Education about HIV and prevention training should be an international priority that produces thousands more trained healthcare workers, teachers, and community leaders—spread throughout all areas of society. A notable impact on prevention cannot occur if large portions of the population are left uneducated. There is not enough time to wait for "trickle down" or "from the centre out" approaches to building education and training infrastructure. One need only travel two hours from major urban areas in developing countries to observe that HIV, but not HIV education, has reached them. Although numbers are not precise, it is likely that 50% or more of the HIV epidemic occurs in rural areas that have limited access to HIV information.

Many of the current educational tools focus on individuals with moderate to high levels of literacy. Information about HIV and AIDS is often not available to healthcare workers, teachers, and students, or for that matter, to community, village, and religious leaders. Currently available information must be translated and adapted to diverse conditions, especially those that exist in rural areas. Because of the low priority given to funding education and training it is not surprising that so many individuals lack basic knowledge on how to prevent HIV infection. Without education at all levels in the community major reservoirs of HV infection and transmission will continue unabated.

Behaviour change does result in a decrease in new HIV infections whether in rich countries such as the US and Europe or in poor ones such as Uganda and Zambia.[2 8] However, without more extensive progress we are deluding ourselves into thinking that the epidemic can be controlled. Behaviour change must encompass all levels—governments, non-governmental organisations, schools, religions, community leaders, and individuals. A good place to start would be with accepting that voluntary counselling and testing should be universally incorporated into health care. Only when these are universally available and accepted by all will individuals know how to protect themselves from becoming infected, how to prevent themselves from transmitting infection, and when to be treated. The amount of HIV testing and the numbers of people infected and uninfected should be the measurement by which we determine the success of prevention programmes.

At this time in the epidemic we don't have the luxury of debating the relative merits of prevention versus treatment. Both are underused and underfunded, and one leads to the other. But being serious about prevention calls for change in behaviour on everyone's part.

Arthur J Ammann *president*

Global Strategies for HIV Prevention, 104 Dominican Drive, San Rafael, CA 94901, USA (GlobalHIV@AOL.com)

Competing interests: None declared.

1 Ammann AJ. Human immunodeficiency virus: an epidemic without precedent. *Ann N Y Acad Sci* 2000;918:3-8.
2 Gayle H. An overview of the global HIV/AIDS epidemic, with a focus on the United States. *Aids* 2000;14(suppl 2):S8-17.
3 Shan H, Wang JX, Ren FR, Zhang YZ, Zhao HY, Gao GJ, et al. Blood banking in China. *Lancet* 2002;360:1770-5.
4 Willis BM, Levy BS. Child prostitution: global health burden, research needs, and interventions. *Lancet* 2002;359:1417-22.
5 Guay LA, Musoke P, Fleming T, Bagenda D, Allen M, Nakabiito C, et al. Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial. *Lancet* 1999;354:795-802.
6 Normile D. China awakens to fight projected AIDS crisis. *Science* 2000;228:2312-3.
7 Fowler MG, Newell ML. Breast-feeding and HIV-1 transmission in resource-limited settings. *J Acquir Immune Defic Syndr* 2002;30:230-9.
8 Uganda tackles AIDS from the very top down. *Aids Alert* 1999;14(suppl 8):s3-4.

Electroconvulsive therapy

Recent recommendations are likely to improve standards and uniformity of use

Papers p 1363

Electroconvulsive therapy is one of the most controversial treatments in medicine. Opinions are often polarised; some consider electroconvulsive therapy to be effective and potentially lifesaving whereas others regard it as unhelpful and harmful and campaign energetically for it to be banned. In response to comments on a mental health white paper, "Reforming the Mental Health Act," the UK Department of Health commissioned two systematic reviews of electroconvulsive therapy in 2001. One assessed its efficacy and safety in the treatment of depression,[1] mania, and schizophrenia and the other reviewed surveys of patients' experiences and is published in this issue of the *BMJ* (p 1363).[2]

So what is the current status of our knowledge about electroconvulsive therapy? Both reviews reveal the limitations of the primary studies and the need for genuinely collaborative high quality research—rather than research done by consumers for consumers and by clinicians for clinicians resulting in research with limited general credibility. Nonetheless both reviews produced some useful results. The systematic review of patients' experiences found that approximately a third describe persistent loss of memory following electroconvulsive therapy.[2] Rose et al report that there were substantial variations between studies in the perception of benefit from electroconvulsive therapy. The finding that surveys conducted by clinicians tend to report higher rates of perceived benefit whereas those performed by consumers' organisations tend to find lower rates is of particular interest. Of course this may be explained by differences in the selection of the populations sampled or, as the authors suggest, by differences in the focus of the questions and the way they were asked. The review of randomised trials found a reasonable body of evidence on the effects of electroconvulsive therapy in depressive disorder, but less on mania and schizophrenia.[1 4] Electroconvulsive therapy produces more improvement on scales of depressive symptoms than simulated electroconvulsive

BMJ 2003;326:1343–4

therapy (in which the patient receives all the procedures including anaesthetic but not the electric current). Treatment with electroconvulsive therapy was more effective than drug treatment in the short term, bilateral stimulation was more effective than unilateral, and high dose more effective than low dose. Most of the trials, however, were old and small. Cognitive functioning was not measured consistently across the trials and pooled analyses were not possible. Very few trials investigated the possibility of long term cognitive impairment but those that did suggested that this was not a substantial problem. In view of the limited reliable long term evidence it is understandable that there should be residual concern about the possible long term adverse effects of electroconvulsive therapy, and this should be reflected in the information given to patients.

The evidence for the National Institute of Clinical Evidence's appraisal of electroconvulsive therapy was primarily drawn from the two reviews commissioned by the Department of Health and a Cochrane review on electroconvulsive therapy in schizophrenia.[3] The National Institute for Clinical Excellence (NICE) has recommended that electroconvulsive therapy only be used to achieve rapid and short term improvement of severe symptoms, after an adequate trial of other treatments has proven ineffective or when the condition is considered to be potentially life threatening, in individuals with severe depressive disorders, catatonia, and a prolonged or severe manic episode.[4] The institute was appropriately influenced by the review of patients' experiences and the recommendations are clearly meant to restrict the use of the treatment. The Royal College of Psychiatrists appealed that the recommendations go beyond the evidence and will prevent patients who would benefit from the treatment from being able to receive it. The appeal was rejected because the recommendations were considered to be sound in the face of uncertainty about long term adverse effects and the findings of the review of patients' experience.[5] As with most policy statements, the recommendations may not be applicable to all individual cases, but clinicians would be well advised to ensure that the clinical circumstances of any deviation are clearly documented with excellent evidence of fully informed consent.

For too long electroconvulsive therapy has been a neglected service with widespread unexplained variations in practice and a low priority with managers: repeated audits by Royal College of Psychiatrists have shown that many hospital trusts fail to adhere to the college's standards.[6 7] The recommendations from NICE, together with the recently announced accreditation service[8] from the Royal College of Psychiatrists, should provide the stimulus to ensure that services are brought up to acceptable standards throughout the United Kingdom.

We predict that most parties will be reasonably satisfied with the NICE appraisal. Those concerned about potential overuse of the treatment can be reassured with the restrictions, increased safeguards, and improved consent procedures. Clinicians with the responsibility for helping the most severely ill patients will still have access to an effective treatment. So far, the process appears to have resulted in an approach that is both evidence based and broadly acceptable to most stakeholders. If this indeed is the result, it will be a substantial achievement in such a difficult area of clinical practice and a finely judged performance by NICE.

Stuart Carney *associate director*

Centre for Evidence Based Mental Health

John Geddes *professor of epidemiological psychiatry*

Department of Psychiatry University of Oxford, Warneford Hospital, Oxford OX3 7JX (john.geddes@psych.ox.ac.uk)

Competing interest: SC and JG are both psychiatrists who were involved in the UK Department of Health systematic review of randomised trials of electroconvulsive therapy.

1 The UK ECT Review Group. Electroconvulsive therapy: systematic review and meta-analysis of efficacy and safety in depressive disorders. *Lancet* 2003;361:799-808.
2 Rose D, Wykes T, Leese M, Bindman J, Fleischmann P. Patients' perspectives on electroconvulsive therapy: systematic review. *BMJ* 2003;326:1363-5.
3 Tharyan P, Adams CE. Electroconvulsive therapy for schizophrenia. Cochrane Schizophrenia Group. *Cochrane Database Syst Rev* 2003;(1): CD000076.
4 National Institute for Clinical Excellence. *Guidance on the use of electroconvulsive therapy*. London: NICE, 2003. www.nice.org.uk/pdf/59ectfullguidance.pdf (accessed 9 Jun 2003).
5 National Institute for Clinical Excellence. *Appraisal of electroconvulsive therapy. Decision of the appeal panel*. London: NICE, 2003. www.nice.org.uk/pdf/ECT_Final_panel_response.pdf (accessed 9 June 2003).
6 Glen T, Scott AI. Variation in rates of electroconvulsive therapy use among consultant teams in Edinburgh (1993-1996). *J Affect Disord* 2000;58:75-8.
7 Duffett R, Lelliott P. Auditing electroconvulsive therapy. The third cycle. *Br J Psychiatry* 1998;172:401-5.
8 Royal College of Psychiatrists. Press release: New accreditation service launched to raise standards for ECT. London: RCPsych, 2003. www.rcpsych.ac.uk/press/preleases/pr/pr_413.htm (accessed 9 June 2003).

Foundation trusts

Where next?

Much heat and light have been generated in the media recently as a result of the second reading in the House of Commons of the Health and Social Care Act 2003. The most controversial aspect of the bill was the proposal to allow NHS trusts to become NHS foundation trusts, with extra freedoms to run their affairs compared with other NHS trusts.[1] Three main freedoms have been granted. Firstly, foundations can borrow capital, sell assets, and importantly retain in-year surpluses. Secondly, direct control from the Department of Health will be relaxed and greater managerial freedoms granted—for example, to reward staff—and foundation trusts will be accountable to a new independent regulator. Thirdly, more freedoms will exist with respect to how foundation trusts are governed, although they will have

BMJ 2003;326:1344–5