Complete Summary

GUIDELINE TITLE

Guidance on the use of electroconvulsive therapy.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Clinical Excellence (NICE). Guidance on the use of electroconvulsive therapy. London (UK): National Institute for Clinical Excellence (NICE); 2003 Apr. 36 p. (Technology appraisal; no. 59).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

- Depressive illness
- Schizophrenia
- Catatonia
- Mania

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Management
Treatment

CLINICAL SPECIALTY

Psychiatry

INTENDED USERS

Advanced Practice Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To establish the clinical and cost effectiveness of electroconvulsive therapy (ECT) for depressive illness, schizophrenia, catatonia, and mania

TARGET POPULATION

Adults with depressive illness, schizophrenia, catatonia, or mania

INTERVENTIONS AND PRACTICES CONSIDERED

Electroconvulsive therapy

MAJOR OUTCOMES CONSIDERED

- Clinical effectiveness
    - Symptom improvement
    - Quality of life
    - Adverse effects
- Cost effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by The University of Sheffield, School of Health and Related Research [ScHARR] and the Nuffield Institute for Health, University of Leeds. (See the "Companion Documents" field.)

Search Strategy: Clinical Effectiveness

Sources Searched

17 electronic bibliographic databases were searched, covering biomedical, health-related, science, social science, and grey literature. A list of databases is provided in Appendix 1 of the Assessment Report (see "Availability of Companion Documents" field). This includes the Cochrane Schizophrenia Group Trials Register, which was searched on behalf of the review team by the Group's Trials Search Co-ordinator.

In addition, the reference lists of relevant articles were checked and 40 health services research related resources were consulted via the Internet. These included Health Technology Assessment (HTA) organisations, guideline producing bodies, generic research and trials registers and specialist psychiatric sites. A list of these additional sources is given in Appendix 2 of the Assessment Report (see "Availability of Companion Documents" field). Finally, citation searches of key papers were undertaken using the Science Citation Index (SCI) citation facility and the reference lists of included studies were checked for additional studies.

Search Terms

A combination of free-text and thesaurus terms were used. "Population" terms (e.g., depression, schizophrenia, catatonia, bipolar disorder, mania, mood disorders, adjustment disorders, psychotic disorders, mental disorders, etc.) were combined with "intervention" terms (e.g., electroconvulsive therapy, electro convulsive therapy, electroshock therapy, electro shock therapy, etc.). Copies of the search strategies used in the major databases are included in Appendix 3 of the Assessment Report (see "Availability of Companion Documents" field).

Search Restrictions

No date or language restrictions were applied. Where necessary (e.g., in the larger databases, such as Medline), searches were restricted to the highest quality of evidence, i.e., practice guidelines, systematic reviews, and randomised controlled trials, using methodological filters (Appendix 4 of the Assessment Report [see "Companion Documents" field]). These were supplemented by strategies designed to pick up other outcomes, such as patient acceptability, side effects and staff training (Appendix 4 of the Assessment Report [see "Availability of Companion Documents" field]).

Search Strategy: Cost Effectiveness

In addition to the searches conducted above, searches were conducted in the National Health Service Economic Evaluations Database (NHS EED) and Office of Health Economics Health Economic Evaluations Database (OHE HEED) to specifically identify cost effectiveness literature (Appendix 3 of the Assessment Report [see "Availability of Companion Documents" field]).

Methodological search filters designed to retrieve economic evaluations and quality of life studies (Appendix 4 of the Assessment Report [see "Availability of Companion Documents" field]) were also applied to the Medline and Embase search strategies.

There were no company submissions.

Inclusion and Exclusion Criteria

Populations

Papers were included in the review if they included the following populations: depressive illness (both unipolar and bipolar), schizophrenia and schizo-affective disorder, catatonia and mania. The Assessment Group also aimed to explore the clinical effectiveness of electroconvulsive therapy (ECT) in particular subgroups including people who are treatment resistant to pharmacotherapy, older people (defined as aged 65 and over), younger people (defined as aged 18 or under) and disorders associated with pregnancy and the puerperium. Papers were excluded if they included populations with more than one diagnosis (for example depression and schizophrenia) and did not stratify randomisation by disease type or report results separately for each diagnosis.

Interventions

Papers were included in the review if they examined the effectiveness or cost effectiveness of electroconvulsive therapy either as a monotherapy or in conjunction with other appropriate pharmacological or psychological treatment, at all doses and frequency of administration, by any technique, in all settings, and administered by any health professional. The Assessment Group also included studies investigating the efficacy of adjunctive and continuation or maintenance ECT or pharmacotherapy and interventions that aimed to improve patient knowledge about ECT.

Comparators

Papers were included if they compared ECT to any pharmacological or non-pharmacological treatment including sham ECT, psychotherapy, or repetitive transcranial magnetic stimulation (rTMS). Studies that compared one or more types of pharmacotherapy post ECT were also included.

Outcomes

Studies were included if they assessed outcomes relating to the efficacy, safety and acceptability of ECT. The primary indicator of the efficacy of ECT were clinically meaningful benefits in symptoms and/or quality of life as measured by a validated rating scale or clinical opinion, secondary indicators were the speed of response to ECT, premature withdrawals by the decision of either the participant, the clinician in charge of their care or the researcher, discharges from hospital and relapses. The primary indicators of the safety of ECT were adverse events including both objective and subjective reports of memory loss (anterograde, retrograde and subjective reports of memory loss) and all cause and cause specific mortality (including suicide). All these outcomes were considered immediately after the course of ECT, at 6 months and 12 month or longer. The primary indicators of acceptability were patients' choice of treatment and their views and experiences of ECT either from questionnaires or interviews.

Study Methodology

Published papers were included in the review according to the accepted hierarchy of evidence. In the first instance papers were only included if they were systematic reviews, randomised controlled trials and economic evaluations. Where no randomised controlled trial evidence was available, non-randomised comparator studies (for example non-randomised trials, controlled cohort studies, and case control studies) were included in the review. Where no evidence from non-randomised comparator studies is available, non-randomised, non-comparator studies (for example case series, case reports, non-controlled cohort studies) were included in the review.

Language

Any studies not available in English were excluded as the time scale of the review precluded time for translation.

NUMBER OF SOURCE DOCUMENTS

Two good quality systematic reviews of randomised evidence of the efficacy and safety of electroconvulsive therapy (ECT) in people with depression, schizophrenia, catatonia and mania were identified. Also identified were 4 systematic reviews on non randomised evidence, though only one of these could be described as good quality.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by the School of Health and Related Research (ScHARR), University of Sheffield and the Nuffield Institute for Health, University of Leeds. (See the "Companion Documents" field.)

Quality Assessment and Selection of Studies

All the abstracts identified by the searches were entered into a reference manager database and reviewed by the relevant author to assess their relevance to the review's objectives in terms of the clinical and cost effectiveness of electroconvulsive therapy (ECT). All potentially relevant papers were ordered and assessed by the relevant author to determine whether they met the study's inclusion criteria in terms of the populations, interventions, outcomes, and study quality.

The assessment of study quality was not conducted blindly and used the following guidelines:

- Systematic reviews were assessed according to the User's guides to evidence based practice.
- Randomised controlled trials were assessed with respect to randomisation procedures, blinding, handling of withdrawals and dropouts, guided by Jadad's scoring system and the Cochrane Collaboration Handbook.
- Non randomised studies using quantitative data, such as case-control, cohort, case series and case reports were assessed with respect to validity using guidelines from the Centre for Health Evidence based upon the Users Guides to Evidence-Based Medicine.
- Qualitative evidence was assessed using the standards proposed by Popay et al.
- The quality of the economic literature was assessed according to the Guidelines for authors and peer reviewers of economic submissions to the British Medical Journal (BMJ).

Data Extraction and Analysis

Two reviewers extracted data on clinical effectiveness using 3 separate, standard abstraction forms for systematic reviews, randomised controlled trials, and non randomised evidence respectively. This was not conducted blind to the authorship of the study.

Where the guideline developers were satisfied that the populations, interventions, and outcomes between trials were sufficiently similar, results were pooled in a meta-analysis.

Clinically meaningful improvement in symptoms was abstracted using both binary and continuous data. For dichotomous data the guideline developers compared the number of responders or relapsers in each treatment arm as defined by the trialists. Other binary outcomes were the number of discontinuations, relapses and deaths. Those leaving the trial early were assigned to the worse outcome, and this was tested using a sensitivity analysis. If the definition of responders or relapsers used by the trialists was not clear, a clinically meaningful cut off was decided by an independent clinician who was blind to the trial authors, the intervention, numbers achieving each outcome in each arm and number in each arm. Where trials used different methods to define responders (for example clinical opinion versus scores on the Hamilton Depression Scale), this was tested using sensitivity analysis. The data was deemed unusable if the number of people meeting responder or relapse criteria were not specified separately in each group, or dropouts were not accounted for on a treatment group basis.

The guideline developers calculated relative risks and confidence intervals using the random effects DerSimonian and Laird method. All analyses were by intention to treat.

For continuous data group means and standard deviations at baseline, immediately after ECT and at 6 months follow up were recorded. The data was deemed unusable if:

- No standard deviations or standard errors and/or means were reported
- The instrument used had not been published in a peer reviewed journal as non validated outcome measures are a serious threat to the validity of meta-analyses
- Baseline and follow up data was based on different samples (for example, baseline data included all participants but follow up data only included the completer sample)
- At least 50% of the sample were lost to follow up

For studies reporting continuous outcome data all measured using the same scale or instrument (e.g., Hamilton Depression rating) the summary statistic used was the weighted mean difference (WMD). Again a random effects model was used with the DerSimonian and Laird method.

For studies reporting continuous outcome data when different scales or instruments were used to measure the effect (e.g., Hamilton Depression rating, Hospital Anxiety and Depression Scale [HADS], Beck Depression Inventor [BDI]), the summary statistic used was the standardised mean difference (SMD). The guideline developer assumed that these instruments were all measuring the same underlying trait of "depression." Again the guideline developer used a random effects model with the DerSimonian and Laird method.

All analyses were carried out in RevMan v4.0 (http://www.cc-ims.net/RevMan).

Heterogeneity was examined both graphically and with a formal statistical test of heterogeneity. If the confidence intervals for the results of each study (typically presented by horizontal lines) do not overlap, it suggests that the differences are likely to be statistically significant. A formal statistical test of homogeneity was also used to examine whether the observed variation in study results is compatible with the variation expected by chance alone. The more significant the results of the test (the smaller the p-value), the more likely it is that the observed differences were not due to chance alone.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Clinical Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE website. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

There are no published economic studies relating to electroconvulsive therapy (ECT), and none of the submissions from consultees contained any economic analyses. The Assessment Group therefore constructed economic models of ECT for depressive illness and schizophrenia based on a review of published evidence. They were not able to construct robust models for mania and catatonia because of the low volume of data in these areas.

See Section 4.2 of the original guideline document for a detailed discussion of the cost-effectiveness analysis.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Consultee organizations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination.

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

- It is recommended that electroconvulsive therapy (ECT) is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with:
    - Severe depressive illness
    - Catatonia
    - A prolonged or severe manic episode
- The decision as to whether ECT is clinically indicated should be based on a documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anaesthetic; current co-morbidities; anticipated adverse events, particularly cognitive impairment; and the risks of not having treatment.

- The risks associated with ECT may be enhanced during pregnancy, in older people, and in children and young people, and therefore clinicians should exercise particular caution when considering ECT treatment in these groups.
- Valid consent should be obtained in all cases where the individual has the ability to grant or refuse consent. The decision to use ECT should be made jointly by the individual and the clinician(s) responsible for treatment, on the basis of an informed discussion. This discussion should be enabled by the provision of full and appropriate information about the general risks associated with ECT and about the risks and potential benefits specific to that individual. Consent should be obtained without pressure or coercion, which may occur as a result of the circumstances and clinical setting, and the individual should be reminded of their right to withdraw consent at any point. There should be strict adherence to recognised guidelines about consent and the involvement of patient advocates and/or carers to facilitate informed discussion is strongly encouraged.
- In all situations where informed discussion and consent is not possible advance directives should be taken fully into account and the individual's advocate and/or carer should be consulted.
- Clinical status should be assessed following each ECT session and treatment should be stopped when a response has been achieved, or sooner if there is evidence of adverse effects. Cognitive function should be monitored on an ongoing basis, and at a minimum at the end of each course of treatment.
- It is recommended that a repeat course of ECT should be considered under the circumstances indicated in the first point (see above) only for individuals who have severe depressive illness, catatonia or mania and who have previously responded well to ECT. In patients who are experiencing an acute episode but have not previously responded, a repeat trial of ECT should be undertaken only after all other options have been considered and following discussion of the risks and benefits with the individual and/or where appropriate their carer/advocate.
- As the longer-term benefits and risks of ECT have not been clearly established, it is not recommended as a maintenance therapy in depressive illness.
- The current state of the evidence does not allow the general use of ECT in the management of schizophrenia to be recommended.
- National information leaflets should be developed through consultation with appropriate professional and user organisations to enable individuals and their carers/advocates to make an informed decision regarding the appropriateness of ECT for their circumstances. The leaflets should be evidence based, include information about the risks of ECT and availability of alternative treatments, and be produced in formats and languages that make them accessible to a wide range of service users.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of electroconvulsive therapy in adults with depressive illness, schizophrenia, catatonia or mania

POTENTIAL HARMS

Side effects of therapy

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation and Audit

- National Health Service (NHS) Trusts should ensure that electroconvulsive therapy (ECT) is carried out in accordance with the recommendations (see the "Major Recommendations" field) and only by clinical staff trained in its application. Such staff should maintain an appropriate level of skill through routine practice and continuing professional development.
- NHS Trusts currently offering ECT, and all clinicians involved in the care of individuals receiving ECT, should review policies and practices regarding its use to take account of the guidance (see the "Major Recommendations" field).
- Local guidelines or care pathways involving ECT should incorporate the guidance (see the "Major Recommendations" field).
- To measure compliance locally with the guidance, the following criteria could be used. Further details on suggestions for audit are presented in Appendix D of the original guideline document.
    - ECT is used only for an individual with any of the following:
        - Severe depressive illness
        - Catatonia
        - A prolonged or severe manic episode.
    - 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 and/or when the condition is considered to be potentially life threatening.

- An assessment of the risks and potential benefits to the individual undergoing ECT is documented. If the individual is pregnant, an older person, or a child or young person, the clinician(s) involved should exercise particular caution and the individual or their advocate or carer should be made aware that the risks associated with ECT may be enhanced in these circumstances.
- The individual undergoing ECT provides valid consent if he or she has the ability to grant or refuse consent. In situations where joint decision making, informed discussion and consent are not possible, advance directives are fully taken into account and the individual's advocate and/or carer is consulted.
- The consent process provides that the clinician(s) responsible for treatment:
    - Involves the individual's advocate and/or carer where possible
    - Provides full and appropriate information in a suitable format and language to enable an informed discussion
    - Explains and discusses the general risks of ECT, risks specific to the individual and potential benefits to the individual
    - Does not pressure or coerce the individual into consent to the treatment
    - Reminds the individual that he or she has the right to withdraw consent at any point.
- 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.
- ECT treatment is stopped once a response is achieved, if there is evidence of adverse effects, or if the individual withdraws consent.
- A repeat course of ECT is considered only for an individual:
    - Under the circumstances described in sections 7.4.1 and 7.4.2 of the original guideline document who has previously responded well to ECT
    - Who has not responded previously but is experiencing an acute episode and all other options have been considered, and following discussion with the individual and/or where appropriate the carer/advocate of the risks and benefits of such a course of action. ECT is not used as a maintenance therapy in depressive illness.
- ECT is not used in the general management of schizophrenia.

- Local clinical audits should include input from service users on at least criteria in sections 7.4.4-7.4.9 of the original guideline document and reference to standards in the current handbook on ECT published by the Royal College of Psychiatrists and the Royal College of Nursing, and the suggested indicators for audit of anaesthesia for ECT published by the Royal College of Anaesthetists.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Foreign Language Translations
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Clinical Excellence (NICE). Guidance on the use of electroconvulsive therapy. London (UK): National Institute for Clinical Excellence (NICE); 2003 Apr. 36 p. (Technology appraisal; no. 59).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Apr

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Appraisal Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Professor R L Akehurst, Dean, School of Health Related Research, Sheffield University; Professor David Barnett (*Chair*) Professor of

Clinical Pharmacology, University of Leicester; Professor Sir Colin Berry, Retired Professor of Morbid Anatomy & Histopathology, The Royal London Hospital; Dr Sheila Bird, MRC Biostatistics Unit, Cambridge; Professor Rosamund Bryar, Professor of Community & Primary Care Nursing, St Bartholomew's School of Nursing & Midwifery, London; Professor Martin Buxton, Director of Health Economics Research Group, Brunel University, Uxbridge; Dr Karl Claxton, Health Economist, University of York; Professor Sarah Cowley, Professor of Community Practice Development, Kings College, London; Mr Chris Evennett (resigned June 2002) Chief Executive, Mid-Hampshire Primary Care Trust, Winchester; Professor Terry Feest, Clinical Director & Consultant Nephrologist, Richard Bright Renal Unit, & Chair of UK Renal Registry, Bristol; Professor Gary A Ford, Professor of Pharmacology of Old Age/Consultant Physician, Newcastle upon Tyne Hospitals NHS Trust; Mrs Sue Gallagher, Former Chief Executive, Merton, Sutton & Wandsworth Health Authority, London; Dr Trevor Gibbs, Head, Global Clinical Safety & Pharmacovigilance, GlaxoSmithKline, Greenford; Mr John Goulston, Director of Finance, St Bartholoemew's Hospital & the London NHS Trust; Professor Philip Home, Professor of Diabetes Medicine, University of Newcastle upon Tyne; Dr Terry John, General Practitioner, The Firs, London; Dr Diane Ketley (term of office ended August 2002) Research into Practice Programme Leader, NHS Modernisation Agency, Leicester; Dr Mayur Lakhani (term of office ended August 2002) General Practitioner, Highgate Surgery, Leicester, & Lecturer, University of Leicester; Mr Muntzer Mughal, Consultant Surgeon, Lancashire Teaching Hospitals NHS Trust, Chorley; Mr James Partridge, Lay Representative, Chief Executive, Changing Faces, London; Professor Philip Routledge, Professor of Clinical Pharmacology, College of Medicine, University of Wales, Cardiff; Professor Andrew Stevens (*Vice-Chair*) Professor of Public Health, University of Birmingham; Dr Cathryn Thomas, General Practitioner, & Senior Lecturer, Department of Primary Care & General Practice, University of Birmingham; Dr David Winfield, Consultant Haematologist, Royal Hallamshire Hospital, Sheffield

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Guidance on the use of electroconvulsive therapy. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE);

2003 Apr. 2 p. (Technology appraisal 59). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

- Electroconvulsive therapy (ECT) for depressive illness, schizophrenia, catatonia and mania. Assessment report. NHS R&D HTA Programme. 186 p. Available in Portable Document Format (PDF) from the NICE Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N0205. 11 Strand, London, WC2N 5HR.

Additionally, Audit Criteria can be found in Appendix D of the original guideline document.

PATIENT RESOURCES

The following is available:

- The use of electroconvulsive therapy. Understanding NICE guidance – information for service users, their advocates and carers, and the public. London (UK): National Institute for Health and Clinical Excellence (NICE); 2003 Apr. 11 p. (Technology appraisal 59).

Electronic copies: Available in English and Welsh in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the Department of Health Publications Order Line 0870 1555 455. ref: N0207. 11 Strand, London, WC2N 5HR.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on July 7, 2006.

The National Institute for Health and Clinical Excellence (NICE) has granted the National Guideline Clearinghouse (NGC) permission to include summaries of their Technology Appraisal guidance with the intention of disseminating and facilitating the implementation of that guidance. NICE has not verified this content to confirm that it accurately reflects the original NICE guidance and therefore no guarantees are given by NICE in this regard. All NICE technology appraisal guidance is prepared in relation to the National Health Service in England and Wales. NICE has not been involved in the development or adaptation of NICE guidance for use in any other country. The full versions of all NICE guidance can be found at www.nice.org.uk.

COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 11/3/2008