



## **Petition 2002/162 of Helen Smith**

Report of the Health Committee

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Forty-eighth Parliament  
(Sue Kedgley, Chairperson)  
November 2007

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*Presented to the House of Representatives*

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## Petition 2002/162 of Helen Smith

### Recommendations

The Health Committee makes the following recommendations to the Government:

We recommend that because of its potential side effects that electro-convulsive therapy (ECT) should only be used as a treatment of last resort when all other options have been considered.

That the Royal Australian and New Zealand College of Psychiatrists urgently develop its guidelines into a national professional standard with the same status and effect as other professional standards. The circumstances where it is appropriate for a patient to be required to undergo ECT should be more restricted, and should be clearly defined in the new standard.

That Section 60 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 be amended to ensure that ECT is administered only with a patient's consent where this is possible, and where this is not possible, on the basis of a truly independent second opinion from certifying clinicians not attached to the institution from which the first opinion is obtained.

The majority of us recommend that ECT be administered to pregnant women with informed consent only in cases of emergency where there is no other option available.

We recommend that data on the rate of administration of ECT to pregnant women in New Zealand be collected, reported on annually and outcomes monitored.

We recommend that ECT should only be administered to children and young people where in the opinion of certifying clinicians there is no other option available. Some of us recommend that ECT should not be used on children and young people.

The majority of us recommend that consideration be given to requiring an order under the Protection of Personal Property Rights Act 1988 when ECT is administered to the elderly, because of its presumption of competence and the least restrictive intervention.

The majority of us recommend that where patients have made valid advance directives to the effect that they do not wish to undergo ECT, these directives should be given effect.

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### Introduction

This petition requests that the House ensure electro-convulsive therapy (ECT) is not administered to children, pregnant women and the elderly. In May 2005 the House referred

this petition to the previous Health Committee, which considered it and made an interim report to the House. Following the general election, the new Parliament reinstated this petition.

The petitioner, Dr Helen Smith, has since added the following specific requests:

- That the use of ECT with children, pregnant women and the elderly be reviewed with a view to banning or severely restricting its use in these groups.
- That the elderly at least be given the opportunity to formally decline ECT prior to becoming elderly or unwell when offered, despite opinions of other family members and psychiatrists. If they do not want ECT this wish should be respected.
- That there be stricter regulatory reporting and controls in place.
- That the use of ECT be on a voluntary basis.

The use of ECT was considered by the previous Health Committee. Its actions and our actions to date are set out in Appendix B.

## Description

ECT is a controversial treatment which uses specialised medical equipment to induce an epileptic seizure by passing a small electrical current across the brain. It is usually prescribed as a course of six to 12 treatments, and is administered twice a week. ECT is used to treat severe depression and some other mental disorders. It was first used in the 1930s, and was widely used in the middle of the last century. Modern practice is to administer ECT on one side of the head only, and with anaesthetic and muscle relaxants. There are widely differing views on ECT's use, administration and effectiveness.

## ECT use

Dr Helen Smith quoted the US Mental Health Foundation that "Shock damages the brain, causing memory loss and disorientation that creates an illusion that problems are gone, and euphoria, which is frequently observed as a result of brain injury."<sup>1</sup> She asserts that there is a contradiction between the alleged effectiveness of ECT on the one hand, and its potential for creating long-term damage on the other. Dr Smith says that psychiatrists do not know ECT works or how the mind or brain works after being subjected to ECT.

The Ministry of Health says that ECT is a valuable and sometimes life-saving treatment despite negative depictions of it in popular culture and the media. It is used mainly to treat severe depression, particularly if complicated by psychosis.

The ministry says that where a patient presents with a severe mental illness such as a major depression, various treatment options will be considered with their risks, benefits and alternatives. It disputes the claim that the risks associated with ECT are always greater than those associated with other treatments, such as antidepressant medication. Some patients may be non-responsive to, or intolerant of, antidepressant medication, and others may require treatment which works quickly. The ministry says that ECT is not always a treatment of last resort, and in certain life-threatening situations it may be the first treatment option.

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<sup>1</sup> 2003 US Mental Health Foundation Fact Sheet.

## Administration

Dr Smith says that modern ECT practice, despite the use of anaesthetic, is still damaging to patients. Dr Pamela Melding disputes this. She says that in the 1970s the technology for delivery of both anaesthesia and ECT was crude compared with current technology. Currently, Dr Melding says the standard practice is that anaesthesia is given for ECT by specialist anaesthetists in well equipped theatres or ECT suites, and the procedure is administered by specialist psychiatrists or trainees under direct supervision. Dr Melding says that the administration of ECT in New Zealand is covered by stringent training requirements for trainee and consultant anaesthetists and psychiatrists. Indeed, higher standards of training and medical expertise are required for ECT than many other public hospital surgical procedures, which may be left to junior doctors.

## Memory loss

There is recent evidence that ECT causes memory loss. After six months a sample of ECT patients were significantly less able to remember specific events from their own lives. For one in eight (12.4 percent) the brain damage was sufficiently severe for researchers to classify it as a marked and persistent retrograde amnesia. Women and older people who receive ECT at particularly high rates were significantly more likely to suffer adverse effects. Severe depressive symptoms, often cited as the reason for memory loss, showed little relationship with cognitive measures. This evidence also indicated that the number of shock treatments was positively related to the extent of memory loss.<sup>2</sup>

The Ministry of Health says some people will experience headaches, muscle aches or soreness, nausea and confusion, usually during the first few hours after the procedure. It says that during a course of ECT it may be difficult for people to remember newly learned information, although this difficulty disappears over the days and weeks following completion of the course. Some people also report a partial loss of memory for events that occurred during the days and months preceding ECT. While most of these memories typically return over a period of days to months after ECT, some people have reported longer-lasting problems with recalling these memories. Others, however, report improved memory after ECT because of its ability to remove the amnesia that is sometimes associated with severe depression. The ministry says that, while short-term memory impairment following ECT is common, it is unclear how much reported longer-term memory impairment is caused by ECT and how much by severe depression itself.

## Brain damage

Brain damage causing memory loss is cited as a reason for banning ECT by the petitioners. Dr John Read says that when ECT was first introduced it was argued that it worked precisely because it causes brain damage and memory loss; lowered intellectual functioning and the loss of memory for unpleasant live events was considered an advantage. It is also consistent with the fact that when steps are taken to limit brain damage and memory loss, for example by placing the electrodes on one side of the head (unilateral ECT), the claimed

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<sup>2</sup> Harold A. Sackheim, Joan Prudic, Rice Fuller, John Keilp, Philip W. Lavori and Mark Olfson, "The Cognitive Effects of Electroconvulsive Therapy in Community Settings", *Neuropsychopharmacology* (2007) 32, pp. 244–254.

efficacy of the treatment is reduced. Dr Read disputes that anything other than brain damage may cause the acknowledged permanent memory dysfunction.

The ministry says that there is no evidence that ECT causes any structural cerebral damage. Dr Melding says several studies have shown that seizures can cause brain damage if they are prolonged under conditions of hypoxia (low oxygenation). Such conditions possibly applied sometimes in the days of unmodified ECT (without anaesthesia and oxygenation) and, together with the crude and now outdated sine wave delivery machines, they may explain many of the memory complaints suffered by patients from that time. In modern ECT brief pulse seizures are lower in dose, highly controlled, and administered under oxygenation and anaesthesia.

### **Effectiveness**

Dr Read says that the claim that ECT is an effective treatment is incorrect. His own review of the literature documents serious methodological flaws in the few studies that claim even a short-term benefit from ECT. A survey of the ECT placebo-controlled literature on ECT for depression found that no study demonstrated a significant difference between real and placebo ECT one month after treatment, and many studies failed to find a difference during the treatment period.<sup>3</sup>

The Ministry of Health says that 70 to 80 percent of patients who receive ECT respond to it well. ECT is the most effective short-term treatment for severe depression. It says most people recover their ability to work and lead productive lives after their depression has been treated with a course of ECT. It has been proven effective in depressed people who do not respond to other forms of treatment.

### **Overall assessment**

The petitioners dispute the need for ECT while the Royal Australian and New Zealand College of Psychiatrists is strongly of the view that ECT remains an important and necessary treatment for various serious psychiatric conditions, most commonly severe depression.

### **Treatment rates**

#### **Variations**

ECT is not a common treatment in New Zealand. We were told it is used to treat only 0.25 percent of potentially seriously depressed people. New Zealand ECT rates are considerably lower than those in the United Kingdom, most areas of the United States of America, and Australia. The average number of treatments per acute course of ECT is seven treatments. A total of 307 people received ECT during the 2004/05 reporting period, equivalent to 7.5 per 100,000 population, and 305 people during the 2003/04 reporting period.

Dr Smith says that a recent review of ECT indicated that only a few places keep detailed statistical data and that there are huge regional variations. The New Zealand average is 10.4 treatments per annum; but the Otago District Health Board region has three times the

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<sup>3</sup> Colin A. Ross, MD, "The Sham ECT Literature: Implications for Consent to ECT", *Ethical Human Psychology and Psychiatry*, Volume 8, Number 1, Spring 2006.

national average. In the Waitematā DHB region 40 percent of treatments are given without consent and in the Counties Manukau DHB area 58 percent. Some DHBs are administering as many as 18 treatments when guidelines state six to ten.

### **Regional variations**

The Ministry of Health acknowledges these regional variations, but was unable to explain them fully. It notes that the following factors will be relevant:

- Regions with smaller populations will be more vulnerable to annual variations in the needs of the population at any time.
- Patients receiving continuous or maintenance treatment will typically receive more treatments in a year than those patients who are treated with an acute course.
- ECT is used more in older people than in younger adults because older people are more likely to have medical problems that make medication inappropriate.
- Some DHBs have better access to ECT services than others, which is likely to influence the rates of use.

Graphs setting out ECT treatments consented to per 100,000 population for each DHB district are attached as Appendix C.

The Royal Australian and New Zealand College of Psychiatrists says that regional variation in New Zealand is consistent with that in other parts of the world, including Australia. Some commentators suggest that this reflects the overuse of ECT in some areas; the college comments that given the low use of ECT in New Zealand compared with other countries it may reflect under-use in some areas. The college says that the importance of this variation is the implication that there may be a lack of uniformity in practice by psychiatrists in the use of ECT. The college is attempting to minimise this disparity in practice by developing and regularly updating guidelines for the practice of ECT.

We are concerned that there are wide regional variations in ECT use. We are concerned that there is no standard governing ECT use in New Zealand and that these guidelines are not adequately explained. We reiterate what the previous Health Committee recommended that district health boards adhere to the best practice guidelines for ECT equipment and administration.<sup>4</sup>

Given it is a controversial treatment we consider it is essential that ECT be governed by a national standard and not by just guidelines. We recommend that the Royal Australian and New Zealand College of Psychiatrists urgently develop its guidelines into a national professional standard with the same status and effect as other professional standards.

### **Course variations**

The ministry says that when a course of ECT is prescribed, it is usually administered twice a week for three to six weeks, that is, a course of six to 12 treatments. Several factors can influence the number of individual treatments that people may need:

- the severity of the patient's illness and the degree of treatment resistance

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<sup>4</sup> Report on 1999/30 Petition of Anna de Jonge and others, p. 4.

- complicating medical factors
- age, because ECT is used mostly for older people who may need more and longer courses
- the timeliness of maintenance medication
- technical factors in the administration of the treatment.

We are concerned about a large variation in the number of ECT treatments consented to in different district health board areas. Tables setting out the treatments per acute course by DHB are attached as appendix D.

We are concerned that disproportionately more women than men receive ECT. We have not yet received a satisfactory explanation as to the reason why. Graphs setting out the age and sex of patients treated with ECT are attached as appendix E.

### **ECT for pregnant women**

Dr Smith says that there is no good evidence to show that this group benefits from modern ECT. She says there is no research on the possible long-term side effects on the unborn child, such as brain damage or other bodily damage from the electroshock itself and the convulsions induced by ECT.

The Royal Australian and New Zealand College of Psychiatrists says there is no data on the rate of administration of ECT to pregnant women in New Zealand, but discussions with colleagues suggest it is very rare. The college says that, while there is no New Zealand data, a single 1994 peer-reviewed article examined over 300 case reports of ECT given during pregnancy from 1942 to 1991, and concluded that ECT can be safely used in all trimesters of pregnancy.<sup>5</sup> The miscarriage rate following ECT given in pregnancy did not increase from the normal rate. The incidence of abnormalities was also unchanged. The college acknowledges that the scientific literature on the children born to mothers who have ECT while pregnant is extremely limited. What information there is, however, indicates that the children of such mothers did not show any untoward effects when followed up years later. The college says that ECT remains an important treatment option when there is a severe risk of harm to the foetus or to the mother resulting from the mother's mental illness.

The Ministry of Health says foetal monitoring during ECT administration has not revealed any untoward effects on the foetus. It considers ECT may be used with confidence during the second and third trimesters. Little information is available on its use in the first trimester, and until more data is available the ministry advises caution.

The Human Rights Commission and the Health and Disability Commissioner say that ECT should be administered to pregnant women only in cases of emergency where there is no other option available. On balance, considering the evidence and reasons for administering ECT to pregnant women, we support their position.

The majority of us recommend to the Government that ECT be administered to pregnant women with informed consent only in cases of emergency where there is no other option

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<sup>5</sup> Miller, L., et al., *Use of electroconvulsive therapy during pregnancy*, *Hospital and Community Psychiatry*, 1994. 45 (5) pp 444-450.

available. We recommend to the Government that data on the rate of administration of ECT to pregnant women in New Zealand be collected, reported on annually and outcomes monitored.

### **ECT for children and adolescents**

Dr Smith says that young brains should not be subjected to ECT. She says there is research documenting brain damage and memory loss. A convulsion and brain injury with internal bleeding and bruising are still produced despite modern procedures. She says that there is insufficient evidence that ECT is beneficial for minors, and there are recent major concerns expressed about New Zealand's high rate of youth suicide. Dr Smith says that there is no evidence to say that ECT protects teenagers from suicide, and some evidence that ECT can lead to more suicides.

The Paediatric Society of New Zealand says that bipolar affective disorder has a suicide rate of 11 to 15 percent.

The Human Rights Commission and the Health and Disability Commissioner have pointed out that in the United Kingdom, MIND (National Association for Mental Health) opposes the use of ECT on children and young people for the following reasons:

- ECT may affect the developing neurological system.
- It may be perceived as a form of torture or punishment.
- It may encourage a sense of hopelessness and give children a negative message about their prognosis.
- While it may alleviate depression in the short term, it does not provide a strategy for coping in the long term.<sup>6</sup>

The Royal Australian and New Zealand College of Psychiatrists says it is extremely rare that pre-pubescent children are given ECT. It is more likely to be used as a treatment in adolescents, but even for this group ECT is rare. In New Zealand for the years 2003/04 2004/05, 2005/06 five, two and one persons respectively under 20 years of age received ECT treatment.

The Human Rights Commission and the Health and Disability Commissioner point out that section 86 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 requires that assessment of a young person under the age of 17 should be carried out by a psychiatrist practising in the field of child psychiatry wherever practicable. Given their vulnerability and the difficulty of separating teenage behaviour and mental disorder it would seem appropriate that if this provision remains then any second opinion should be provided by a specialist in child psychiatry. However, given the lack of substantive evidence that treatment is successful, they say ECT should never be used on children and young people.

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<sup>6</sup> MIND fact sheet: "Children and young people and mental health" UK (2007)

We recommend ECT should only be administered to children and young people where in the opinion of certifying clinicians there is no other option available. Some of us recommend to the Government that ECT should not be used on children and young people.

### **ECT for older people**

The elderly are the main group receiving ECT in New Zealand. In the years 2003/04 and 2004/05 Ministry of Health statistics indicate that 45 and 46 percent respectively of patients receiving ECT were over 60. The Royal Australian and New Zealand College of Psychiatrists says that ECT is a very important treatment in older people.

Dr Read says that the extensive research on older people, although of variable quality methodologically, strongly suggests that the risks from ECT are greater in older people, partly because of the higher convulsion threshold of older people, which necessitates higher voltages to induce seizure. He says some studies seem to indicate an acceleration of the dementia process in some older people as a result of ECT.

The college acknowledges that ECT is used more often with older people than with other age groups. The college says that older people are more subject to severe depression than younger people, more disabled by depression, less responsive to standard treatments, and often unable to tolerate them. Some of the unwanted effects of medications are more significant for older people, and chronic, sometimes treatment-resistant depression is more common. These factors explain the higher use of ECT with older people.

The college says older people have fewer options for the treatment of depression. Often medical illness can complicate or make conventional psychiatric treatment inappropriate. Depression in older people carries a very high completed suicide risk. The college is convinced that suicides by some patients would result from any ban on ECT. The Human Rights Commission and the Health and Disability Commissioner say that as extreme care is necessary in administering ECT to elderly people and because of the complex issues involved, consideration should be given to requiring an order under the Protection of Personal Property Rights Act 1988. They say it is easier to safeguard the interests of patients under this Act than under the Mental Health (Compulsory Assessment and Treatment) Act 1992. They say that under the welfare guardian provisions of the former Act it is possible to avoid the use of the stringent medical clinical model for treatment set out in the latter Act, obviate the stigma of compulsion, and operate on the presumption of patient competence and the least restrictive intervention. They say that the use of this act is not unprecedented and cited court cases in which it had been applied to proposed ECT treatment.

The majority of us recommend to the Government that consideration be given to requiring an order under the Protection of Personal Property Rights Act 1988 when ECT is administered to the elderly, because of its presumption of competence and least restrictive intervention.

### **Consent**

Dr Smith says that an elderly person may not want ECT but may be too feeble to make a stand, and may have no say in the matter as the psychiatrist consults the family members

rather than the elderly person him- or herself. She and Dr Read say that a wish not to receive ECT when elderly should be respected in law; and people should be able to make a binding request not to be given this treatment no matter what the circumstances. Dr Read also recommends that the right to receive full and impartial information about the benefits and risks of treatment be enshrined in law.

The Ministry of Health says that if people are not competent to give informed consent, or unwilling to consent, ECT cannot be given without legal authorisation. Competency is a clinical notion whereby people understand that they need help because they are depressed, the choices they have and the risks of treatment. The legal framework for administering ECT to people who are unable to give consent because they are incompetent is provided by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (that is, they are committed under the Act). Committed people can be given ECT without their consent only if a psychiatrist appointed by the Mental Health Review Tribunal has given a second opinion to the effect that the course of treatment is in their interests. Clinicians will generally make this decision after discussing the options with family or whānau and considering any statements by the patient that may be relevant. The ministry says that 84 patients were treated with ECT during the 2004/05 reporting period who were subject to the Act, which represents 23 percent of all patients treated with ECT.

The Royal Australian and New Zealand College of Psychiatrists says ECT is usually needed in the most severe forms of depressive illness, which can affect decision making capacity in several ways, causing, for example, slowed thinking, indecisiveness, or failure to interact or communicate with caregivers. It says it is common practice amongst New Zealand Psychiatrists to begin a course of ECT without consent from the patient and sanctioned by the Act, but as the patient improves and regains competency, consent is sought and voluntarily given to complete the course. Most patients are capable of informed consent, but for some, the most important issue is not their willingness to consent but their ability or competency to make decisions concerning their treatment.

The Health and Disability Commissioner considers that as it currently stands the ability to require a patient to undergo ECT is too broad. He is concerned that under section 60 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 the opinion of one psychiatrist as to what is in the best interests of the patient is decisive, without any requirement that this opinion be supported by evidence.

The commissioner argues that regulations in other jurisdictions illustrate some preferable approaches. For example, in the Northern Territory of Australia providers are required to certify that they have considered an incompetent patient's clinical condition, history or treatment, and other appropriate alternative treatments, and that without ECT the patient is likely to suffer serious mental or physical deterioration—all of which seem reasonable and sensible requirements to protect patients. He says that other Australian states also appear to require reference to similar considerations, which are preferable to the very broad and rather simplistic New Zealand criteria. While he concedes that there are some circumstances where it is appropriate for a patient to be required to undergo ECT, he is of the view that these instances need be better defined and more restricted. We agree with his position. We recommend that the circumstances where it is appropriate for a patient to be required to undergo ECT should be more restricted, and should be clearly defined in the new standard.

ECT is not addressed as a specific provision in the Mental Health (Compulsory Assessment and Treatment) Act 1992. Under section 60(a) ECT may be given with the written consent of the patient. If a patient refuses ECT it may still be administered if a psychiatrist appointed by a Review Tribunal considers it to be in the patient's interest. In the Human Rights Commission's and the Health and Disability Commissioner's experience the psychiatrist is not always truly independent, and may be a colleague of the clinician who wishes to administer ECT. They say that section 60 should be amended to ensure that ECT is administered only with a patient's consent; or at the very least more stringent controls should be established, either by requiring a truly independent second opinion from someone not attached to the institution where the patient is being treated, or by developing an objective test for the best interests of the patient. We agree with their position.

We recommend to the Government that section 60 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 be amended to ensure that ECT is administered only with a patient's consent where this is possible, and where this is not possible, on the basis of a truly independent second opinion from certifying clinicians not attached to the institution from which the first opinion is obtained.

### **Advance directives**

The advance directive is promoted as a mechanism by which people may make choices in the present about treatment they would want or not want should they, in future, lose their capacity for decision-making. Dr Smith says that advance directives may go some way to safeguarding the elderly, although she believes that they would not be sufficient to correct the "imbalance" between the wishes of an elderly person expressed in the advance directive and practitioners intent on overriding these wishes. Dr Read reasons that, while advance directives would provide only limited protection of the human rights of New Zealanders in relation to ECT, they will make a significant difference to the well being and sense of self-determination for a small number of people, and should therefore be supported.

The Royal Australian and New Zealand College of Psychiatrists says the concept of advance directives is well established throughout New Zealand in general medical care. While intuitively appealing to consumers and service providers, the concept in psychiatric care is complex, particularly regarding whether directives should be legally binding for defined treatment options such as ECT.

The Human Rights Commission and the Health and Disability Commissioner say that there is no express legal provision in New Zealand for advance directives, although the Code of Rights provides that "every consumer may use an advance directive in accordance with the common law".<sup>7</sup> They say that an advance directive in which an appropriately informed, competent person refuses consent to ECT should be treated the same way as a contemporaneous refusal by a still competent person, and the Mental Health (Compulsory Assessment and Treatment) Act 1992 should be amended to reflect this. They note that guidelines to the Act issued by the Ministry of Health should be amended to indicate that an advance directive made previously by an adequately informed and competent person be given the same weight as a refusal by a person considered still competent. They suggest that the second sentence in the third paragraph of the guidelines should be replaced with

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<sup>7</sup> Right 7(5) of the Code of Rights

the following sentence. “Where there is a valid advance directive refusing consent to undergo ECT this should be decisive in the same way as if a competent person refuses consent”.

Having considered the arguments for giving effect to advance directives, the majority of us support their position. The majority of us recommend that where patients have made valid advance directives to the effect that they do not wish to undergo ECT, these directives should be given effect.

### **New Zealand National minority view**

National’s view on the use of ECT in the groups described is that it is an important life-saving treatment option that must remain available to clinicians.

We note the low rates of ECT usage in children, young people and pregnant women. For reasons outlined in the main report, ECT rates in the elderly are higher. We believe that in modern New Zealand the decision to perform ECT on a patient is not taken lightly by psychiatrists. It is generally a treatment of last resort, with a very real risk of suicide if the patient were to be left untreated.

One of the features of severe depressive illnesses is a loss of insight, meaning that it is impractical to absolutely require informed consent from a patient suffering from such an illness. For similar reasons, requiring an order under the Protection of Personal Property Rights Act 1988 is impractical, as such an order would presume that a person has the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare.

Currently if a patient refuses to give consent for ECT, the treatment may still be administered on the advice of a second clinician appointed by the Review Tribunal. This report calls for “a truly independent second opinion from certifying clinicians not attached to the institution from which the first opinion is obtained.” While National supports this recommendation, we note that in reality it may not result in any alteration to established practice.

National’s view is that advance directives stating that an individual does not wish to undergo ECT will mean that such individuals may be precluded from receiving optimal treatment for their condition. The consequences for such an individual might well be fatal. For this reason, we do not support advance directives in this context.

National is concerned about regional and demographic variations in ECT administration, but notes that higher rates do not automatically indicate overuse of the treatment. While National supports the use of professional standards in this area, it would require expert input to determine whether existing guidelines could be developed into such a standard, or whether the application of anything more rigid is impractical.

## Appendix A

### Committee procedure

The petition was presented by Dianne Yates on 10 May 2005. The previous committee requested and received a submission from the petitioner. It also considered material from the Ministry of Health originally submitted as evidence on a briefing on electro-convulsive therapy. The Parliamentary Library prepared a background paper.

We requested further submissions on the previous committee's report. We heard evidence from the petitioner, Dr Helen Smith, several of her medical colleagues, the Royal Australian and New Zealand College of Psychiatrists, Dr Pamela Melding, the Paediatric Society of New Zealand, and the Chief Commissioner of the Human Rights Commission and the Health and Disability Commissioner jointly. Responses to specific questions and statistics were received from the Ministry of Health.

Positions of witnesses mentioned in this report:

Dr Helen Smith, Medical Doctor, Commissioner for the Citizens Commission on Human Rights

Dr John Read, Senior Lecturer, Psychology Department, University of Auckland

Dr Pamela Melding, Psychiatrist, Head of the ECT Service for Waitematā DHB and Senior Lecturer in Psychiatry, University of Auckland

### Committee members

Sue Kedgley (Chairperson)

Lesley Soper (Deputy Chairperson)

Dr Jackie Blue

Dr Jonathan Coleman

Jo Goodhew

Ann Hartley

Jill Pettis

Hon Luamanuvao Winnie Laban

Hon Tony Ryall

Barbara Stewart

Tariana Turia

The Hon Luamanuvao Winnie Laban replaced the Hon Maryan Street, and Jill Pettis replaced Sue Moroney on 6 November 2007.

## Appendix B

### Action to date

The use of ECT was considered by the previous Health Committee. In February 2003 it presented a report on petition 1999/30 of Anna de Jonge and others, which requested that the House of Representatives accept a petition against ECT treatment. This report made nine recommendations to the Government, including that it request the Mental Health Commission or an independent reviewer to undertake a comprehensive review of the safety and efficacy of ECT and the adequacy of regulatory controls on its use in New Zealand.

The report of an independent review was published in March 2005.<sup>8</sup> The review concluded that ECT was an effective short-term treatment for severe depressive illness and some other forms of serious and potentially life-threatening mental illness. It noted short-and long-term risks and adverse effects associated with ECT, but considered them to be at an acceptably low level. It recommended some changes to the law and guidelines relating to ECT to ensure greater emphasis on obtaining informed consent, the use of advance directives,<sup>9</sup> and the use of guidelines. The review also sought to prohibit the use of ECT on competent people who objected to it. The previous committee received a briefing from the Ministry of Health on the review report in April 2005, which the committee followed up by seeking clarification of several issues.

The current petition was referred to the previous committee in May 2005. As the petition addressed issues the committee had been following up with the ministry, it resolved to incorporate the material it had received on the briefing into its consideration of this petition. It sought a submission from the petitioner, and requested that the Parliamentary Library research the provision of ECT to children, pregnant women, and the elderly in Australia, the United Kingdom, Canada, the United States of America, and Europe, and any established effects of ECT on people in these groups, including children born after their mothers received the therapy.

### Recommendations on the Petition of Anna de Jonge

Progress on the recommendations made to the Government on petition 1999/30 of Anna de Jonge is set out below:-

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<sup>8</sup> *Use of electroconvulsive therapy (ECT) in New Zealand: a review of efficacy, safety, and regulatory controls* is available on the Ministry of Health website [www.moh.govt.nz](http://www.moh.govt.nz)

<sup>9</sup> Advance directives are written or oral directives in which patients set out choices about their health care, which govern any health-care decision taken at any time when patients are not competent to make such decisions themselves.

**Recommendation 1**

That the Mental Health Commission or an independent reviewer undertake a comprehensive review of the safety and efficacy of electro-convulsive therapy and the adequacy of regulatory controls on its use in New Zealand.

The response was that the Government agreed that the Minister of Health approve an independent expert to conduct a comprehensive review of the safety and efficacy of ECT and the adequacy of regulatory controls on its use in New Zealand. The Mental Health Commission supported this review being undertaken by an expert in evidence-based health and being able to draw on additional expertise from the legislative and human rights fields.

**Recommendation 2**

That the Mental Health Commission review the powers of compulsory treatment with ECT under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The response was that the Government agreed that an independent reviewer should undertake a review of compulsory treatment using ECT. It said that this should be incorporated within the review proposed in response to recommendation 1. The Mental Health Commission supported this approach.

After consultation with the Mental Health Commission, the Ministry of Health commissioned an independent review of electroconvulsive therapy (ECT) in New Zealand. The review group, chaired by Professor Craig Anderson, was a six member group that included clinical research, legal, and consumer representatives. The group's findings were published in December 2004, in a publication entitled "*Use of electroconvulsive therapy (ECT) in New Zealand: a review of efficacy, safety, and regulatory controls*".

**Recommendation 3**

To ensure consistent monitoring, collection and recording of national data (broken down by District Health Boards) on ECT, to be reported annually.

The response was that the Government agreed that the Ministry of Health would produce an annual report on the number of patients who received ECT, and the number of ECT treatments per patient, by DHB. The first annual report was to be available after July 2004 for data collected from July 2003. The Ministry would monitor the collection of this data by DHBs.

**Recommendation 4**

Ensure consistent monitoring, collection and recording of national data (broken down by District Health Board) on the administration of ECT given under compulsion by DHBs, reported annually.

The response was that the Government agreed that the Ministry of Health would produce an annual report on the number of patients who received ECT, under compulsion and the number of compulsory ECT treatments per patient, by DHB. The first annual report was

to be available after July 2004 from data collected from July 2003. The Ministry of Health would monitor the collection of this data by DHBs.

### **Recommendation 5**

Establish national technical and quality standards for electro-convulsive therapy and administration.

The response was that the Government noted that since 1992 the Australian technical standard for ECT equipment had been harmonised for use in New Zealand. (NZS/AS3200.2 14-92). The New Zealand Standards Council approved the Australian Standard under the provisions of the Standards Act 1988. Any future changes to the standard would be harmonised between Australia and New Zealand.

The Government also noted that under the Health and Disability Services (Safety) Act 2001 mental health services were required to meet the National Mental Health Sector Standard (NZS 8143:2001) by October 2004.

The current best practice standard and professional guideline for use of ECT was the Royal Australian and New Zealand College of Psychiatrists *Guidelines on the Administration of ECT (Clinical Memorandum number 12)* and this guideline was implicit in the Standard. The college had agreed to make this guideline explicit by allowing it to be added to the list of relevant acts, regulations and related documents that appeared in the standard. This change was due to occur when the standard was reviewed during 2004.

The Ministry of Health understands that Standards New Zealand has not completed its review of the National Mental Health Sector Standard (NZS 8143:2001). However a draft report of the review has been prepared, which includes a new standard specific to the safe and effective use of ECT. The standard states that “ECT is provided according to currently accepted good practice guidelines”, and that “good practice guidelines include but are not limited to Ministry of Health Guidelines.”

The *Royal Australian and New Zealand College of Psychiatrists (RANZCP) Clinical Memorandum number 12* is to be incorporated in the schedule to the new standard that lists relevant acts, regulations, and related documents, thus making it explicit that the clinical memorandum describes the current best practice and professional guidelines for the use of ECT. It is anticipated that the review of the National Mental Health Sector Standard will be finalised before the end of 2007.

### **Recommendation 6**

To ensure District Health Boards are adhering to the best practice guidelines for the use of electro-convulsive therapy.

The response was that the Government noted that the Ministry of Health had recently undertaken an audit of ECT administration and was providing DHBs with feedback and recommendations on those aspects of ECT administration which required improvement to fully align their services in accordance with the RANZCP *Clinical Memorandum Number 12*.

The Government agreed that the Ministry of Health would advise designated auditors under the Health and Disability Services (Safety) Act 2001 of the expectation that they should include in their audits of DHB mental health services consideration of ECT use in accordance with the RANZCP *Clinical Memorandum Number 12*.

The new standard (mentioned above in relation to recommendation 5) contains a series of standards which Designated Auditing Agencies are required to audit services against.

### **Recommendation 7**

Ensure the best practice guidelines for the use of electro-convulsive therapy are available in all the major languages.

The response was that the Government noted the the RANZCP *Clinical Memorandum Number 12* was not intended for a non-clinical readership, and there was little to be gained from its publication in languages other than English.

The Government agreed that the Ministry of Health would request that all DHBs ensure patients and their families were provided with the RANZCP public statement on ECT or a referenced information sheet with at least the information contained in the RANZCP publication. As well as this information, the Ministry of Health would be recommending that patients and their families were given information that reflected local practices and general pre and post ECT requirements.

The Government agreed that the Ministry of Health would request that DHBs consider having this information translated into the languages commonly encountered.

The Ministry of Health intends to request that all DHBs consider having information from the RANZCP's public statement on ECT or a referenced information sheet with the information contained in the RANZCP publication, translated for their various population groups. To this end the Ministry of Health is awaiting the final review mentioned above, and is working towards developing an information resource, mentioned below.

### **Recommendation 8**

Develop a code of ethics for the use of electro-convulsive therapy.

The response was that the Government noted that the codes of ethics of the medical and nursing professions and the Code of Health and Disability Services Consumer Rights, apply to ECT administration and could be used in evidence in any Disciplinary Tribunal hearings.

### **Recommendation 9**

Develop protocols for the use of electro-convulsive therapy with Māori clients, and clients from other cultural groups, and their families.

The response was that the Government noted that all DHBs that participated in the recent Ministry of Health ECT audit were aware of cultural issues for Māori in the use of ECT and sought Māori cultural advice for people who were to have ECT and their families.

The Government agreed that the Ministry of Health would request DHBs to develop and implement written protocols for the use of ECT with Māori clients and clients from other cultural groups and their families.

The Ministry of Health has contracted a nurse consultant and an educationalist to develop an information resource for patients for whom ECT is recommended. The Ministry of Health is developing the resource on behalf of DHBs, which, when completed, will be available for use by all DHBs. Completion of the information resource was delayed by the need to seek the approval of the Multi Regional Ethics Committee for the research necessary to inform the development of the resource. Ethical approval was granted subject to various undertakings, including obtaining support from the Māori advisers of the DHBs selected to participate in developing the information resource. The information resource will include an information pamphlet as well as a DVD for patients and their families/whanau.

#### **Further evidence required**

The previous committee identified several areas where it considered further evidence was needed to assist in the consideration of this petition. It noted that very little research had been done to determine whether the administration of ECT to pregnant mothers has any long-term effect on their children and considered such research should occur. It considered it would be helpful to seek a professional opinion from paediatricians on this issue. It noted that data was not collected on the number of pregnant women treated with ECT and considered monitoring of outcomes for pregnant women, and collection of relevant data, should occur.

The committee also considered that further information on issues surrounding informed consent and compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992<sup>10</sup> would assist further consideration. The main recommendations of the independent review suggested some changes in this area, and issues of consent were frequently at the centre of concerns about ECT. The committee was surprised by the high rate of compulsory treatment orders in some district health board areas and considered further information on this could be gathered. It believed that future consideration could draw upon the views of medical professionals responsible for prescribing and administering ECT. The committee noted the use of advance directives should be considered.

#### **Further evidence received**

We received written and oral evidence from Dr Helen Smith, several of her medical colleagues, the Royal Australian and New Zealand College of Psychiatrists, the Paediatric Society of New Zealand, and the Chief Commissioner of the Human Rights Commission and the Health and Disability Commissioner jointly on the matters raised in the previous committee's interim report to the House. Some of the submitters also commented on the previous committee's report on the petition of Anna de Jonge and the report of the independent review, which dealt with ECT matters generally rather than the matters

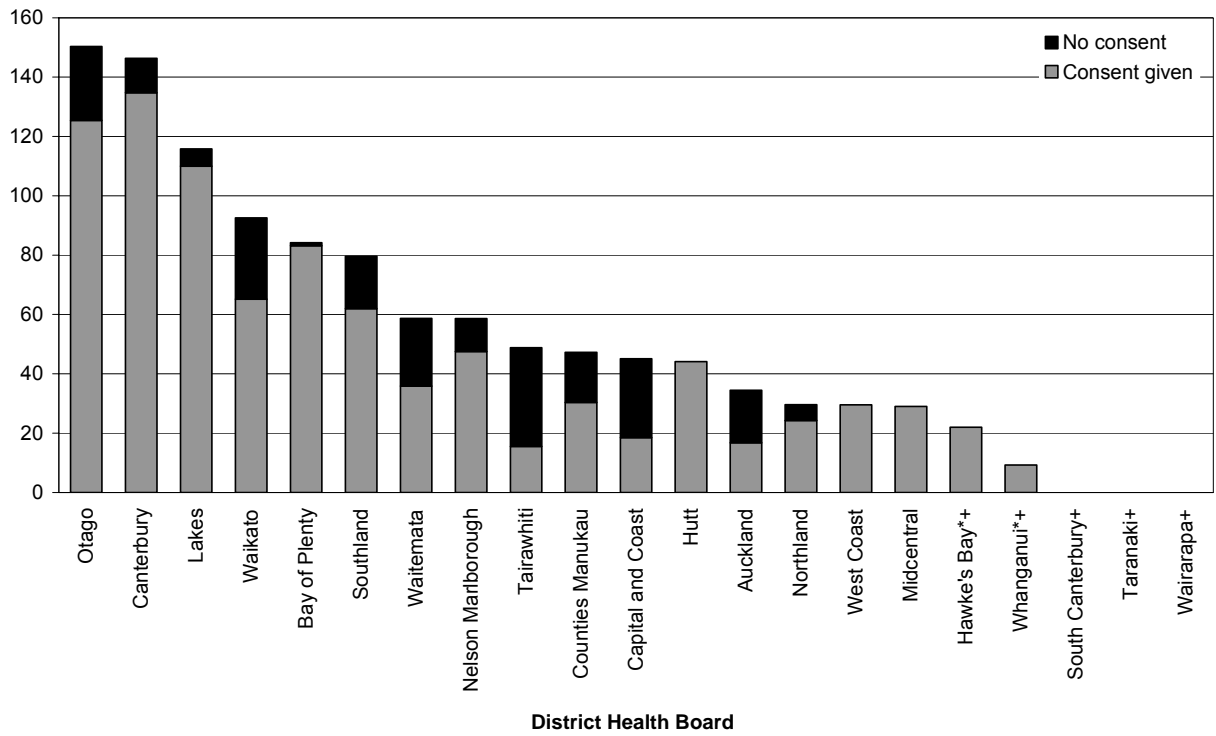
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<sup>10</sup> The Mental Health (Compulsory Assessment and Treatment) Act 1992 provides for compulsory treatment of mental disorder, and for Family Court judges to make compulsory treatment orders. The Act defines some circumstances in which the right to refuse to undergo medical treatment can be overridden.

relating to the specific groups of people highlighted in the current petition from Dr Helen Smith. We have concentrated our consideration on the use of ECT for these groups, although we are commenting on the use of ECT generally.

**Appendix C**

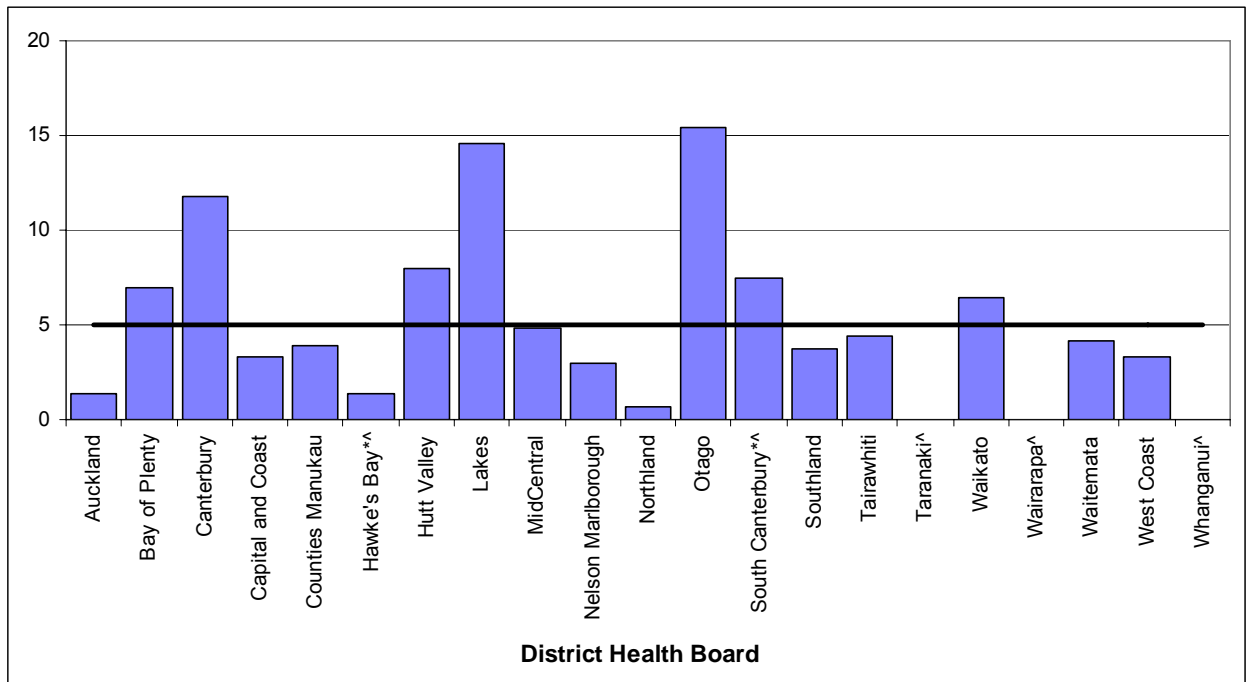
Population-adjusted figures for the number of ECT treatments consented to per 100,000 population, 1 July 2004–30 June 2005



+ DHB does not have an ECT machine

\* ECT performed at MidCentral DHB

Number of patients treated with ECT per 100,000 population, 1 July 2005-30 June 2006



^ DHB does not have an ECT machine

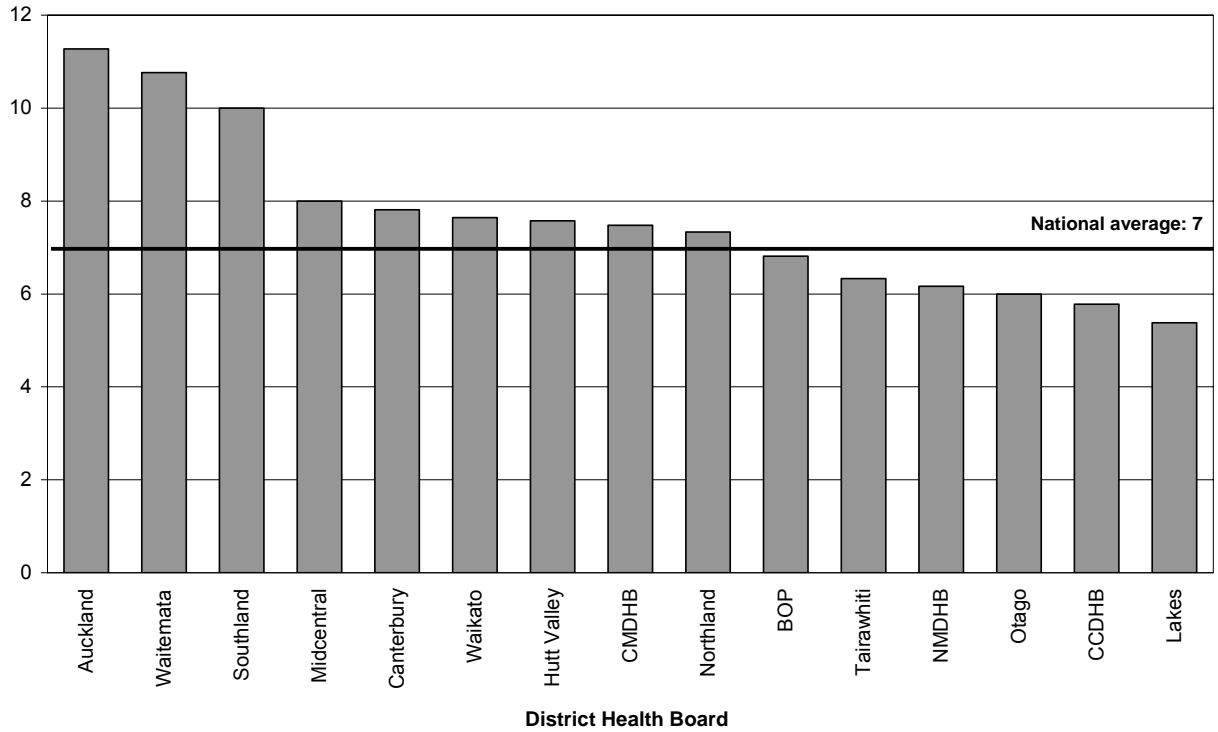
\* ECT performed at another DHB

**Appendix D**

ECT treatments per acute course, by DHB, 1 July 2004–30 June 2005

| <b>DHB</b>  | <b>No. of courses</b> | <b>No. of treatments</b> | <b>No. of treatments per acute course:<br/>mean (range)</b> |
|-------------|-----------------------|--------------------------|---|
| Auckland    | 11                    | 124                      | 11 (4–18)   |
| Waitemata   | 17                    | 183                      | 11 (2–19)   |
| Southland   | 3                     | 30                       | 10 (5–19)   |
| MidCentral  | 10                    | 80                       | 8 (4–12)  |
| Canterbury  | 63                    | 492                      | 8 (2–18)  |
| Waikato     | 31                    | 237                      | 8 (3–14)  |
| Hutt Valley | 7                     | 53                       | 8 (4–14)  |
| CMDHB       | 23                    | 172                      | 7 (3–13)  |
| Northland   | 6                     | 44                       | 7 (3–11)  |
| BOP         | 16                    | 109                      | 7 (2–15)  |
| Tairāwhiti  | 3                     | 19                       | 6 (4–10)  |
| NMDHB       | 12                    | 74                       | 6 (3–12)  |
| Otago       | 38                    | 228                      | 6 (2–14)  |
| CCDHB       | 9                     | 52                       | 6 (4–8)   |
| Lakes       | 21                    | 113                      | 5 (3–8)   |

ECT treatments per acute course, by DHB, 1 July 2004–30 June 2005



## ECT treatments per acute course, by DHB, 1 July 2005–30 June 2006

| District Health Board          | No. of courses | No. of treatments | No. of treatments per acute course: mean (range) |
|--------------------------------|----------------|-------------------|--|
| Auckland                       | 6              | 33                | 5.5 (1–10)                                       |
| Bay of Plenty                  | 10             | 67                | 6.7 (4–12)                                       |
| Canterbury                     | 51             | 349               | 6.8 (1–13)                                       |
| Capital and Coast              | 9              | 70                | 7.8 (6–17)                                       |
| Counties Manukau               | 22             | 136               | 6.2 (3–17)                                       |
| Hawke's Bay <sup>^*</sup>      | <5             | 12                | 4.0 (1–6)  |
| Hutt Valley                    | 11             | 73                | 6.6 (4–13)                                       |
| Lakes                          | 20             | 92                | 4.6 (1–10)                                       |
| MidCentral                     | 7              | 39                | 5.6 (5–10)                                       |
| Nelson Marlborough             | 5              | 32                | 6.4 (4–12)                                       |
| Northland                      | <5             | -                 | -  |
| Otago                          | 43             | 244               | 5.7 (1–17)                                       |
| South Canterbury <sup>^*</sup> | <5             | 30                | 7.5 (4–12)                                       |
| Southland                      | 5              | 33                | 6.6 (4–10)                                       |
| Tairāwhiti                     | <5             | 9                 | 4.5 (3–6)  |
| Taranaki                       | 0              | 0                 | -  |
| Waikato                        | 22             | 174               | 7.9 (1–16)                                       |
| Wairarapa <sup>^</sup>         | 0              | 0                 | -  |
| Waitemata                      | 24             | 230               | 9.6 (2–16)                                       |
| West Coast                     | <5             | 29                | 9.7 (8–11)                                       |
| Whanganui <sup>^</sup>         | 0              | 0                 | -  |

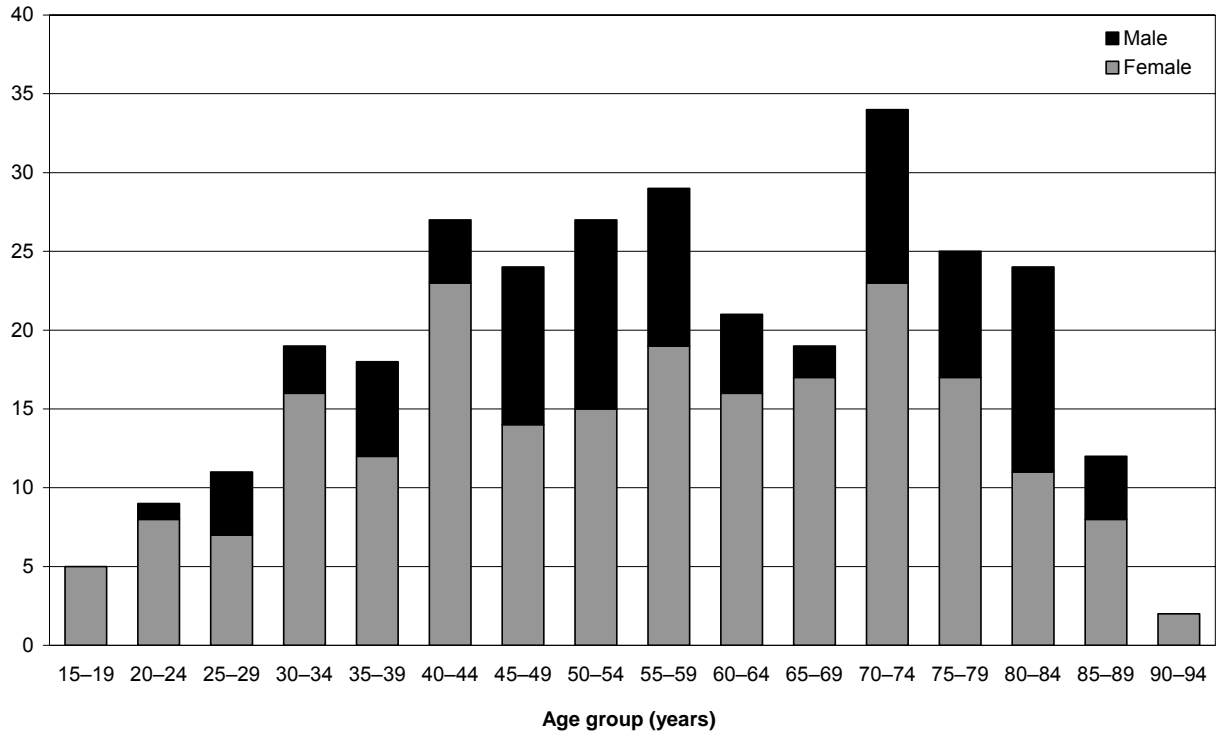
Notes:

\* ECT performed at another DHB

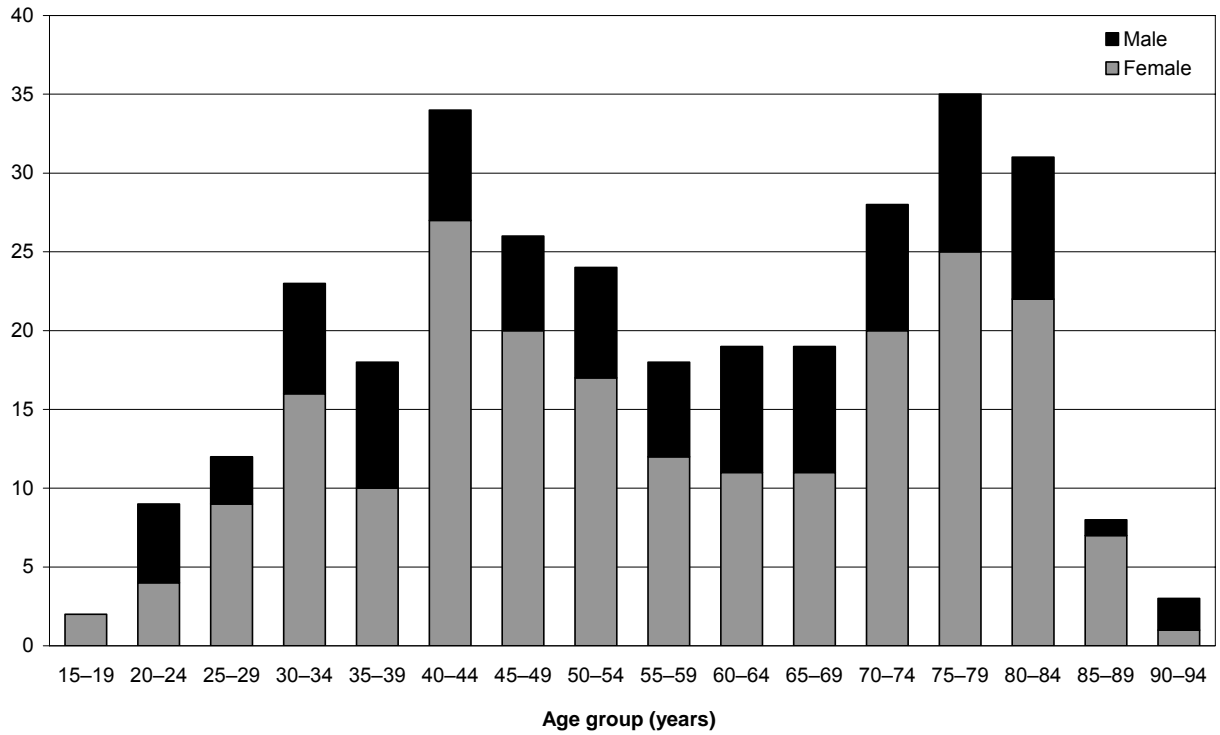
<sup>^</sup> DHB does not have an ECT machine

**Appendix E**

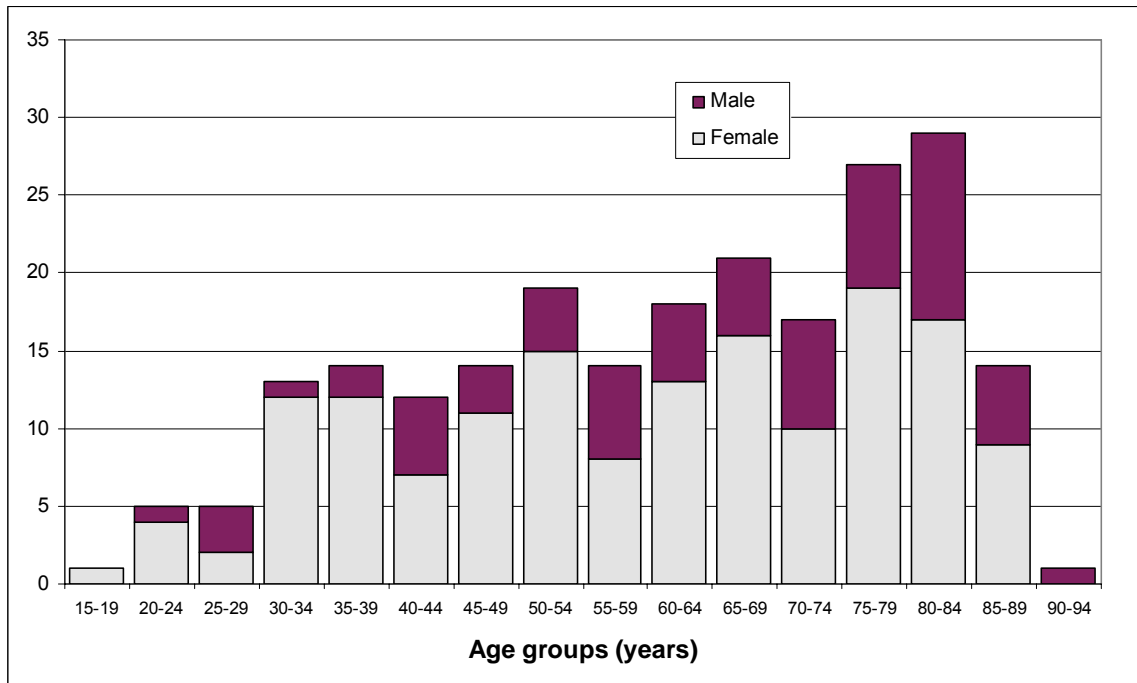
Age and sex of patients treated with ECT, 1 July 2003–30 June 2004



Age and sex of patients treated with ECT, 1 July 2004–30 June 2005



Age and sex of patients treated with ECT, 1 July 2005–30 June 2006



## Appendix F

### Ethnicity of Patients Treated with ECT

This table represents the ethnicity breakdown of people who were treated with ECT during the period 1 July 2003–30 June 2005.

Ethnicity of people treated with ECT, 1 July 2003–30 June 2005

| Ethnicity      | Number of patients 2004/05 | Number of patients 2003/04 |
|----------------|----------------------------|----------------------------|
| Asian          | 5 (2%)                     | 2 (1%)                     |
| European       | 260 (85%)                  | 258 (84%)                  |
| Māori          | 18 (6%)                    | 15 (5%)                    |
| Pacific people | 7 (7%)                     | 6 (2%)                     |
| Other          | 17 (17%)                   | 24 (8%)                    |

The ethnic spread suggests Asian people, Māori and Pacific peoples are under-represented for their population demography. However, the numbers are so small it would be unhelpful to show how the percentages relate to the proportion of each ethnic group in the total population.

Ethnicity of people treated with ECT, 1 July 2005–30 June 2006

| Ethnicity       | No. of patients |
|-----------------|-----------------|
| Asian           | 9 (4%)          |
| European        | 193 (86%)       |
| Māori           | 9 (4%)          |
| Pacific peoples | 4 (2%)          |
| Other           | 9 (4%)          |

The ethnic spread suggests Asian people, Māori and Pacific peoples are under-represented for their population demography. However, the numbers are so small that it is not statistically appropriate to show how the percentages relate to the proportion of each ethnic group in the total population.