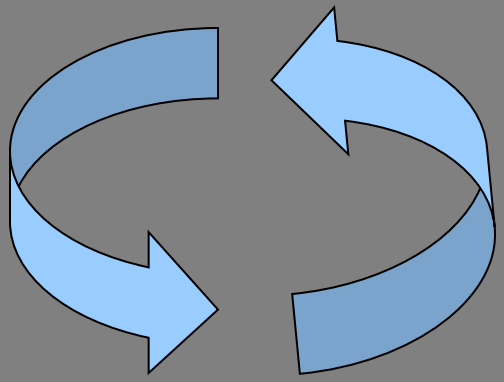


Self – review

The Accreditation Process

First contact with ECTAS

Self – review

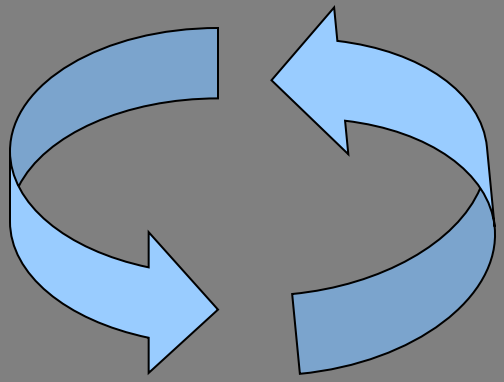


Peer – review

The Accreditation Process

First contact with ECTAS

Self – review



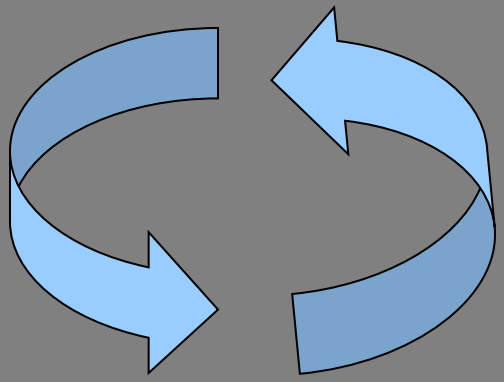
Peer – review

Accreditation Advisory Committee

The Accreditation Process

First contact with ECTAS

Self – review



Court of Electors

Peer – review

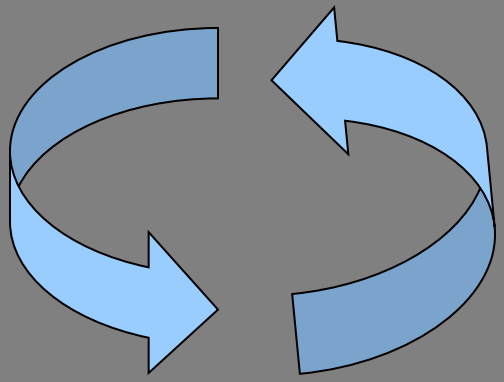
Accreditation Advisory Committee

The Accreditation Process

First contact with ECTAS

Accreditation

Self – review



Court of Electors

Peer – review

Accreditation Advisory Committee

The Accreditation Process

- AAC suggest Accreditation rating
- Validated by Court of Electors
- Awarded one of 4 categories:
    1. Approved with excellence
    2. Approved
    3. Approval deferred
    4. Not approved
- Accredited for 3 years with annual self-review
- Right to Appeal

Liste des unités

Member clinics

Table 1: Status of the 98 active ECTAS clinics (October 2009)

		Cycle 1[1]	Cycle 2[1]
Accredited as excellent		7	23
Accredited	First time	7	24
	Following deferral	11	9
Accreditation deferred		0	2
Not accredited		0	0
In self-/peer-review stage		8	7
Total		**33**	**65**

[1]33 of the clinics are in their first three-year review cycle and 65 are in their second.

Recommendations for Europe

- Don’t go for individual accreditation or privileging, waste of time
- Wont improve standards
- ECT is a process
- ECT is a team activity
- Depends on size of country, number of clinics, closeness of clinical community

Gloucestershire ECT pathways

Training

Three day training course for nurses

Â 3 day training course has been devised in collaboration with NALNECT based upon the nurse competencies for ECT. For more details about this training course (including dates, location and pricing), please download the flyer below:

ECT Practitioners

Â yearly training day is run for ECT practitioners. For more information, please visit the Education and Training Centre webpage

ECTAS Newsletter

Issue 8-July 2008

Edited by Nicola Scanlon

Hello and welcome to the eighth edition of the ECT Accreditation Service newsletter. ECTAS is member-led and promotes an inclusive, interactive approach to quality improvement. If you would like to write an article in our next newsletter please get in touch (details on p3)

NEWS

The ECTAS Team

For those of you who have recently joined us, here's an overview of the ECTAS team and our roles:

Joanne Cresswell: Jo is our Programme Manager and Nurse Adviser. She is currently a part-time ECT nurse for SLaM NHS Trust, and also manages the AIMS project

Chloë Hood: Chloë is the Deputy Programme Manager, and also works on the AIMS project.

Nicola Scanlon: Nicola is the Quality Improvement Worker for ECTAS. She monitors the discussion group and will normally be your first point of contact for general ECTAS queries.

Update

ECTAS currently has 97 member clinics. Many of our clinics have been through a second ECTAS cycle, with 32 being reaccredited. 11 of these progressed to excellence during cycle 2.

NALNECT Conference

Nicola and Jo attended the NALNECT conference, and Jo presented on behalf of ECTAS. We enjoyed meeting staff from some of our member clinics, and hope you enjoyed the day.

NALNECT Nurse Award Update

The closing date for applications for this award has been brought forward to 26th September to allow for the judging panel to include the NALNECT Chair, a Service User, a Senior Representative from the RCN and a Lead ECT Consultant. For further information please email rebeccaauton@aol.com.

Competencies and nurse training

Preparations for the ECT nurse training course are well underway. There will be three courses, two in London and one in Leeds. The flyers can be downloaded from our website, www.ectas.org.uk.

Psychiatrist competencies have been circulated, and we have received some useful feedback. Competencies for other ECT specialties are being developed and will be circulated shortly.

Memory testing and ECT

Chris Freeman circulated a summary about memory testing and ECT, and recommended that clinics should be using the AMI-SF and the modified MMSE after the ECT course and during follow-up appointments. The AMI is currently being piloted in various member clinics in the UK and further recommendations will be made based upon the results of this pilot stage. ECTAS would be interested to hear what you and your patients think about the memory tools.

Protocols

Many of you have been asking about sample protocols. Most of these have been devised and will be available to download from the ECTAS/NALNECT website shortly.

Second National Report

The second ECTAS National report has now been published. The report compares performance between the first and second cycles and looks at amalgamation of units and the patient experience. The report is available to download from www.ectas.org.uk.