



Ohio Administrative Code

Rule 5122-3-03 Evaluation and referral for electroconvulsive therapy (ECT).

Effective: September 20, 2010

(A) The purpose of this rule shall be to establish standards and criteria, indications, contraindications and limits for referral of adult ODMH regional psychiatric hospital (RPH) inpatients to an outside facility for ECT.

(B) The provisions of this rule shall be applicable to all RPHs under the managing responsibility of the department.

(C) Definitions

(1) "Chief clinical officer" and "CCO" mean the medical director of an RPH as defined in division (K) of section 5122.01 of the Revised Code.

(2) "Psychiatrist" means a licensed physician who has satisfactorily completed a residency training program in psychiatry, as approved by the residency review committee of the American medical association, the committee on post-graduate education of the American osteopathic association, or the American osteopathic board of neurology and psychiatry, or who on July 1, 1989, has been recognized as a psychiatrist by the Ohio state medical association or the Ohio osteopathic association on the basis of formal training and five or more years of medical practice limited to psychiatry.

(3) "ECT" is a somatic psychiatric treatment mediated by a modified grand mal seizure, which is induced by the application of electrical current of the brain.

(4) "Informed consent" means the voluntary and knowing permission given by a person who has received all appropriate information.

(D) Requirements for referral

(1) ECT shall not be administered in ODMH RPHs.



- (2) Only adult ODMH RPH inpatients shall be referred for ECT.

- (3) The RPH psychiatrist must present clinical data to the RPH CCO to obtain approval for ECT referrals.

- (4) It is required that any patient, voluntary or involuntary, competent or incompetent, shall be given a full explanation of ECT consistent with the specific items cited below:
 - (a) An explanation of the procedures to be followed and their purposes including identification of any procedures which are experimental. This explanation is to be given in such a way as to enable the individual to make a decision to grant/deny consent;

 - (b) A description of any attendant discomforts and risks reasonably to be expected;

 - (c) A description of any benefits reasonably to be expected;

 - (d) A disclosure of any appropriate alternative procedures/treatments that might be advantageous for that patient including an explanation of the consequences of those procedures/treatments;

 - (e) An offer to answer any inquiries concerning the procedures and answers to any such inquiries;

 - (f) An instruction that the individual may refuse to consent and that the individual is free to withdraw his consent and to discontinue the treatment at any time without prejudice unless informed consent for the ECT is given by guardian or court-ordered; and

 - (g) A notification that the individual may consult with an independent specialist and counsel.

- (5) The competence of a patient to give informed consent shall be determined by the attending psychiatrist. The written opinion shall be incorporated into the patient's permanent medical record.

- (6) The criteria for determining the competence of the patient, include but are not limited to:



(a) Whether or not the patient is physically and mentally able to receive the information required to be furnished;

(b) Whether or not the patient is able to explain his/her understanding of the information provided;
and

(c) Whether or not the patient demonstrates that he/she has evaluated the information provided.

(7) Competent adult patients

No competent adult patient shall be given ECT unless his/her informed consent has been obtained.

(8) Adult incompetent involuntary patients

(a) If an adult patient has been adjudicated incompetent to give informed consent for medical treatment by a probate court, the patient's guardian may give informed consent.

(b) If an adult patient has been determined to be incompetent to give consent according to the procedure outlined above, and has no guardian, ECT may be administered only under the following conditions:

(i) The attending psychiatrist must certify in writing that an indication for ECT use as outlined in paragraph (E) of this rule is evident;

(ii) The chief clinical officer recommends in writing the administration of ECT; and

(iii) If a durable power of attorney for healthcare issues exist, it should be followed. Otherwise, approval for ECT shall be obtained from the probate court.

(E) Indications for use

(1) General statement



Referrals for ECT are based upon a combination of factors, including the patient's diagnosis, nature and severity of symptomatology, treatment history, consideration of anticipated risks and benefits of viable treatment options, and patient preference. At present there are no diagnoses which should automatically lead to treatment with ECT. In most cases, ECT is used following treatment failure on psychotropic agents, although specific criteria do exist for use of ECT as a first-line treatment.

(2) Primary use of ECT

Situations where ECT may be used prior to a trial of psychotropic agents include, but are not limited to, the following:

- (a) Where a need for rapid, definitive response exists on either medical or psychiatric grounds; or
- (b) When the risks of other treatment outweigh the risks of ECT; or
- (c) When history of poor drug response and/or good ECT response exists for previous episodes of the illness; or
- (d) Patient preference.

(3) Secondary use of ECT

In other situations, a trial of an alternative therapy should be considered prior to referral for ECT. Subsequent referral for ECT should be based on at least one of the following:

- (a) Treatment failure, taking into account issues such as choice of agent, dosage, and duration of trial;
- (b) Adverse effects which are unavoidable and which are deemed less likely and/or less severe with ECT; and
- (c) Deterioration of the patient's condition such that criterion in paragraph (E)(2)(a) of this rule is met.



(4) Major diagnostic indications

Diagnoses for which either compelling data are present for efficacy of ECT or a strong consensus exists in the field supporting such use.

(a) Major depressive disorder. ECT is an effective treatment for all subtypes of major depressive disorder;

(b) Bipolar disorder. ECT is an effective treatment for all sub-types and phases of bipolar disorder including manic, depressed and mixed phases.

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(c) Schizophrenia, schizoaffective disorder and other psychoses.

ECT may be an effective treatment for psychotic schizophrenic exacerbations including catatonia, when prominent affective symptoms are present and when there is a history of favorable response. ECT may be effective in other psychotic disorders.

(d) Mental disorders due to a general medical condition. ECT may be effective in the management of severe affective and psychotic symptoms concomitant with general medical conditions, or in treating delirium of various etiologies, including toxic and metabolic.

(e) Other diagnostic indications.

(i) For people with diagnoses for which efficacy data for ECT are only suggestive, or where only a partial consensus exists in the field, support its use. In such cases, ECT should be recommended only after standard alternatives have been considered as a primary intervention. The existence of such indications, however, should not deter the use of ECT for treatment of a concurrent major diagnostic medication.

(ii) Although ECT has sometimes been of assistance in the management of mental disorders other



than those described above, such usage is not adequately substantiated and should be carefully justified in the clinical record on a case-by-case basis.

(f) Medical disorders

(i) The neurobiologic effects associated with induced generalized seizure activity may be of benefit in treating a small number of medical disorders.

(ii) Such conditions include, but are not limited to:

(a) Catatonia secondary to medical conditions (ECT is indicated for catatonia of all causes);

(b) Hypopituitarism;

(c) Intractable seizure disorder;

(d) Neuroleptic malignant syndrome; and

(e) Parkinson's disease.

(F) Contraindications and situations of high risk

(1) There are no absolute contraindications to ECT.

(2) Situations associated with substantial risk

(a) Situations exist in which ECT is associated with an appreciable likelihood of serious morbidity or mortality. In such cases, the decision for ECT should be based upon the premise that the patient's condition is too grave, (i.e., life threatening) to leave untreated, and that ECT is the safest treatment available.

(b) In these instances, careful medical evaluation of risk factors should be carried out prior to ECT, with specific attention to treatment modifications which may diminish the level of risk.



(c) Specific conditions associated with substantially increased risk include the following:

(i) Space-occupying cerebral lesion, or other conditions with increased intracranial pressure;

(ii) Seizure disorder;

(iii) Recent myocardial infarction with unstable cardiac function;

(iv) Recent intracerebral hemorrhage;

(v) Bleeding, or otherwise unstable, vascular aneurysm or malformation;

(vi) Retinal detachment;

(vii) Pheochromocytoma; and

(viii) Significant anesthetic risk.

(d) Concomitant medications. The following medications should be discontinued or dosage reduced:

(i) Benzodiazapines, as they are anti-convulsants - should be held for at least eight hours;

(ii) Lithium, as it can increase postictal delirium and prolong seizure activity - should be reduced in dose;

(iii) Bupropion, as it can induce late appearing seizures - should be discontinued;

(iv) Lidocaine markedly increases seizure threshold - should be held for at least eight hours;

(v) Theophylline increases the duration of seizures - should be discontinued;

(vi) Reserpine can cause respiratory and cardiovascular problems and should be discontinued; and



(vii) Other medications as determined by the IBHS pharmacy and therapeutics committee.

(G) Medical evaluation

When a patient remains an ODMH RPH patient when receiving ECT, the following medical evaluation will need to be completed by the ODMH RPH staff:

- (1) Medical examination;
- (2) Neurological examination;
- (3) Laboratory evaluations including CBC and differential; blood and urine chemistries;
- (4) Electrocardiogram;
- (5) X-ray of lumbosacral region if spinal problems are suspected;
- (6) Chest x-ray, if clinically indicated;
- (7) In the presence of central nervous system symptoms (seizure disorder or a space occupying lesion), EEG and brain computed tomographic scan or magnetic resonance imaging;
- (8) Dental examination for elderly patients and those with dental problems; and
- (9) Anesthesiologist consults to evaluate risk of anesthesia. This may be completed at the facility where ECT is administered prior to ECT occurring.

(H) Referred facility requirement

- (1) Properly accredited hospital or outpatient facility.
- (2) The psychiatrist who is responsible for the administration of ECT has been credentialed and



privileged in ECT by the facility where the ECT is being administered.

(I) Training

When ODMH RPH patients are receiving ECT as outpatients, the RPH nursing staff shall be provided with appropriate training on nursing care for these patients to assure competent care of pre- and post-ECT treatment.

(J) Reference

"Recommendations for Treatment, Training, and Privileging: A Task Force Report of the American Psychiatric Association, 2nd ed., 2001".