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ECT and COVID-19

Electroconvulsive therapy (ECT) is a highly effective treatment with a strong evidence base, particularly for the treatment of severe depressive disorders. To continue to provide and prioritise this important treatment, ECT services in Australia, New Zealand and worldwide have been considering the implications of COVID-19 for ECT treatment. The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) Section of ECT and Neurostimulation has developed the following information in relation to considerations and precautions for the delivery of ECT in relation to COVID-19 and the current situation. Psychiatrists should also ensure that they follow local guidance and protocols. This RANZCP information will be reviewed and updated as necessary in response to the changing situation.

Psychiatric considerations – should ECT be given?

The ECT procedure involves a risk of virus transmission because of the ventilation procedure during general anaesthesia. That is, aerosols may be produced while intubating a patient. With a closed ventilator circuit, aerosol risk is low. Additional precautions should be adopted in all ECT services; however these precautions cannot eliminate the risk. The need for ECT treatment can be classified as:

- 1) **Elective** – ECT is indicated but the patient is not at significant risk if ECT is not given, e.g. chronic, treatment resistant depression but without significant suicide risk, maintenance ECT where alternative pharmacological or psychotherapeutic prevention strategies may be effective in preventing relapse.
- 2) **Essential** – ECT is indicated and the patient is at significant risk if ECT is not given, e.g. depression with significant suicide risk, maintenance ECT where the patient is likely to relapse quickly when ECT is withdrawn, despite the use of other relapse prevention strategies.
- 3) **Urgent/emergency** – ECT is indicated and the patient is at risk if ECT is not given e.g. malignant catatonia, severe and/or psychotic depression with poor oral intake, acute suicide risk.

Each hospital and health system provider is likely to have its own prioritisation and guidance for service continuity, and decisions may have already been made about ECT in line with local policies. Given the pandemic situation, there is need to minimise people going in and out of the hospital environment. The complex clinical decision about whether to proceed with ECT should take into account local policies, with a plan to minimise, postpone, or cancel electively scheduled ECT procedures based on carefully considering the individual needs of each patient. The patient's treating psychiatrist is best placed to make the decision as to whether ECT is essential, in consultation with a credentialed ECT psychiatrist and the patient/family/carer. Emergency ECT

should follow the COVID protocols in place for emergency surgical procedures in the hospital or health system.

The patient's treating psychiatrist should discuss with the patient the need for ECT, considering the risks and benefits when making a decision to proceed with acute or continuation/maintenance ECT OR to defer treatment to a later date (when the risk of COVID-19 may be less) OR not to proceed with ECT at all.

It is also recognised that patients receiving ECT are usually amongst the most mentally unwell and are likely to be severely affected by a halt in treatment. Given the potential life-saving nature of the treatment, services faced with difficult decisions should try not to withdraw anaesthetic staff from ECT lists, or ECT equipment, without prior clinical consultation with psychiatric colleagues about the urgency of patients to be treated.

Anaesthetic considerations

ECT is an aerosol generating procedure (AGP) and as such has considerations for the use of personal protective equipment (PPE). The Department of Health in Australia has developed [guidance on the use of PPE equipment in hospitals during the COVID-19 outbreak](#). The Ministry of Health in New Zealand has also issued [guidance on the use of PPE in healthcare](#). National and local guidelines should be followed in respect to ECT procedures.

If a patient who requires ECT is known to have COVID-19 infection, they should be treated in a hospital where facilities required for their safe treatment can be provided. The [Australian Society of Anaesthetists \(ASA\)](#) and the [Australian and New Zealand College of Anaesthetists \(ANZCA\)](#) have developed information to support anaesthetists during COVID-19 including on personal protective equipment (PPE).

Additional precautions for consideration in ECT services

In delivering ECT treatments, it is important to follow the latest [Department of Health](#) (Australia) and [Ministry of Health](#) (New Zealand) advice as well as organisation protocols with regards to patient and staff health and safety, and anaesthetic pre-assessment. The following precautions are listed only a guide.

1. Staff working in the delivery of ECT should follow organisation protocols with regards to fitness to work in respect to COVID pandemic, COVID screening and PPE. Services are encouraged to identify back up staff members for each service so that so that ECT services can continue in the event of unexpected staff shortages.
2. Prior to commencement of an ECT course: All ECT patients should be screened for COVID-19 risk – refer to local guidelines and protocols for screening questions required. The referring doctor should make an assessment of the risk or likelihood of COVID-19 infection and discuss this with the anaesthetist before the patient is sent for ECT.
3. For day-patients having ECT, the ECT team should contact the patient the day before treatment, to screen for COVID-19 risk factors, and the development of respiratory symptoms. If any of these risk factors are positive, the patient's treating psychiatrist should be informed and the decision to have ECT reconsidered.

4. Prior to each ECT treatment, on arrival at the ECT suite: Patients should be observed to use hand sanitizers; patients should be screened for the presence of respiratory symptoms; a full set of observations should be taken, including temperature; and no visitors should be allowed in the suite and other local protocols in regard to visitors followed.
5. ECT waiting room – stage the arrival of patients so there are only a few patients in the room at a time (depending on size waiting room, allowing at least 4 m² per patient).
6. ECT treatment room – the number of staff in the treatment room should be kept to a minimum, so that only those required for the safe delivery of ECT are present. The one person per 4 m² rule should be observed wherever possible. Case notes should be kept outside the treatment room or in line with local organisational protocols.
7. Patients should be treated in order of patient profile – e.g. inpatients, then outpatients; older patients, then younger patients. Any patient with respiratory symptoms but where there is no indication this is likely to be COVID-19 infection (and whom the anaesthetist judges is fit for ECT) should be treated towards the end of the session. Patients known to have COVID-19 infection should be treated at the end of the session. For large services, consider grouping inpatients according to the wards they come from.
8. PPE for staff in the treatment and recovery rooms should be as per national and local PPE guidelines. Hands should be washed and gloves changed between patients. It is acknowledged that recommendations may be revised if the rate of infection in the community spreads (e.g. the need for routine use of surgical masks may become necessary).
9. Cleaning - Before commencing treatment of each patient, carefully clean with disinfectant wipes (e.g. alcohol >70%):
 - ECT equipment (metal electrodes, stimulating lead, EEG leads, hand pieces, headband, ECT machine, ECT work area)
 - Anaesthetic and monitoring equipment (tourniquet, pulse oximeter probe and lead, ECG leads)
 - All surfaces (ECT work area, anaesthetic trolley, ECT and drug register area, beds).

It is acknowledged that this cleaning may slow down turnaround time for each procedure, which may limit the capacity of the ECT service in terms of number of patients treated per session. Therefore, the considerations about triaging the necessity for ECT may be useful to manage ECT provision.

10. Due to the need for regular cleaning (e.g. as outlined in the [Australian Department of Health COVID-19 environmental cleaning and disinfection principles](#)) in between treatments, and possibly limited capacity for ECT treatments, psychiatrists will need to explore ways to manage ECT treatment schedules. Careful consideration should be given to the type of ECT prescribed, specifically pulse width and electrode placement combinations that might lead to a more rapid response with fewer treatments required, balancing this with the need to minimise cognitive side effects in individual patients. It may be appropriate to give ECT twice per week instead of three times per week. This will require a careful consideration of each patient's unique circumstances.

ECT Resource:

Weiss, Hussain, Ng et al. (2019). [Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy](#). *Australian and New Zealand Journal of Psychiatry* 53: 609-623.

Disclaimer

This information is intended to provide general guidance to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances, information or material that may have become subsequently available.

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