ENIGMA

NEWS AND VIEWS ON MENTAL HEALTH

Summer Edition
December 2012

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This newsletter was put together by the staff of the Otago Mental Health Support Trust with contributions from lots of other people.
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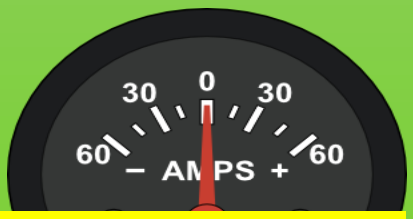

OTAGO MENTAL HEALTH SUPPORT TRUST

- Bipolar Network
- Information
- Education
- Peer Support
- Advocacy
- Resource centre for Tangata Whaiora
- Consumer Networking

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Polarised Opinions

Many people are amazed to learn that electric shock is still used to treat mental illness. Watching *One Flew Over the Cuckoo's Nest* is probably the full extent of their education about this controversial treatment. In that movie Jack Nicholson's character McMurphy is given shock treatment for punishment and control, a barbaric yet common practice in psychiatric hospitals not so many years ago. Consumer outrage has ensured that it is extremely unlikely that shock treatment (ECT) would be used in a punitive way these days. Why then is the treatment still controversial? For some people perhaps ECT conjures up thoughts of electric fences, electric chairs, lightning, pain…? We are taught from an early age to be extremely cautious with the potentially lethal force, electricity. Naturally we squirm at the thought of electrodes near our brains. Doctors who prescribe ECT are convinced that it is safe, painless, and works well. However, the scientific evidence for ECT is equivocal, perhaps even more so than for other psychiatric treatments.

ECT is now used as a last resort to treat severe depression for which drugs and psychotherapy have not brought relief. It is occasionally used to treat catatonia and mania, again when other treatments have failed. ECT today is given under general anaesthetic with a muscle relaxant drug to ensure that no longer are bones broken by the force of the muscle spasms produced by the shock.

The objective with ECT is to cause a generalised epileptic seizure. Shock treatment was originally invented to treat schizophrenia because someone held the misguided idea that people with epilepsy do not get schizophrenia. At first drugs like metrazol were used to induce the seizure until the Italian Cerletti, having watched pigs at the slaughterhouse calmed but not killed by electric shock, tried shocking people.

Does ECT work? Our Ministry of Health commissioned a major review of the safety and efficacy of ECT, published in 2004. Regarding efficacy they concluded that:

"ECT is an effective treatment and should be considered for use in high-risk patients, including those with severe depression, schizophrenia, mania or catatonia."

Being effective does not mean we know how something might work. ECT was invented almost 75 years ago. There have been many theories about how it might work but no definitive scientific evidence in support of any one of them.

As Harold Himwich wrote: *"Perhaps we are doing the right thing but in a very crude way just as if one were trying to right a watch with a hammer."*(American *Journal of Psychiatry*, 1943.)

The Ministry of Health review considered whether ECT was safe and concluded:
"There are risks associated with the general anaesthesia administered before ECT. These are mainly related to the cardiorespiratory system. Special care should be taken when administrating ECT to people with existing cardiac disease."
"Many patients experience disturbances in memory following ECT. These disturbances usually resolve within a few weeks for most patients. A minority of patients experience
long-term effects on memory, which is subjective and difficult to measure."

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(Polarised Opinions continued)

The Ministry considers that there is little physical risk with ECT. They ignore the fact that people do not receive one dose of ECT. They receive multiple doses, with all the risks of anesthesia each time. They acknowledge but play down the damage to people's memory.

The Ministry of Health review of ECT acknowledges that the scientific evidence for the benefits of ECT is poor and that the treatment has risks. However, in their opinion:

"Many health professionals consider ECT to be a safe and effective treatment for certain forms of mental illness. Sometimes it is the only effective treatment and can be life saving."

Many other health professionals do not agree, believing instead that *"...the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified." (Read and Bentall, 2010).*

ECT rates rocket in Otago and Southland

The 2011 annual report of the Director of Mental Health provides statistics on some psychiatric practices in New Zealand. It shows that the rate of use of ECT in New Zealand is increasing. In 2009/2010, 5.4 people out of every 100,000 in our population were given ECT. In 2011 this increased to 6.5 per 100,000 people. Some District Health Boards prescribe very little ECT, for example about 2 people per 100,000 population for Auckland and Whanganui, and 3 per 100,000 in Hutt. Fifteen of the 20 DHB's provide less than the national average rate of ECT. The startling exception is our own Southern District Health Board at a whopping 19 people per 100,000 population given ECT. What is so different about the South that creates this difference? Is this a good thing? Do we have better access down here to a treatment that our Northern cousins are missing out on? Do we perhaps have psychiatrists here who are more willing to use ECT? Do our doctors recognise earlier that drugs are not fixing the depression and give ECT instead?

The previous annual report (2010) from the Director of Mental Health also showed the Southern District Health Board to be the top user of ECT (that rate has since doubled). When that report was published, in October 2010, the Otago mental health medical director Dr. James Knight published an article in the Otago Daily Times (25/10/11) in response to the apparently high rate of ECT in the South. Dr. Knight announced an audit of ECT use in order to dispel any ideas that our psychiatrists are particularly enthusiastic about using ECT. He suggested that:

- Otago's ECT rates are tracking down over time anyway.
- High ECT rates might be a good thing. We may have better access to an effective treatment.
- The rates might be high because our population has more older people and less Maori. Older people are more likely to get ECT and Maori less likely.
- The figures are inaccurate. They include people from Southland who come to Dunedin for ECT but only use the Otago population to calculate the rate.

Are those arguments reasonable? Enigma would argue:

- From 2010 to 2011 ECT rates in the SDHB did not track down. They doubled from 9 to nearly 18 people per 100,000 population.
- Many other DHB's with good access to ECT facilities use them at a much lower rate than us.
- 13.8% of the SDHB population is over 65 years old compared with 12.3% for the whole of New Zealand and 8% of our population is Maori compared with 14% for the whole country (Census 2006). Correcting for these factors would only bring our ECT rate from 18 per 100,000 population down to 17 per 100,000, still grossly higher than any other DHB.
- The latest Ministry of Health figures are calculated using the correct population figure.

Unfortunately a year has passed and the announced audit of ECT use does not seem to have happened. We are still none the wiser as to why ECT is used much more freely in the South of New Zealand than it is in the North, let alone why it is given to women, especially older women, twice as much as men.

No Scientific Justification for ECT Use

Dr. John Read is a clinical psychologist at the Department of Psychology, University of Auckland. In 2010 he received the New Zealand Psychological Society's Sir Thomas Hunter Award for 'excellence in scholarship, research and professional achievement'. Dr. Read believes that *"The cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified."* With Richard Bentall, Professor of Psychology at the University of Bangor in Wales, Dr. Read published a review in 2010 of the effectiveness of ECT. Read and Bentall were critical of the poor design of most studies of ECT efficacy. The strongest research evidence for any treatment comes from studies where the active treatment is compared with a placebo, and where the researchers are blinded; they are not aware of which participants are getting the real treatment and which are getting the placebo. Without placebo and blinding, there is a great risk that studies will be biased and researchers will see the results they want to. With ECT studies the placebo means that half the people are given real ECT and the other half get "sham" ECT. They get the general anaesthetic, the muscle relaxant and the electrodes, but not the actual shock.
Read and Bentall found ten ECT depression studies which used a placebo. Five of these found no significant difference between sham and real ECT. Two studies found that people getting real ECT improved faster than those getting sham ECT, only on some measures of depression, and only early in the treatment. Two studies found an advantage of ECT over sham ECT particularly for people with "deluded" type of depression. The fifth study found that ECT was better than sham ECT for relieving depression, although both groups improved. It is important to note that in all these studies people's depression improved, sometimes dramatically, whether they were receiving the real or the fake ECT. This was the case even for those with rigorously defined melancholic depression. That is depression generally thought to be biological and not responsive to placebo.

Suicide Prevention?

An important argument for ECT is that it acts quickly

continued

Suicide prevention continued

and therefore could prevent some suicides in severely depressed people. Read and Bentall (and the Ministry of Health review) both concluded that there is no quality scientific evidence to back up this claim. Indeed most studies show no difference and two studies show an increased risk of suicide in people receiving ECT.
Read and Bentall considered the evidence as to whether the positive effects of ECT are lasting. They found no evidence that any benefits of ECT last beyond the treatment period. One study said *"…without active treatment, virtually all remitted patients relapse within 6 months of stopping ECT."*

Brain Damage and other risks?

Read and Bentall found strong evidence that ECT causes permanent memory impairment. Virtually everyone receiving ECT has trouble afterwards for a few weeks retaining new information. Many people lose childhood memories, permanently. Read and Bentall also found that authorities routinely underestimate the death rate from ECT to be comparable with minor surgery, about one death per 13,000 treatments. Our Ministry of Health ECT Guide estimates the risk of death from ECT to be 1 in 50,000.Studies show the real risk of death to be at least ten times greater.

In plain English, considering the best quality scientific evidence:

- Many people's depression improves whether they are given real or fake ECT.
- In half the studies fake ECT is just as effective as the real thing.
- For a few people ECT is a little more effective than the fake.
- In several studies only the psychiatrist saw an improvement; relatives and nurses saw none.
- There is no definitive evidence that ECT prevents suicide.
- ECT causes memory disruption in most people, permanent in many.
- Any advantage of ECT is temporary; it disappears when the treatment stops.
- ECT carries a small but significant risk of death.

Phobic phone line

This is a 24 hour a day, seven day a week free phone line staffed by volunteers. It is to help people who are experiencing panic attacks or OCD thoughts and need to talk to someone. 0800 142694389- for more information www.phobic.org.nz

"Don't worry,' the nurse grinned down at me. 'Their first time, everybody's scared to death.' 'I tried to smile, but my skin had gone stiff, like parchment. Doctor Gordon was fitting two metal plates on either side of my head. He buckled them into place with a strap that dented my forehead, and gave me a wire to bite.

'I shut my eyes. There was a brief silence, like an indrawn breath. Then something bent down and took hold of me and shook me like the end of the world. Whee-ee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant. 'I wondered what terrible thing it was that I had done. (Sylvia Plath, The Bell Jar)

By the roots of my hair some god got hold of me.
I sizzled in his blue volts like a desert prophet.

The nights snapped out of sight like a lizard's eyelid:
A world of bald white days in a shadeless socket.

A vulturous boredom pinned me in this tree.
If he were I, he would do what I did. -Sylvia Plath
"The Hanging Man"
(A poem about her experience with electroshock therapy)

Modern ECT

What Sylvia Plath describes in her graphic writing is un-modified ECT. The person is fully aware of their surroundings until the moment the shock from the electrodes attached to each temple sends their brain into a major epileptic seizure. The force of the seizure was sometimes sufficient to break major bones. Today, in most countries, the experience resembles many minor surgical procedures. There will be blood tests, possibly a chest x-ray and other tests to confirm that you are physically healthy enough for the procedure and for the anaesthetic. A general anaesthetic is used. A muscle relaxant is also injected. This ensures that there are no powerful contractions of the muscles and so no danger of broken bones as in the past. Usually, these days an electrode is only put on one temple rather than both. This unilateral ECT is thought to have lower risk of memory loss than bilateral ECT.

Notice of Annual General Meeting of the Trust

You are invited to the annual general meeting of the Otago Mental Health Support Trust. The meeting will be held immediately following the March meeting of the board of trustees.

Date: Tuesday12th of March 2012
Time: 1pm
Place: The Trust's office, Third floor, Queens Building, 109 Princes Street, Dunedin

Many thanks to these people for their support:

ACE Shacklock Charitable Trust, Balance, Dempsey Trust, , Colortronics. DCC, Pat Sivertsen –Dehaan Travel, Lone Hill Vineyard, 17 Frames, DCC Community grants Scheme