

CF OPERATING PROCEDURE
NO. 155-40

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, May 20, 2021

Mental Health/Substance Abuse

USE OF ELECTROCONVULSIVE TREATMENT FOR RESIDENTS OF
STATE MENTAL HEALTH TREATMENT FACILITIES

1. Purpose. This operating procedure describes minimum requirements for the use of electroconvulsive treatment for individuals served in the State Mental Health Treatment Facilities.
2. Scope. This operating procedure is applicable to the state civil and forensic mental health treatment facilities, whether operated by the Department of Children and Families or private entities, including the Sexually Violent Predator Program at the Florida Civil Commitment Center.
3. References.
 - a. Chapter 394, Florida Statutes (F.S.), Mental Health (ss. 394.459, 394.4598, 394.9223).
 - b. Chapter 458, F.S., Medical Practice (ss. 458.325).
 - c. Chapter 916, F.S., Mentally Deficient and Mentally Ill Defendants (ss. 916.107).
 - d. Chapter 65E-5, Florida Administrative Code (F.A.C.), Mental Health Act Regulation (ss. 65E-5.170).
 - e. Chapter 65E-20, F.A.C., Forensic Client Services Act Regulation (ss. 65E-20.005).
 - f. American Psychiatric Association (1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; phone: 1-888-357-7924; email: apa@psych.org).
4. Definitions. For the purposes of this operating procedure, the following definitions shall be understood to mean:
 - a. Electroconvulsive Therapy (ECT).
 - (1) ECT is a highly effective medical treatment generally reserved for those with severe mental illnesses who are unresponsive to or unable to tolerate other therapies such as psychotherapeutic medications or psychotherapy. ECT is:
 - (a) The most effective and most rapidly acting treatment available for individuals with severe major depression;
 - (b) Helpful in the treatment of individuals with most forms of mania, some forms of schizophrenia, and a few other mental and neurological disorders;
 - (c) Useful in treatment of these illnesses in older individuals for whom certain medications may be unadvisable due to side effects; and,

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(d) Effective when a resident presents with life threatening symptoms that need rapid improvement, such as when a resident is suicidal, seriously self-injurious, refusing to eat or drink, cannot or will not take medication as prescribed, or presents some other danger to him/herself.

(2) Modern methods of administering ECT employ low "doses" of electric stimulus to the brain along with general anesthesia and muscle relaxants to minimize the risk and unpleasantness for the individual. Electric currents are passed through the brain to trigger a brief seizure which seems to cause changes in brain chemistry that reverse certain symptoms of mental illnesses. A resident will typically receive ECT two to three times a week for a total of six to twelve treatments, depending on the severity of symptoms and how quickly the symptoms respond to the treatment. Side effects of this treatment may include mild confusion, memory loss, and other cognitive problems which are common yet typically short-lived.

b. Express and Informed Consent (hereafter referred to as consent). Permission voluntarily given in writing by a competent person after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

c. Incompetent to Consent to Treatment. A resident's judgment is so affected by his or her mental illness that he/she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

d. Side Effect. An action or effect of treatment other than the therapeutic effect for which it is prescribed, whether it is harmful or not. Some side effects may be common and minor annoyances, while other side effects may be rare, serious, and potentially life-threatening.

5. General. The American Psychiatric Association's (APA) position statement on ECT indicates it is a safe and effective evidence-based medical treatment that is endorsed by the APA when administered by properly qualified psychiatrists for appropriately selected patients.

6. Procedure.

a. When ECT is recommended for a resident by his or her attending psychiatrist, the recommendation will be accompanied by a supportive recommendation from at least one other psychiatrist who has not been directly involved with the resident's care and, at a minimum, has reviewed the resident's health record and documented his/her supportive recommendation in the resident's health record.

b. The recommendations, with an updated/current psychiatric history and examination, will be discussed with the recovery team and the resident (or legal representative) and the outcome of the discussions will be documented in the resident's health record.

c. Medical clearance will be obtained for each resident being considered for electroconvulsive therapy.

(1) At a minimum, the following will be completed:

(a) A thorough physical examination including documentation of cognitive assessment, vital signs, dentition, and updated/current medical history;

(b) A comprehensive neurological examination;

(c) Laboratory tests including a complete blood count, comprehensive metabolic panel, urinalysis, and a pregnancy test;

(d) Chest x-rays, including posterior–anterior and lateral, to rule out any spinal defects or pulmonary contra-indications;

(e) A 12 lead electrocardiogram to rule out any cardiac abnormalities; and,

(f) An anesthesia evaluation to identify and address the nature and extent of anesthetic risk and the need for modification of medications or anesthetic technique.

(2) Additional testing will be completed as determined by the physician to be needed for thorough evaluation of the resident's medical problems prior to ECT being scheduled. In assessing indications for caution (e.g., recent myocardial infarction, cardiac arrhythmias, intracranial space-occupying lesions), the relative risks and benefits should be carefully weighed in collaboration with the physician, an anesthesiologist, and other specialists, as deemed necessary.

d. Once completed, the pre-ECT psychiatric and medical evaluations will serve as the basis for a specific, individualized discussion of the risks and benefits of ECT relative to other therapeutic options as part of the informed consent process. Documentation will include the rationale for the treatment, risk benefit analysis for this treatment modality, and expected outcome of the treatment as discussed with the person providing consent.

e. Consent will be obtained from the resident if he or she has been deemed competent to make an informed decision. The determination of capacity to provide consent will be based on the resident's ability to:

(1) Understand that he or she has an illness for which the electroconvulsive therapy is being recommended; and,

(2) Comprehend and process the information provided about the electroconvulsive therapy in a manner by which a reasoned decision can be made.

f. If a resident committed under Chapter 394, F.S., is determined to be incompetent to consent to treatment and a guardian to consent to mental health treatment has not already been appointed or the resident has not designated a health care surrogate, the facility will seek a guardian advocate with express court approval to consent for electroconvulsive therapy.

g. If a resident committed under Chapter 916, F.S. is determined to be incompetent to consent to treatment, consent can be obtained from a legally appointed guardian for the resident.

h. In the absence of consent, the administrator or designee of the facility can petition the court for an order authorizing electroconvulsive therapy for the resident based on the recommendations of the two psychiatrists for this essential treatment.

i. When a community psychiatrist will not perform electroconvulsive therapy based solely on the resident's consent, a court hearing will be requested for authorization to proceed with electroconvulsive therapy.

j. When a court hearing is requested for authorization of electroconvulsive therapy, the resident will be: physically present (unless his/her medical condition precludes such presence); represented by counsel; and provided the right and opportunity to be confronted with, and cross-examine, all witnesses attesting to the medical necessity of the electroconvulsive therapy. In such proceedings, the burden of proof by clear and convincing evidence shall be on the party alleging the medical necessity of the procedure.

k. Consent will be obtained on form CF-MH 3057F, "Authorization for Electroconvulsive Treatment for a Resident of a State Mental Health Treatment Facility" (available in DCF Forms). The consent for treatment may include up to twelve (12) therapy sessions. If further treatment is determined to be needed, consent will be re-obtained.

l. Consent will be obtained by the psychiatrist and will include an explanation in plain language of what ECT involves, what other treatments might be available, and the potential benefits and risks of these procedures. The Electroconvulsive Therapy (ECT) information sheet (Appendix A to this operating procedure) will be discussed with the person providing consent and a copy shall be provided to them.

m. The resident and person providing consent, if not the resident, will be informed of when, where, and by whom the treatment will be administered and that consent may be revoked orally or in writing prior to or at any time during treatments.

n. Electroconvulsive therapy will not be provided in state mental health treatment facilities. This therapy will be obtained when determined to be needed for a resident served in a state treatment facility from a provider in the community who is properly licensed to administer electroconvulsive therapy. The provider of ECT may also obtain consent prior to performing the treatments.

o. Following each treatment, the attending psychiatrist will document the resident's progress in the medical record and update the person providing consent, the clinical director, and the recovery team of the resident's progress.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

JACQUELINE A. YOUNG
Director, State Mental Health Treatment Facilities

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

No substantive changes have been made in this operating procedure.

Electroconvulsive Therapy (ECT) Information Sheet

Electroconvulsive Therapy, more commonly known as “ECT,” is an extremely safe and effective medical treatment for certain psychiatric disorders. With this treatment, a small amount of electricity is applied to the scalp and this produces a seizure in the brain. The procedure is painless because the patient is asleep and under general anesthesia. The effectiveness of ECT in treating severe mental illnesses is recognized by the American Psychiatric Association, the American Medical Association, and the National Institute of Mental Health.

Indications for Use and Effectiveness

In the United States, about 100,000 individuals are estimated to receive ECT each year. ECT is generally used when patients have severe depressive illness, mania, some forms of schizophrenia, or a few other mental and neurological disorders. Frequently, ECT is given when patients have not responded to other treatments such as medications, when other treatments appear to be less safe or difficult for the patient to tolerate, or when patients have responded well to ECT in the past.

Not all patients improve when treated with medications or psychotherapy. For some patients, the risks of medications are greater than the risks for ECT. When patients have life-threatening psychiatric problems, such as suicidal tendencies, ECT is often recommended because it usually provides faster relief than medications. Overall, about 70 to 90 percent of depressed patients treated with ECT show substantial improvement. This makes ECT the most effective of the antidepressant treatments.

ECT is very effective in providing relief from psychiatric symptoms but permanent cures from mental illness are rare, regardless of the treatment given. To prevent relapse following ECT, most patients require further treatment with medication or with ECT. If ECT is used to protect against relapse, it is usually administered on a weekly or monthly basis.

Administration of ECT

ECT is administered by a treatment team of highly skilled health professionals including a psychiatrist, an anesthesiologist, and nurses. The physicians responsible for administering ECT are experienced specialists.

Before ECT is administered, the patient’s medical condition is carefully assessed. This included a complete medical history, a physical examination, and medical tests, as needed.

When the patient goes to the ECT treatment room, an intravenous line is started. Sensors for recording brain activity, electroencephalogram (EEG), are placed on the head. Other sensors are placed on the chest for monitoring the heart, electrocardiogram (EKG). A cuff is wrapped around the arm for monitoring the patient’s blood pressure. When everything is connected, an anesthetic medication is injected through the intravenous line that will cause the patient to sleep for 5 to 10 minutes. Once the patient falls asleep, a muscle relaxant is injected. This prevents movement so that during the seizure there are only minimal contractions of the muscles.

When the patient is completely asleep and their muscles are well relaxed, the treatment is given. A brief electrical charge is applied to the electrodes on the scalp. This stimulates the brain and produces the seizure that lasts for about a minute. Throughout the procedure, the patient receives oxygen through a mask. This continues until the patient no longer needs assistance breathing. When the treatment is completed, the patient is taken to a recovery area for monitoring by trained staff. Usually within 30 to 60 minutes, the patient can leave the recovery area. A course of treatment with ECT usually consists of six to twelve treatments. One treatment is given three times a week for a month or less.

Risks

Any medical procedure entails a certain amount of risk. However ECT is no more dangerous than minor surgery under general anesthesia, and may at times be less dangerous than treatment with antidepressant medications. This is in spite of its frequent use with the elderly and those with coexisting medical illnesses. A small number of other medical disorders increase the risk associated with ECT, and patients are carefully screened for these conditions before a psychiatrist will recommend a patient for ECT treatment.

Side Effects

After the treatment, the patient will experience some confusion on awakening. This is partly due to the anesthesia and partly due to the treatment. The confusion typically clears within the hour. Some patients have a headache which is usually relieved by Tylenol or aspirin. Other side effects like nausea, muscle ache, or soreness can last for a few hours but are relatively uncommon.

The side effect that has received the most attention is memory loss. ECT can result in two types of memory loss. The first involves rapid forgetting of new information such as conversations or things the patient has recently read. This type of memory loss is short-lived and usually does not last but a few weeks following ECT treatment. The second type of memory loss concerns events from the past. Some patients have memory gaps in the weeks or months and, less commonly, years prior to the treatment course. The amount and duration of memory problems vary among patients and more extensive memory loss is reported in a minority of patients. The extent of memory loss may vary with the type of ECT that is used and appears to be less of a concern with unilateral ECT (where one side of the head is stimulated electrically) than with bilateral ECT.

Many psychiatric illnesses result in impairments of attention and concentration. Consequently, when the psychiatric disturbance improves following ECT, there is often a improvement in these aspects of thinking. Shortly following ECT, most patients show improved scores on tests of intelligence, attention, and learning.

Myths About Brain Damage

Researchers have found no evidence that ECT damages the brain. There are medical conditions such as epilepsy that cause spontaneous seizures which, unless prolonged or otherwise complicated, do not harm the brain. ECT artificially stimulates a seizure; but ECT induced seizures occur under much more controlled conditions than those that are “naturally occurring” and are safe. A recent study by Coffey and colleagues found no changes in brain anatomy with ECT, as measured by very sensitive scans of the brain using magnetic resonance imaging (MRI) equipment. Other research has established that the amount of electricity which actually enters the brain (only a small fraction of what is applied to the scalp) is much lower in intensity and shorter in duration than that which would be necessary to damage brain tissue.

Patient Rights

Before a psychiatrist can administer ECT, he or she must first obtain written consent from the patient or, if the patient is too ill to make an informed decision for him or herself, from a court appointed representative who has been given the authority to make mental health decisions for the patient.

Under the APA’s recommended “informed consent” protocol, permission to administer ECT comes after a careful review of the treatment. The psychiatrist explains in clear language what ECT involves, what other treatments might be available, and the benefits and risks these procedures may entail. The patient or legal representative is informed of when, where, and by whom the treatment will be administered and the number of treatments expected. Questions are encouraged. The person consenting to the procedure is kept informed of progress as the treatment continues, and may withdraw consent at any time.