

Attitudes of consultants to prescribing ECT for patients involuntarily admitted under MHA 2001

Diana Schirliu, Edyta Truszkowska, Colm McDonald

Ir J Psych Med 2011; 28(4): 196-200

Abstract

Objectives: The Mental Health Act (MHA) 2001 provides the legislative structure in Ireland for the involuntary admission and treatment, including with ECT, of patients suffering from mental disorders. A recent Seanad Bill proposed removing the option of administering ECT to involuntary patients who do not provide informed consent. This controversial issue has stimulated extensive media and stakeholder debate. In this study we explored the attitudes of consultant psychiatrists towards prescribing ECT for involuntary patients.

Methods: We compiled a current list of consultant psychiatrists attached to approved centres nationwide. We sent a study specific questionnaire to consultants of all adult psychiatry specialties.

Results: From the 249 individualised anonymous questionnaires posted, 164 (66%) were returned and analysed. When clinically indicated for involuntary patients willing to consent to ECT treatment, 159 (97%) consultants stated that they would and three (2%) would not prescribe ECT. For involuntary patients who lack capacity and are unable to consent, 157 (96%) consultant psychiatrists stated that they would and six (4%) that they would not prescribe ECT. For involuntary patients who have capacity to consent but are unwilling to do so, 52 (32%) consultant psychiatrists stated they would and 104 (63%) would not prescribe ECT.

Conclusions: The overwhelming majority of consultant psychiatrists would prescribe ECT for involuntary patients who are unable to consent to this treatment. Divergent attitudes emerged for treating patients who are unwilling to consent, with most consultant psychiatrists stating they would not prescribe ECT for this patient group.

Key words: ECT; Capacity; Consent; MHA 2001

Introduction

The role of coercive treatment of patients with mental illness remains contentious among service users, mental health professionals and the wider public. Areas of controversy centre upon the ethical and legal framework for balancing an individual's rights to autonomy with their best interests and

with public protection. This issue is particularly pointed when it comes to administering electroconvulsive therapy (ECT) to patients without their consent, itself a highly controversial treatment associated with predominantly negative attitudes among the public.¹

Electroconvulsive therapy is a fast acting effective treatment with an average 60-70% remission rate.²⁻⁴ Its precise mechanism of action remains to be fully elucidated, but there is accumulating evidence for a range of therapeutic effects including enhanced monoamine transmitter function and neurogenesis with ECT treatment.⁵ There are continuing concerns however about adverse effects on cognitive function.^{6,7} There is consequently substantial variation in the current recommendations for ECT in various jurisdictions. ECT is recommended as a first line treatment under certain conditions in the US,⁸ and for treatment resistant depression or severe and life threatening depression in the UK.⁹ However ECT is available only in specialist centres in Belgium and Germany, is prohibited in Slovenia and in some cantons in Switzerland, and is severely restricted in Italy.¹⁰

In Ireland, the Mental Health Act (MHA) 2001 provides the legislative structure for the involuntary admission and treatment of mental disorders. Section 56 of the MHA 2001 defines consent as obtained freely without threats or inducements, where the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment, and has received adequate information, in a form and language that they can understand. Section 57 states that the patient must consent to treatment unless (s)he is incapable and the treatment is necessary. Section 59(1) allows ECT to be administered to a patient admitted involuntarily when the patient consents to it or, where the patient does not consent to ECT, when two consultant psychiatrists concur that the involuntary patient is unable or unwilling to consent.

There is no specific reference in the Act to the assessment of capacity to consent to ECT. It is implicit in the option within Section 59 of 'unwilling' as distinct from 'unable' that patients with capacity to consent, but unwilling to do so, can be administered ECT; however these terms are not defined in the Act. The Mental Health Commission (MHC) has produced a set of Rules Governing the Use of ECT¹¹ in accordance with section 59(2) of the Mental Health Act. These guidelines outline capacity to consent to ECT as ensuring that the patient can: a) understand the nature of ECT; b) understand why ECT is being proposed; c) understand the benefits, risks and alternatives to receiving ECT; d) understand and believe the broad consequences of not receiving ECT; e) retain the information long enough to make a decision to receive or not receive ECT; f) make a free choice to receive or refuse ECT; and g) communicate the decision to consent to ECT.

A Bill recently debated in the Seanad proposed altering

Diana Schirliu, MB, MRCPsych, Registrar, Edyta Truszkowska, MB, Senior House Officer, *Colm McDonald, MB, MRCPsych, PhD, Professor of Psychiatry, Department of Psychiatry, National University of Ireland Galway, Ireland.
Email: colm.mcdonald@nuigalway.ie

*Correspondence

SUBMITTED: DECEMBER 8, 2010. ACCEPTED: MARCH 8, 2011.

the legislation to remove the option of administering ECT to involuntary patients without their consent.¹² This proposed legislative change has prompted substantial media debate and comment by stakeholders. Some commentators proposed retaining the option of administering ECT to involuntary patients if they lacked capacity to provide informed consent. For example, the College of Psychiatry in Ireland proposed removal of the option of administering ECT to involuntary patients who were 'unwilling' to consent to this treatment, and stressed the urgent need for proposed capacity legislation to be enacted.

The voluntary support group Shine has also called for the removal of the word 'unwilling' from the legislation along with a number of other safeguards to be implemented (www.shineonline.ie/index.php/press-releases).

In this study, we sought to explore the attitudes towards prescribing ECT to involuntary patients of consultant psychiatrists currently likely to be faced with the actual clinical decision. We were particularly interested in the distinction psychiatrists might make between those patients who lack capacity (are 'unable') to consent to ECT, as compared to those who implicitly retain capacity to consent to ECT, but are 'unwilling' to do so.

Methods

We contacted the Mental Health Act administrators of each approved centre listed on the MHA 2001 Register of Approved Centres by the Mental Health Commission, in order to compile an accurate list of consultant psychiatrists working in approved centres. There were 61 centres and all forwarded information except two: one refused to forward details of the consultants and the second did not respond to the contact. We designed a brief questionnaire which was individualised and sent to all general adult and adult subspecialty consultants along with a stamped addressed envelope for return of the questionnaire. The actual questionnaire was anonymous and consisted of questions about experiences and attitudes, together with some explanatory material.

The initial questions gathered demographic details and any previous experience prescribing ECT for involuntary patients. The remaining questions asked about the consultant's attitudes towards prescribing ECT for involuntary patients under their care, when it was clinically indicated. Three scenarios were presented, where a detained patient:

- Was willing to give consent
- Lacked capacity and was unable to give consent
- Had capacity and was unwilling to give consent.

There was also an optional comments section at the end of the questionnaire. Included with the questionnaire was an explanatory page containing the relevant sections of the MHA 2001 and a common definition of capacity.

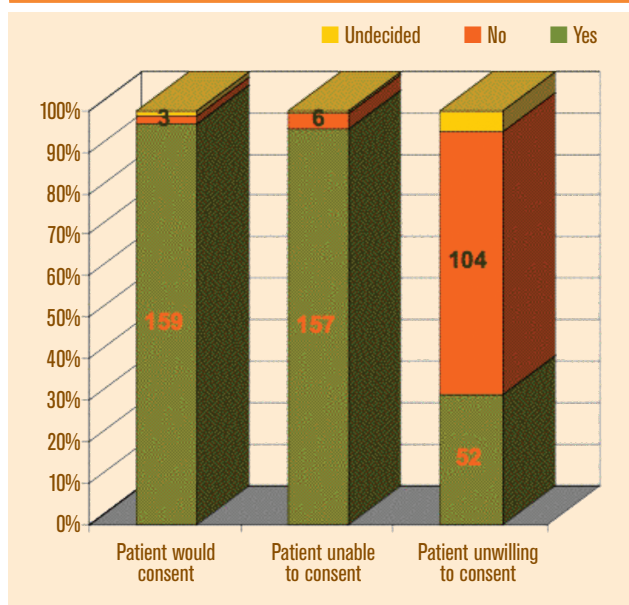
Results

From the 249 individualised anonymous questionnaires sent, we received 169 (68%) responses. Four were returned blank with explanations why: two stated a lack of an ECT facility, another maternity leave, another resignation from work. One further questionnaire only contained answers to the demographic questions. Therefore 164 (66%) questionnaires were analysed. The demographic details of the respondents are provided in *Table 1*.

Table 1: Demographic details of the respondents

Speciality	Gender			Experience as a consultant psychiatrist		
	Male	Female	Not stated	< 10 yrs	10-20 yrs	> 20 yrs
General adult 123 (75%)	63 (51%)	46 (38%)	14 (11%)	48 (39%)	41 (33%)	34 (28%)
Later life 18 (11%)	9 (50%)	7 (39%)	2 (11%)	10 (55%)	7 (39%)	1 (6%)
Other 23 (14%)	8 (35%)	13 (57%)	2 (8%)	12 (52%)	9 (39%)	2 (9%)
Total 164 (100%)	80 (49%)	66 (40%)	18 (11%)	70 (43%)	57 (35%)	37 (22%)

Figure 1: Proportion of consultant psychiatrists who would prescribe ECT for an involuntary patient under MHA 2001



Fifty-one (31%) of the respondents stated that they had prescribed ECT in the past for involuntary patients under MHA 2001: 36 (29%) of the general adult specialty psychiatrists who responded, 12 (67%) of the later life specialty psychiatrists and three (13%) of the other specialty psychiatrists. Approximately 100 involuntarily admitted patients were treated with ECT by these respondents since the introduction of the MHA 2001 in November 2006.

In relation to the attitudes of the respondents towards prescribing ECT for involuntary patients in the future when clinically indicated, 159 (97%) consultants stated that they would prescribe ECT when the patient was willing to consent, three (2%) would not and two (1%) were undecided. All five consultants who did not answer 'yes' to this question were general adult psychiatry consultants.

Of note, two of these consultants stated elsewhere in their questionnaire that they would prescribe ECT to an involuntary patient lacking capacity to consent. Furthermore, the one reply that was undecided queried in a comment whether such patients could have capacity to consent, and was also willing to prescribe ECT to patients lacking capacity. It is likely therefore that these three consultants took issue with the

possibility of an involuntary patient having capacity to provide informed consent for ECT, and that only two consultants (1%) from the sample took the position of being unwilling ever to prescribe ECT for involuntary patients.

For involuntary patients who lack capacity and are unable to consent, 157 (96%) consultants stated that they would and 6 (3.5%, five general adult psychiatry, one rehabilitation psychiatry) would not approve ECT and one (0.5%) was undecided.

For involuntary patients who have capacity to consent to treatment but are unwilling to do so, there was a marked divergence of opinion. The minority of consultants, 52 (32%) stated that they would still approve treatment with ECT for this patient group and 104 (63%) consultants stated that they would not approve ECT. Eight (5%) consultant psychiatrists stated that they were undecided. The results are displayed graphically in *Figure 1*. All of the 52 (32%) consultant psychiatrists, who stated that they would prescribe ECT for involuntary patients who have capacity to consent to treatment but are unwilling to do so, stated they would also prescribe ECT for involuntary patients who consent, and for those who lack the capacity and are unable to consent. Of the 51 consultants who had already prescribed ECT in the past for involuntary patients, 20 (39%) stated that they would prescribe ECT for involuntary patients who have the capacity but are unwilling to consent, 30 (59%) stated that they would not, and one (2%) was undecided.

A comparison of demographic details of consultants divided by their response to the question of approving ECT for patients unwilling to consent is provided in *Table 2*. There was no statistically significant difference between subgroups in relation to their specialty (Pearson Chi-Square = 4.1, $p = 0.13$), gender (Pearson Chi-Square = 0.07, $p = 0.78$), experience (Pearson Chi-Square = 0.79, $p = 0.67$), or if they had prescribed ECT in the past (Pearson Chi-Square = 1.57, $p = 0.21$).

Comments of the respondents

Sixty-three (38%) of consultants entered comments in the questionnaire and these represent some of the ethical and legal concerns of consultants when considering these clinical situations. A selection of these comments are provided in *Table 3*, divided by the consultants attitude towards prescribing ECT to patients who are unwilling to consent.

Of the two consultants who would not approve ECT in any of the three scenarios, both provided comments. One commented that the involuntary ECT section should be deleted from the MHA 2001 and should be covered by capacity legislation, and the other that she did not use ECT “since the findings in the last few years of more long-term memory loss following (it)”.

Of the eight consultants who did not answer whether or not they would prescribe ECT for involuntary patients who have capacity and are unwilling to consent, two provided the following explanations in the comments section to reflect the complexity of such a clinical situation: “it depends on the circumstances, the degree of loss of quality of life, family input” “Having capacity to consent” appears simple but is not. Does, for example, the patient have the capacity to refuse, is his refusal reasonable, is he facing inanition then due to starvation, or is he facing possible suicide, etc” and “I can’t

Table 2: Demographic details of consultants divided by their response on whether they would give ECT to patients who are unwilling to consent

Question: Should it be clinically indicated in the future, do you think that you would approve ECT therapy for an involuntary patient under the MHA 2001 who has capacity to consent to treatment but is unwilling to provide consent?

		Yes	No	Not sure
Specialty	General adult (123)	41	77	5
	Later life (18)	8	10	0
	Other (23)	3	17	3
Gender	Male (80)	24	53	3
	Female (66)	21	41	4
	Unknown (18)	7	10	1
Experience	< 10 yrs (70)	21	46	3
	10-20 yrs (57)	21	34	2
	> 20 yrs (3)	10	24	3
Have given ECT in past to involuntary patient under MHA 2001	Yes (51)	20	30	1
	No (113)	32	74	7
	Total (164)	52	104	8

answer yes or no to this, it would depend on circumstances, family opinion, previous experience and response and condition of the patient. If the patients life was at risk then ‘yes’ but with a number of safeguards in place, probably a second opinion, family discussion and possibly legal opinion”.

Discussion

The use of ECT to treat detained patients is an emotive and controversial issue which polarizes public opinion. This study portrays the views of a representative sample of those consultant psychiatrists actually likely to be faced with the clinical situation of prescribing ECT for involuntary patients under their care.

An overwhelming majority of consultant psychiatrists stated that they would prescribe ECT to consenting patients and to patients who lack capacity to consent, when ECT is clinically indicated and the patients are detained under MHA 2001. The preferred practice of the vast majority of consultants in caring for involuntary patients unable to consent to ECT would therefore be curtailed should this option be removed from the legislation.

A substantial divergence of opinion emerged when patients had capacity to consent but were unwilling to do so, with the majority of consultant psychiatrists stating that they would not prescribe ECT for involuntary patients who have capacity, but are unwilling to provide consent. However, a substantial minority of consultants stated that they would prescribe ECT under this circumstance. The preferred practice of the majority of consultants that participated in our survey would therefore not be affected by removal from the MHA 2001 legislation of the option of giving ECT to involuntary patients who are ‘unwilling’ to consent to it.

Several other jurisdictions have legislated for the administration of ECT to those who lack capacity to consent. In Scotland, patients who are capable of providing informed

consent, but refuse to, cannot be given ECT. However patients who lack capacity to consent can be prescribed ECT when authorised by an independent psychiatric opinion under either the Adults with Incapacity (Scotland) Act 2000, or The Mental Health (Care and Treatment) (Scotland) Act 2003, if the patient is detained or resists ECT.

In 2009, 27% of patients who received ECT in Scotland did so without providing informed consent due to lack of capacity, and 85% of these showed a definite improvement with treatment.¹³ In England and Wales, the Mental Health Act 1983 did allow the use of ECT on detained patients whether or not they had capacity to consent to it, when authorised by a Mental Health Act Commission panel psychiatrist, however the recently implemented MHA 2007 – Amendments to Mental Health Act 1983 Section 58, regulates that capacity of the patient should be assessed and gives people who retain decision-making capacity the right to refuse ECT, unless in emergency.¹⁴

In the US, involuntary ECT may not be initiated by a physician without a judicial proceeding. As a rule, such petitions are granted only where the prompt institution of ECT is regarded as potentially lifesaving.^{15,16} In Australia, the Victorian Mental Health Act 1986 allows for prescription of ECT without informed consent “if the patient is incapable of giving informed consent”, with clinical provisions and after “all reasonable efforts have been made to contact patient’s guardian or primary carer.”¹⁷

Clearly key to the decision about whether a patient can give informed consent to undergo a recommended medical procedure is the patient’s capacity to consent at that point in time. According to the Mental Health Commission, 49 involuntary patients were administered ECT in Ireland in 2008 without their consent, of whom two thirds were described as ‘unable’ and one third ‘unwilling’ to consent to treatment.

Of note, in 10% of cases the treating and second opinion consultant psychiatrists had differing opinions about whether the same patient was ‘unwilling’ or ‘unable’ to consent to treatment.¹⁸ Uncertainty about what determines capacity to consent to ECT was reflected in some of the comments collected for our study. For example, certain comments from the consultant psychiatrists, who stated that they would prescribe ECT for involuntary patients who are unwilling to consent, related to clinical situations where the patients could be considered to lack capacity to consent to ECT treatment, eg. patients in life threatening situations where they are refusing to drink or eat with severe psychotic depression.

Several consultant psychiatrists commented on the need to implement capacity legislation in Ireland. If a patient is deemed to lack capacity then other legal provisions could be considered – such as advanced directives or appointment of a guardian. This is particularly relevant for voluntary patients who lack capacity to consent to ECT, but are not seeking discharge from hospital – they can only be administered ECT as involuntary patients under MHA 2001 under current legislation. Despite repeated calls however there has been a failure to progress the proposed The Mental Capacity and Guardianship Bill 2007.¹⁹

The generally positive attitudes of psychiatrists towards ECT is similar to that found in previous research. Most psychiatrists surveyed in other jurisdictions consider ECT to be a safe and effective treatment for their patients, and around

Table 3: Selection of comments made by consultant psychiatrists on the questionnaire

Consultants who stated that they would not prescribe ECT for patients who have capacity but are unwilling to consent:

- “If the patient truly has capacity, then ECT should only be given if they consent for same. If a patient is severely depressed and suicidal and is refusing ECT as he believes he is doomed and nothing will work, in my opinion he doesn’t have the capacity”
- Capacity legislation required (this – comment was entered by several consultants)
- I strongly feel people should not be discriminated against based on presence or absence of mental illness. Full autonomy should be respected.
- If a patient has capacity then should have the right to refuse treatment. Their voluntary/involuntary status should be irrelevant
- I would have an ethical problem with enforced ECT as outlined in Q8 (ie. where patient is unwilling)
- I see no indication to give ECT to patients who have capacity but refuse consent
- Absolutely vital that we continue to be able to treat involuntary patients who lack capacity
- I see the role of ECT in involuntary patients to be for severely ill patients who are unable to consent to treatment by virtue of severity of their mental illness or by cognitive issues and whose physical health is precarious
- In very occasional circumstances – not eating, drinking and retarded; the decision to treat involuntary patients without consent is rare but may be life saving

Consultants who stated that they would prescribe ECT for patients who have capacity but are unwilling to consent:

- ECT is life saving where the involuntary patients are refusing to drink or eat and deteriorating or severe or psychotic depression where the life is at risk
- ECT used in treating involuntary patients who can’t provide informed consent is lifesaving especially in older patients. I’ve only use ECT when patients are refusing to eat/drink and were physically deteriorating. I have never heard from ECT opponents what alternative I should use
- We must administer ECT as we prescribe medication. We must not be caught in the present Anti-ECT hysteria. ECT is life saving and good for some patients
- As a specialty we need to advocate strongly on this issue using solid clinical examples
- My position is based on the following: 1) ECT is an effective treatment and 2) therefore it should be considered in a manner consistent with other effective treatments for involuntary patients
- I see ECT as life saving in some instances, eg. severe depressive illness – where time is of the essence or medication has failed to work. Undoubtedly it will be obsolete as a treatment in time – but not any time soon
- There are individual specific criteria for its use and to abandon this form of treatment would be disastrous
- Decision based on clinical need and risk of withholding the treatment
- Good question! – However my impression is that a patient, when sufficiently unwell to require detention under the MHA 2001 – and sufficiently unwell to require ECT, usually lacks capacity to consent?? I would respect patients wishes if I thought they retained capacity

90% of psychiatrists state that it is a treatment which they would opt for themselves if clinically indicated.^{20,21}

A major strength of the study is the high response rate from a strongly representative group of consultant psychiatrists, as well as the comprehensive comments of past challenging clinical situations. The questionnaire was necessarily brief to encourage a high response rate, however ideally further

information about consultants' attitudes towards assessing capacity could have been collected in the survey. Useful additional information would have included whether consultants are aware of the MHC guidelines on capacity to consent to ECT, and whether they routinely assess and document an assessment of capacity to consent to ECT for involuntary or indeed voluntary patients.

Only consultant psychiatrists were surveyed in the present study and it would be informative to explore the attitudes of representative samples of other mental health professionals and of service users towards this issue of administering ECT to involuntary patients who lack capacity to consent to treatment.

Conclusions

The prescribing of ECT to involuntary patients remains a controversial subject which polarizes public opinion. Most consultant psychiatrists would approve the use of ECT treatment when clinically indicated for involuntary patients who either consent or are unable to consent, but the majority would not approve it for patients who are unwilling to consent.

This study indicates that removing the option in Ireland of prescribing ECT to involuntary patients who lack capacity and are unable to consent to treatment would be opposed by the majority of consultants faced with such a clinical challenge.

Declaration of interest: None.

Acknowledgements

We would like to thank Mary Neylon for her help in identifying and contacting the mental health act administrators nationwide, and all the mental health act administrators for providing up to date lists of consultant psychiatrists attached to each approved centre.

References

1. Teh SPC, Helmes E, Drake DG. A Western Australian Survey On Public Attitudes Toward And Knowledge Of Electroconvulsive Therapy. *Int J Soc Psych* 2007; 53: 247-273
2. Kellner CH, Knapp RG, Petrides G et al. Continuation electroconvulsive therapy vs pharmacotherapy for relapse prevention in major depression: a multisite study from the Consortium for Research in Electroconvulsive Therapy (CORE). *Arch Gen Psych* 2006 Dec; 63(12): 1337
3. Sackeim H, Prudic J, Devanand P et al. A prospective, randomized, double-blind comparison of bilateral and right unilateral electroconvulsive therapy at different stimulus intensities *Arch Gen Psych* 2000;57: 425-434
4. UK ECT Review Group. Efficacy and safety of electro-convulsive therapy in depressive disorders: a systematic review and meta-analysis. *Lancet* 2003; 361: 799-808.
5. Merkl A, Heuser I, Bajbouj M. Antidepressant electroconvulsive therapy: Mechanism of action, recent advances and limitations. *Experimental Neurol* 2009; 219: 20-26.
6. Rose D, Fleischmann P, Wykes T, Leese T, Bindman J. Patients' perspectives on electroconvulsive therapy: systematic review. *BMJ* 2003; 326: 1363-1367.
7. Sackeim HA, Prudic J, Fuller R, Keilp J, Lavori PW, Olfson M. The cognitive effects of electroconvulsive therapy in community settings". *Neuropsychopharmacol* 2007; 32(1): 244-54.
8. American Psychiatric Association. *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging* (2nd Ed). Washington, DC: American Psychiatric Association, 2001: 24-5, 77-9
9. National Institute for Clinical Excellence. *Depression: the treatment and management of depression in adults*. Oct 2009.
10. Philpot M, Treloar A, Gormley N, Gustafson L. Barriers to the use of electroconvulsive therapy in the elderly: a European survey. *Eur Psych* 2002; 17(1): 41-5.
11. Mental Health Commission. *Rules governing the use of electro-convulsive therapy*. Mental Health Commission, October 2009
12. Mental Health (Involuntary procedures) (Amendment) Bill 2008. An Act to amend the law on mental health in relation to the use of involuntary procedures, No 36 of 2008
13. Scottish ECT Accreditation Network. *Annual Report 2010*. NHS National Services Scotland/Crown Copyright 2010.
14. Mental Health Act 2007 (c. 12), Part 1 – Amendments to Mental Health Act 1983, Chapter 3 – Safeguards for patients, no 27.
15. Mental Health: A Report of the Surgeon General – Chapter 4. 1999-12-29. Task Force on Electroconvulsive Therapy. *The practice of electroconvulsive therapy: recommendations for treatment, training, and privileging*. 2nd Ed. Washington, DC: American Psychiatric Publishing, 2001.
16. Harris V. Electroconvulsive Therapy: Administrative Codes, Legislation, and Professional Recommendations. *J Am Acad Psych Law* 2006, 34(3): 406-411.
17. Mental Health Act 1986, No. 59 of 1986, Version No. 092, Version incorporating amendments as at 1 July 2007
18. Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008, Mental Health Commission, Nov 2009
19. Dunne R, Kavanagh A, McLoughlin DM. Electroconvulsive therapy, capacity and the law in Ireland. *Ir J Psych Med* 2009; 26(1): 3-5.
20. Finch JM, Sobin PB, Carmody TJ, DeWitt AP, Shiwach RS. A Survey of Psychiatrists Attitudes Towards Electroconvulsive Therapy. *Psych Serv* 1999; 50(2): 264-265.
21. Taylor M, Brown T. "Do Unto Others As..." – Which Treatments do Psychiatrists Prefer? *Scot Med J* 2007; 52(1): 17-19.