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ECT and COVID-19

Electroconvulsive therapy (ECT) is a highly effective treatment with a strong evidence base for select neuropsychiatric disorders, 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 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depression with significant suicide risk, maintenance ECT where the patient is likely to relapse quickly when ECT is withdrawn, despite the use of other relapse prevention strategies.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.

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. Whilst COVID-19 remains prevalent worldwide, additional precautions should be adopted in all ECT services, however these precautions cannot eliminate the 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. Whilst COVID-19 remains a risk there is likely to remain a preference to minimise people going in and out of the hospital environment. However, depending on prevailing incidence of

COVID-19 infection in local regions, there is likely to be a need to regularly adapt and consider decisions, particularly in regard to the relative risks and benefits of ECT treatment.

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 should proceed in consultation with a credentialed ECT psychiatrist and the patient/family/carer. Emergency ECT should follow the COVID-19 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, psychiatrists should work with anaesthetic staff in regard to how to manage ECT lists and equipment, to ensure that ECT treatment continues to be available to those who need it during the pandemic.

It is noted that past COVID-19 infection may also pose additional medical risks to the patient having ECT. This should be considered as part of the medical work up and discussed with the ECT anaesthetist as part of decision to have ECT¹.

Considerations for provision of ECT during COVID-19

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.

It is suggested that, as the COVID-19 situation progresses in Australia and New Zealand, different levels of precautions will be required depending on the incidence of cases. Over time, it is expected that ECT services will more closely align to a pre-COVID-19 situation as incidence decreases. This process will likely be different for every country, and potentially for every state, or even hospital/service. Listed below are principles that could be applied depending on prevailing incidence of cases. The following precautions are listed only a guide.

1. Ongoing precautions to continue for ECT services during COVID-19 pandemic

Until COVID-19 is either eliminated or there is a vaccine in place, the following precautions should remain. Lifting of these precautions should occur only when the COVID-19 risk is felt to be as close to zero as it can be and when most, if not all, community restrictions have eased. These precautions should continue to be applied in line with national and local protocols.

Use of personal protective equipment (PPE) and 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

¹ For further information see [Australian and New Zealand College of Anaesthetists \(ANZCA\) living guidelines on surgical patient safety and COVID-19](#)

and local guidelines should be followed in respect to ECT procedures, as well as guidance from The [Australian Society of Anaesthetists \(ASA\)](#) and the [Australian and New Zealand College of Anaesthetists \(ANZCA\)](#).

- The use of PPE should continue whilst COVID-19 transmission remains a risk. 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 PPE recommendations may be revised if the rate of infection in the community changes.

Cleaning

- Whilst COVID-19 remains a potential risk, even if very small, cleaning is essential to infection control.
- Regular cleaning should continue to be in operation in line with standard guidelines for prevention and control of infection in health care, as well as taking account of any COVID-19 specific requirements (e.g. as outlined in the [Australian Department of Health COVID-19 environmental cleaning and disinfection principles](#)). Before commencing treatment of each patient, the following should be carefully cleaned:
 - 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 and psychiatrists will need to explore ways to manage ECT treatment schedules.

Screening of patients and staff prior to procedures

- Patients and staff should continue to be screened for COVID-19 symptoms. Depending on the resources and testing kits availability, routine testing for COVID-19 infection pre-procedure might be appropriate.
- 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.
- 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.
- Prior to each ECT treatment, on arrival at the ECT suite: Patients should be observed to use hand sanitisers; patients should be screened for the presence of respiratory symptoms; a full set of observations should be taken, including temperature; and local protocols in regard to visitors followed.

Physical distancing

- Adherence to physical distancing, as much as can be done with a procedure like ECT, should be retained for as long as these measures remain advised for the wider community.
- Considerations specific for ECT include:
 - 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).
 - 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.

General considerations

- Staff working in the delivery of ECT should follow organisation protocols with regards to fitness to work in respect to COVID-19 pandemic, COVID-19 screening and PPE. Services are encouraged to identify back up staff members for each service so that so that ECT can continue in the event of unexpected staff shortages.

2. Precautions for ECT services during low incidence of COVID-19

Providing incidence of cases remain low, there may be a justification for reducing restrictions associated with patients who require elective ECT or maintenance ECT, as well as recovery suite management. Any decisions taken will need to be a local (service by service) decision as to what is appropriate.

Treatment with ECT of patients defined as 'elective'

- During the COVID-19 emergency, it is appropriate to delay ECT treatment for elective patients. However, they are still unwell and ECT potentially plays an important role in their care. Accordingly they should return to having ECT available when it is safe to do so, or if their condition deteriorates.
- It is recognised that triaging is required to keep ECT lists manageable because of the increased time per patient owing to PPE and cleaning requirements as outlined above. However, as the system gets more efficient, many services would be able to accept these elective patients for treatment. This will depend on the site's capacity to manage any increase in numbers, especially if they have only a finite time allocated for ECT in a hospital that provides ECT in a multi-use procedural room.

Provision of maintenance ECT

- In line with the information above in respect of elective ECT patients, where there is a clear benefit to a patient in offering it, access should not be unnecessarily restricted. This would be a service by service decision, as with elective ECT above, based on capacity.

Grouping of patients for treatment by profile

- During COVID-19 it is suggested that optimal procedure is for patients to 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 who are known to have COVID-19 infection should be treated at the end of the session. Larger services should also consider grouping inpatients according to the wards they come from.

- However, when the Covid-19 infection rates become very low, the likelihood of patient-to-patient transmission in the recovery suite or waiting room is likely to be also low. Services should give consideration to whether the risk reduction associated with the process of patient grouping is sufficient to outweigh any benefits, given organisation of this slows progress of the treatment list and takes considerable effort to manage.

3. Precautions for ECT services that should only apply during high or increasing incidence of COVID-19

Concerns about access to ECT either because of unavailability of anaesthetic and psychiatric staff due to redeployment, illness or quarantine, would only apply in situations of high or increasing incidence of COVID-19. Unless there is a risk of high incidence occurring, there is justification in removing restrictions that would only be appropriate to apply in this situation. Any decisions taken will need to be a local (service by service) decision as to what is appropriate.

Type of ECT prescribed

- In a situation of high incidence of COVID-19, 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.
- In a situation of low incidence of COVID-19 psychiatrists should return to best practice prescription for the individual patient, in line with evidence, unless there are specific reasons why this is not possible.

Teaching of trainees in the ECT room

- Training of ECT is an important part of the RANZCP Fellowship Program. Only in a case of very high incidence and risk of COVID-19 should trainees be excluded from the treatment room.

Limiting ECT to only those in the urgent category

- The decision to only provide ECT only to people in the urgent /emergency category is only appropriate in very high incidence or risk situations. People within urgent and essential categories should be provided with ECT based on the capabilities of the services and individual patient need taking into account risks and benefits.

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.

REVISION RECORD

Contact: Executive Manager, Policy, Practice and Research Department

Date	Version	Approver	Description
04/2020	1.0	B2020/5 R2	Temporary information developed in response to the COVID pandemic
07/2020	2.0	B2020/9 R2	Update to temporary information developed in response to the COVID pandemic
08/2022	3.0	PPPC Executive	Renewed, with inclusion of statement that past COVID-19 infections should be considered as part of ECT process
08/2023	4.0		NEXT REVIEW

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