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Correspondence

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Provision of electroconvulsive therapy in Italy

24 March 2022

Sashidharan lauds Trieste's 'humane, person-centred and effective' psychiatric services[1] but omits to mention that, in common with most Italian cities, it has no electroconvulsive therapy (ECT) service.[2] Indeed, only a handful of Italian centres offer the treatment, a lack of provision that has its basis entirely in politics rather than science.[3] Since ECT was first developed in Rome in 1938[3,4] and its lifesaving properties promptly recognised, it has been refined and improved to enhance its safety and effectiveness, while a large evidence base has built up to inform its ongoing use.[5] An extremely safe treatment, it is undoubtedly the most effective strategy for moderate to severe depressive illness[5] and one of the most effective treatments across the whole of psychiatry.[4] Yet, staggeringly, Sashidharan's fellow ideological proponent of the Trieste model of care, Mezzina, has written positively of the lack of access its patients have to ECT, as though this vast gap in service provision were something of which to be proud.[2] This could not happen in any other branch of medicine: it is akin to an oncologist boasting of an inability to provide patients with chemotherapy. It has been convincingly argued that refusal to provide ECT, when clinically indicated, is an infringement of patients' human rights.[4] Indeed, most low- and middle-income countries strive to provide ECT services, even if access is limited owing to minimal resources. A supposedly 'humane, person-centred and effective'[1] psychiatric service in western Europe cannot continue to justify denying its patients such a safe and effective treatment.

Declaration of interest

None

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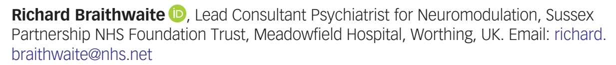
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Author's reply

17 May 2022

My article[1] was about the political threats facing, arguably, one of the best mental health services in the world and not about use of ECT. In this context, it is specious and misleading for Dr Braithwaite to suggest that Trieste's services somehow fall short of providing effective, humane and person-centred care because ECT is not part of routine clinical practice. This is not unique to Trieste; there are many mental health services and psychiatrists, including in the UK, that do not use ECT. There are others that use it frequently and routinely. This, by itself, does not mean that patients are being deprived of an effective treatment or that they are subject to treatment they may not need. It is perverse to suggest otherwise and to imply that the use of ECT should be considered as a hallmark of good mental healthcare.

Apart from offering the usual paean of praise for ECT, Dr Braithwaite does not provide any evidence which indicates that people in Trieste are being deprived of effective treatment or appropriate care. I am not aware of any clinical evidence of this, nor of any concerns raised by anyone familiar with Triste's mental health services at any time or in any literature relating to the remarkable achievements of the mental health reforms in Trieste over the past 40 years. If Dr Braithwaite has evidence to the contrary, he should present it rather than resorting to a strawman fallacy. The question is not why ECT is not used in Trieste but why there been no need to use ECT in Trieste in the past 40 years.

It is depressing to see the continuing antipathy towards Trieste within British psychiatry. Our rejection of Trieste has never been based on facts or on a detailed understanding of mental healthcare there and its ethos and culture. Dr Braithwaite's comments are in keeping with this, but I am glad that such attempts to discredit Trieste are increasingly at odds with the growing recognition of the value and long-term benefits of the key components of the Trieste model of mental healthcare.[2]

Declaration of interest

None

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Is there enough evidence for ECT?

21 March 2022

In an opinion piece in the *BJPsych*, Gergel[1] dismisses research that raises significant concerns about whether electroconvulsive therapy (ECT) is an effective treatment for depression. The author found net benefit from her own treatment, but the scientific approach does not generalise from personal experience. Research is a better basis for practice, and for ECT there is very little evidence.

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The bare facts are that no placebo-controlled study of ECT for depression has been conducted since 1985 and according to a 2019 review by Read et al,[2] the 11 previous studies, which constitute the entire evidence base for ECT versus sham ECT, were mostly of poor design and together involved just 224 ECT treated patients and 187 sham ECT controls. They concluded that the combined research barely supports short-term benefit of ECT and contains no indication of long-term benefit, suicide reduction or greater effectiveness in older patients. The review also unearthed troubling mortality data in addition to frequent cognitive damage.

If 'ECT' in Gergel's article were replaced with 'insulin coma therapy', readers would be surprised at the claims for benefit and the lack of danger of treatment. With ECT, however, we are content to accept its continuing use despite the scarcity of effectiveness and safety data. Psychiatrists and researchers have a responsibility to find out how much ECT helps and harms the patients we treat rather than muddle on with so little understanding of what we are doing to people.

The *BJPsych* seems content to publish strong pro-ECT views despite the lack of evidence. The journal included a commentary on Gergel containing the remarkable claim that ECT is 'one of the most effective treatments in all of psychiatry'.[3] Is this the voice of a rigorous scientific journal? A call for large, well designed, placebo-controlled trials of ECT would be more appropriate.

Declaration of interest

None

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RE: 'Shock tactics', ethics and fear: an academic and personal perspective on the case against electroconvulsive therapy

9 June 2022

Author's reply: I thank Dr Yeomans for his letter and will answer his concerns point by point. Yeomans' suggestion that there is no evidence to support the effectiveness of ECT is based on a review by Read et al summarising details about a handful of placebo-based studies which are now between 60 and 40 years old.[1] As Meechan et al clearly explain, the selected studies 'would not meet contemporary standards of evidence-based medicine',[2] and Yeoman's letter ignores substantial recent evidence-based research, including randomised controlled trials, showing the benefits of ECT versus active comparators.[2,3] In addition, there is significant research showing ECT's physical safety.[3,4]

He also suggests that I 'generalise from personal experience' rather than using a 'scientific approach'. My personal experience recounted here is by no means a replacement for science, and Yeomans clearly overlooks the fact that all my key points about ECT are supported by references to the scientific literature. I chose to include my own experiences as an illustrative vignette, the authenticity of which may be harder for ECT critics to dismiss, given that I am describing my own case. As the stigma surrounding ECT makes it difficult for ECT recipients to be open about having received treatment, I aimed to offer some responses to questions often raised about experiencing this treatment.

Yeomans refers to the point that some psychiatrists have strong reservations about ECT, without providing any references or evidence for this claim. Neither Read nor any co-author of the review cited by Yeomans is a psychiatrist. In fact, in relation to his 2020 review, Read has himself written 'I am indeed biased against ECT'.[5] However, even if Yeomans' claim is true, it certainly does not invalidate the strong general support amongst psychiatrists and the international medical community for ECT. Moreover, studies have shown that clinicians' concerns about ECT can be assuaged through experience of seeing ECT in practice.[6]

Finally, a common trope within ECT critiques suggests some global psychiatric conspiracy. What Yeomans and the other ECT critics fail to point out is that ECT is a multidisciplinary process, involving not only psychiatrists, but also anaesthetists, operating department practitioners and mental health nurses. In the UK, the National Association of Lead Nurses in ECT has an underlying philosophy that 'ECT is one of a variety of beneficial treatments available and should be viewed as part of a holistic process'[7] and have championed the use of nurse-led ECT. As I make clear in my article, ECT is not always successful. However, in general, those who work in ECT clinics see large numbers of patients experience dramatic recoveries from the most severe states of mental illness, which in itself convinces them of its effectiveness. Combined with a strong evidence base, Paris's claim that ECT is 'one of the most effective treatments in all of psychiatry' is understandable and not, as Yeomans says, 'remarkable' or out of place in 'a rigorous scientific journal'.[8]

Declaration of interest

None

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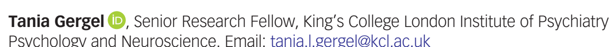

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