

Electroconvulsive Therapy (ECT)

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications.

Electroconvulsive Therapy (ECT) is a procedure during which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity. The individual receiving ECT is placed under general anesthesia, and muscle relaxants are given to prevent body spasms. ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement). Unilateral placement is usually to the non-dominant side of the brain, with the aim of reducing cognitive side effects. The amount of current to induce a seizure (the seizure threshold) can vary up to 40-fold among individuals. ECT may cause short- or long-term memory impairment of past events (retrograde amnesia) and of current events (anterograde amnesia). The number of sessions undertaken during a course of ECT usually ranges from 6 to 12. ECT is most commonly performed at a schedule of three (3) times per week. Maintenance ECT is most commonly administered at one- to three-week intervals.

The decision to recommend the use of ECT derives from a risk/benefit analysis for the specific individual. This analysis considers the diagnosis of the individual and the severity of the presenting illness, the individual's treatment history, the anticipated speed of action and efficacy of ECT, the medical risks, and anticipated adverse side effects. These factors should be considered against the likely speed of action, efficacy, and medical risks of alternative treatments in making a determination to use ECT.

The principal indication for ECT are the following:

- a. Major depression with or without psychosis that has not been responsive to adequate trials of medication or when medication is contraindicated
- b. Previous therapeutic response to ECT
- c. Severe depression with life-threatening behaviors (e.g., refusal to eat or drink, compulsive and impulsive suicide tendencies) when the latency of action of medication places the Member at added risk

Components of Service

1. The ECT treatment team consists of a psychiatrist with formal training in using ECT consistent with facility privileging criteria, an anesthetist, and a recovery nurse.

Pre-ECT Evaluation:

Although components of the evaluation for ECT vary on an individual-by-individual basis, each facility ensures it has documented a minimal set of procedures to be undertaken for all individuals. These include:

1. Psychiatric history and examination to determine the indication for ECT, including previous response to ECT if pertinent. The psychiatric diagnostic assessment includes a DSM-5 diagnosis, inclusive of psychosocial and contextual factors and disability, as applicable. Target symptoms are identified, and a full mental status assessment including, at a minimum, a Mini Mental Status Examination Score (Folstein) is performed and documented. Past treatments are carefully reviewed and documented. Documentation of previous pharmacotherapy includes each medication prescribed, dosage, duration of each trial, compliance, response, side effects, and response to augmentation strategies where appropriate.
2. Medical evaluation specifically focused on the safety of ECT includes, at a minimum, an updated history and physical examination with a focus on major areas of risk including cardiovascular, pulmonary, and neurologic systems, as well as risks for the induction of anesthesia, including a mouth and dental examination. The facility ensures an evaluation of concurrent medications the individual is taking to determine their impact on ECT.
3. Laboratory studies include an EKG, blood chemistries, electrolytes, and HGB/HCT.
4. Radiographic studies as indicated.

Administering ECT:

1. The individual should be fasting overnight.
2. The ECT psychiatrist should determine the choice of electrode placement. The ECT psychiatrist should be skilled in both unilateral and bilateral ECT, and the utilization of either procedure should be based on an ongoing assessment of risk versus benefit to the individual.
3. Close monitoring is provided during and after treatment until the individual is fully recovered from anesthesia.
 - a. During treatment, monitoring includes observation of seizure duration, airway patency, agitation, vital signs, and adverse effects. Additionally, any onset of new risk factors, or significant worsening of those present at pre-ECT, should be evaluated prior to the next treatment.
 - b. After treatment:
 - i. For ECT administered in an acute setting: individuals are monitored for at least 24 hours to assess for cognitive side effects, or prolonged or late seizures (tardive seizures) that may occur after the ECT session;
 - ii. For ECT administered in an outpatient setting: individuals are clinically assessed prior to each ECT session and after each ECT session for any adverse effects that may occur during the postictal recovery period. Please refer to the American Psychiatric Association's (APA) guidelines for ECT.
4. A neurology consultation is obtained if recurrent prolonged seizures or tardive seizures occur. Changing from bilateral to unilateral ECT may be necessary for individuals who become manic during the course of treatment.
5. The individual's clinical status is assessed following each ECT session, and the individual's cognitive function is monitored on an ongoing basis and, at a minimum, at the end of each course of treatment.

6. ECT treatment is usually done in 6-12 sessions at a frequency of 2-3 times a week. ECT frequency may change when a positive response is obtained, with the ECT psychiatrist and the attending psychiatrist working in consultation.

Staffing Requirements

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Senior Whole Health service-specific performance specifications, and the credentialing criteria outlined in the Senior Whole Health Provider Manual, as referenced at www.SWHMA.com.
2. ECT treatment requires a multi-disciplinary team that includes:
 - a. Board-certified psychiatrist trained to administer ECT and privileged by the facility for ECT
 - b. Anesthetist
 - c. Nurse skilled in the care of unconscious individuals
 - d. Consultant internist, neurologist, ob-gyn, radiologist, and other specialists as appropriate.

Process Specifications

Assessment, Treatment Planning, and Documentation

1. The provider ensures there is documentation in the Member's health record that ECT is being used for treating target symptoms in an individual with one of the following conditions: severe depressive illness, a prolonged or severe manic episode, the affective components of schizophrenia and related psychotic disorders, catatonia, or neuro-malignant syndrome (NMS). ECT is used only to achieve rapid and short-term improvement of an individual's severe symptoms after an adequate trial of other treatment options has proven ineffective or when the condition is considered to be potentially life threatening.
2. There is documentation in the Member's health record of an assessment of the risks and potential benefits to the individual undergoing ECT.
3. There is documentation that the informed consent process is documented as a dialogue in the health record when the Member is able to give informed consent. There is documentation of substituted judgment if the individual is not able to give consent. The consent process provides full and appropriate information in a suitable format and in language that allows there to be an informed discussion. There is an explanation of the general risks of ECT, risks specific to the individual, and potential benefits to the individual.

Discharge Planning and Documentation

1. Components of Discharge Planning incorporate Member's identified concerns, including but not limited to: housing, finances, healthcare, transportation, familial, occupational, and social supports.

Performance Specifications

Electroconvulsive Therapy

2. The treatment team staff member who is responsible for implementing a Member's discharge plan documents in the medical record all of the discharge-related activities that have occurred while the Member is in the facility, including Member participation in its development.
3. The completed discharge form, including referral to any agency, is available to and given to the Member, and when appropriate, the Member's family/caregiver or guardian at the time of discharge, which includes, but is not limited to, appointments, medication information and emergency/crises information.
4. Follow up care, appointments, and discharge plan must be in place and documented in Member's medical record prior to discharge.
5. For Members discharged on medications, at least one psychiatric medication monitoring appointment is scheduled no more than 14 days after discharge.

Service, Community, and Collateral Linkages

1. The ECT treatment team collaborates with the Member's inpatient and/or outpatient providers in the development of treatment and discharge plans.
2. The facility ensures that a written aftercare plan is available to the Member on the day of discharge. When consent is given, a copy of the written aftercare plan is forwarded at the time of discharge to the referral source, family/caregiver/guardian/significant other, DMH, (if DMH member), outpatient or community-based provider, PCP and/or primary care team (PCT), and other entities and agencies that are significant to the Member's aftercare.
3. When necessary, the program provides or arranges transportation for the Member as his/her needs demonstrate.
4. When necessary, the facility will ensure that the Member has appropriate monitoring and support after each treatment. This may necessitate a referral to a day treatment or partial hospital program.
5. The program, with consent of the Member, confers with the referral source, Adult Mobile Crisis Intervention provider and prior treaters, particularly if he/she has received prior ECT treatment, in order to identify treatment needs, to obtain treatment history and to develop a treatment plan incorporating this information.