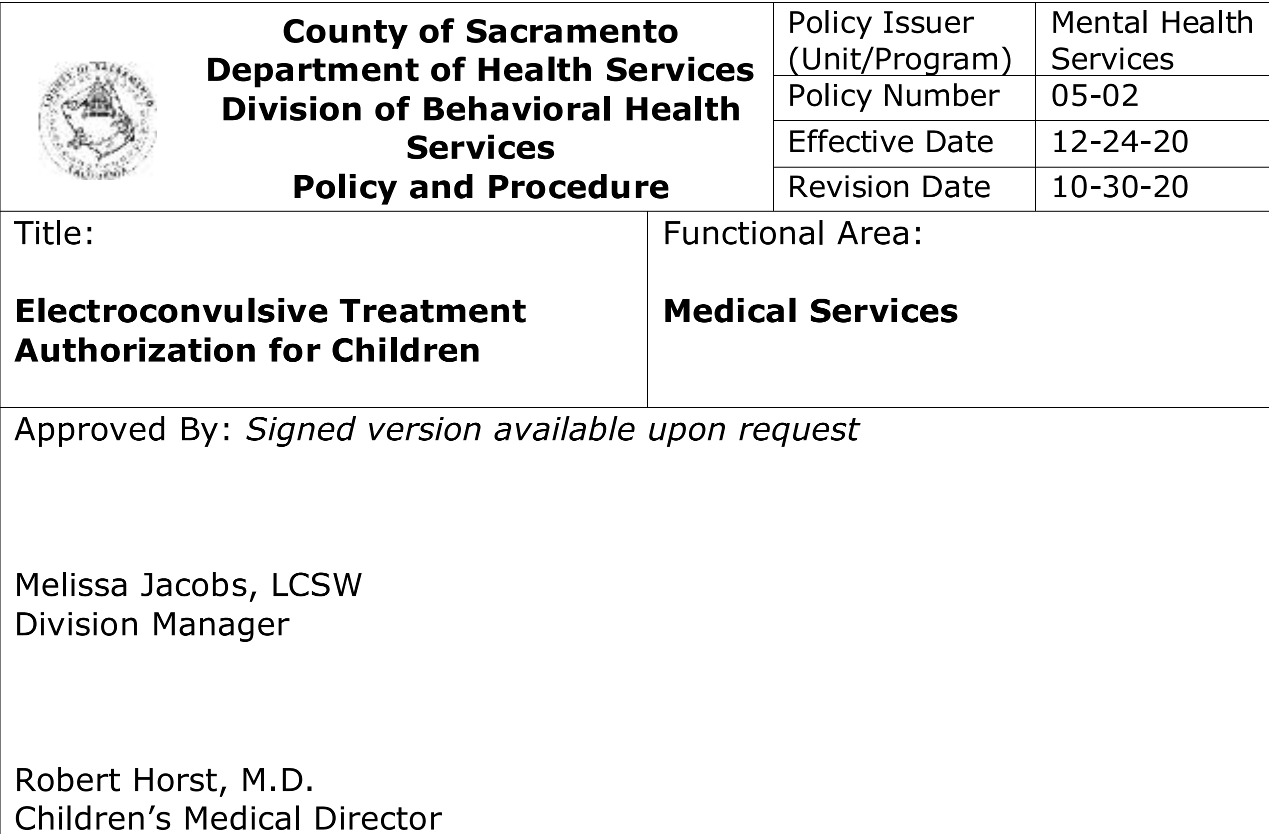

County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health Services
	Policy Number	05-02
	Effective Date	12-24-20
	Revision Date	10-30-20
Title: **Electroconvulsive Treatment Authorization for Children**	Functional Area: **Medical Services**	
Approved By: *Signed version available upon request* Melissa Jacobs, LCSW Division Manager Robert Horst, M.D. Children's Medical Director		

Background/Context:

Sacramento County Division of Behavioral Health Services (BHS) reviews and considers all requests for Electroconvulsive Treatment (ECT) for eligible children ages 12 to 17 with severe emotional disturbance. The BHS Children's Medical Director is the designated point of contact for this service.

Definitions:

Avatar: Electronic Health Record System for Sacramento County Behavioral Health Services

Purpose:

To establish a process for evaluating and authorizing services for Sacramento County beneficiaries, ages 12 to 17 to receive ECT treatment in an ethical manner, when ECT is clinically indicated and is the least drastic alternative available.

Details:

A. ECT Authorization Requests

1. The client's clinical treatment team completes the following and sends to the BHS Children's Medical Director:

    a. Request for ECT referral form (per the referring party)

    b. ECT Informed Consent Form (Welfare and Institutions Code 5326.85) or court documentation indicating court authorized involuntary treatment.

    c. Supporting clinical documentation in recommendation of ECT, including current diagnoses, other treatment modalities attempted, coordination efforts with an outpatient provider if relevant, and any other relevant findings.

2. Requests from an inpatient provider for ECT treatment must be submitted for review no less than three (3) business days before the BHS Children's Medical Director's evaluation/opinion is needed.

3. Requests from an outpatient provider for ECT treatment must be received no less than five (5) business days before the BHS Children's Medical Director's evaluation/opinion is needed.

4. The BHS Children's Medical Director reviews the referral packet and gathers any additional information needed (Welfare and Institutions Code 5326.75).

5. **For children ages 12 to 15:** Once the required documentation is confirmed, the BHS Children's Medical Director sends the content of the referral packet listed above along with the following information to two (2) board-certified or board-eligible psychiatrists:

    a. ECT referral packet (see contents in item 1 above).

    b. A copy of the individual's Diagnosis & Movement History Report from Avatar (when applicable).

    Once received, the two (2) psychiatrists will review the ECT referral packet and notify the BHS Children's Medical Director whether they approve the request or not. The two (2) psychiatrists and the BHS Children's Medical Director have to assess and agree that ECT is the most appropriate primary intervention or treatment. Once the three

(3) child psychiatrist panel unanimously agree, the request is forwarded to the BHS Director for final approval.

For children ages 16 to 17: The BHS Children's Medical Director will complete an evaluation and determine if ECT is clinically indicated and is the least drastic alternative available for the patient at this time.

For children under 12 years of age: Per Welfare and Institutions Code 5326.8, under no circumstances shall convulsive treatment be performed on a minor under 12 years of age.

6. The BHS Children's Medical Director will inform the referring party if there are any concerns with authorization.

7. For approved ECT Requests, the BHS Children's Medical Director will authorize initially for no more than twelve (12) treatments within a six (6) month period.

8. The BHS Children's Medical Director or designee will send the authorization for ECT to the designated BHS Program Coordinator (subject to the provisions of Welfare and Institutions Code 5326.7).

9. Once authorized, the designated BHS Program Coordinator or designee will complete the following:

    a. Maintain a record of all ECT Requests and dispositions.

    b. Enter all ECT Requests and supporting documentation into Avatar, including, but not limited to: date of receipt, authorization period, number of treatments authorized, and any additional approval needed and requests for "excessive" ECT per California Code of Regulations Title 9, Division 1, Chapter 4, Article 5 guidelines authorization.

    c. Fax the authorization for ECT to the ECT service provider (currently Sutter Center for Psychiatry).

    d. Inform the individual's inpatient/outpatient treatment provider that ECT has been authorized, along with the following information:
        i. Name and contact information of the ECT provider.
        ii. Authorization period

iii. Number of treatments authorized.

10. To ensure payment, the ECT service provider will submit to the designated BHS Program Coordinator the following documentation along with invoicing for each treatment provided:

a. Progress notes indicating coordination of care between the ECT provider and the inpatient provider or the MHP outpatient provider, who will hold primary responsibility for ongoing care in consultation with the ECT service provider.

b. Progress notes indicating the client's response to treatment.

B. Excessive ECT

BHS adheres to the California Code of Regulations, Title 9, regarding excessive ECT treatment. Specifically, "Convulsive treatments shall be considered excessive if more than fifteen (15) treatments are given to a patient within a thirty (30) day period, or a total of more than thirty (30) treatments are given to a patient within a one year period."

1. Requests for re-authorization for additional treatments exceeding the above limits must include documentation of prior approval from the County ECT Medical Review Committee.

2. Requests for additional treatments shall include documentation of the diagnosis, the clinical findings leading to the recommendation for the additional treatments, the consideration of other reasonable treatment modalities, and the opinion that additional treatments pose less risk than other potential effective alternatives available for the particular patient at the present time. A maximum number of additional treatments requested will be specified.

3. The ECT service provider shall provide a written copy of the contractor's internal review committee's approval of excessive ECT treatment.

4. The Mental Health Directors of the following programs will make up the standing members of the County ECT Medical Review Committee:

a. Sacramento County BHS Children's Medical Director (or designee)

b. Sacramento County Mental Health Treatment Center Medical Director

Reference(s)/Attachments:

Attachment A: ECT Informed Consent Form

Welfare and Institutions Code 5326.7

Welfare and Institutions Code 5326.75

Welfare and Institutions Code 5326.8

Welfare and Institutions Code 5326.85

Distribution:

Enter X	DL Name	Enter X	DL Name
X	County Mental Health Staff	X	Children's Contract Providers
X	Publish to Internet	X	Publish to Intranet

Contact Information:

Robert Horst, M.D., Children's Medical Director, Division of Behavioral Health Services, (916) 876-6937, HorstR@saccounty.net

ELECTROCONVULSIVE TREATMENT (ECT), INFORMED CONSENT FORM

DO NOT SIGN THIS FORM UNTIL YOU HAVE ALL THE INFORMATION YOU DESIRE CONCERNING ELECTROCONVULSIVE TREATMENT (ECT).

The nature and seriousness of my mental Condition, for which ECT is being recommended, is

____

RECOMMENDATION: I understand that ECT involves passage of an electrical stimulus across my brain for a few seconds, sufficient to induce a seizure. In my case the treatments will probably be given ________ times per week for _______ weeks, not to exceed a total of ________ treatments and not to exceed 30 days from the first treatment. Additional treatments cannot be given without my written consent.

Reasonable alternative treatments (such as psychotherapy and/or medication) have been considered and are not presently recommended by my doctor because

IMPROVEMENT: I understand that ECT may end or reduce depression, agitation and disturbing thoughts. In my case there may be permanent improvement, no improvement, or the improvement may last only a few months. Without this treatment my condition may improve, worsen or continue with little or no change.

SIDE EFFECTS AND RISKS: I understand there is a division of opinion as to the effectiveness of this treatment as well as uncertainty as to how this procedure works.

I also understand this treatment may have brief side effects: headaches, muscle soreness and confusion.

There may be some memory loss which could last less than an hour or there may be a permanent spotty memory loss. Memory loss and confusion may be lessened by the use of unilateral (one-sided) electrical brain stimulation rather than bilateral (two-sided) stimulation.

Anesthesia and muscle relaxants will be used during these treatments to prevent accidental injury. Oxygen will be administered to minimize the small risk of heart, lung, brain malfunction or death as a result of the anesthesia or treatment procedures.

My physician states I have the following medical condition(s) which increase the risk in my case, as follows:

I HAVE THE RIGHT TO ACCEPT OR REFUSE THIS TREATMENT. IF I CONSENT, I HAVE THE RIGHT TO REVOKE MY CONSENT FOR ANY REASON AT ANY TIME PRIOR TO OR BETWEEN TREATMENTS.

Dr. ______________________________ has explained the above information to my satisfaction. At least 24 hours have elapsed since the above information was explained to me. I have carefully read this form or had it read to me and understand it and the information given to me.

I HEREBY CONSENT TO ECT ____

Signature | Date and Time

____

Witness Signature