The Regulation and Quality Improvement Authority

Report on the Administration of Electroconvulsive Therapy in Northern Ireland

November 2014

informing and improving health and social care
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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care services in Northern Ireland.

RQIA was established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to drive continuous improvements in the quality of services, through a programme of inspections and reviews.

The Mental Health and Learning Disability team undertakes a range of responsibilities for people with mental ill health and those with a learning disability under the Mental Health (Northern Ireland) Order 1986 as amended by the Health and Social Care Reform Act (Northern Ireland) 2009. This includes preventing ill treatment, remedying any deficiency in care or treatment or terminating improper detention in hospital or guardianship.

RQIA takes into consideration relevant standards and guidelines, the views of the public, health care experts and current research, in any review of services provided. We highlight areas of good practice and make recommendations for improvements and report on our findings on our website at www.rqia.org.uk.

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Glossary

Anterograde Amnesia	The loss or partial loss of the ability to create new memories after the event that caused the amnesia.
Bilateral ECT	The two electrodes are placed across the temporal region of the head, one on either side.
Consultant Psychiatrist	A medical practitioner appointed to consultant grade, who specialises in the diagnosis and treatment of mental disorders.
Depressive Disorders	A disorder characterised by an all-encompassing low mood accompanied by loss of interest in normally enjoyable activities, loss of weight and poor sleep and other symptoms.
Detained Patient	A detained patient is a person who has been admitted to hospital for assessment on grounds specified in the Mental Health (Northern Ireland) Order 1986, (a) he is suffering from mental disorder of a nature or degree which warrants his detention in a hospital; and (b) failure to detain him would create a substantial likelihood of serious harm to himself or to other persons. After the two week period of assessment he may be detained for a further period in hospital for treatment.
ECT	Electroconvulsive therapy (ECT) is a form of medical treatment for certain psychiatric disorders in which seizures are induced by passing electricity through the brain of an anesthetised patient (generally used as a treatment for severe depression).
Part II Medical Practitioner	Consultant Psychiatrist appointed by RQIA for the purposes of Part II of the Mental Health (NI) Order (MHO) 1986.

Part IV Medical Practitioner	Consultant Psychiatrist appointed by RQIA for the purposes of Part IV of the MHO.
Responsible Medical Officer	The Consultant Psychiatrist (usually a Part II Medical Practitioner) in charge of the patient's assessment or treatment.
Retrograde Amnesia	The loss or partial loss of memories that existed before the event that caused the amnesia.
Unilateral ECT	The two electrodes are placed on one side of the head only.
Voluntary Patient	A voluntary patient is a person who voluntarily remains in a mental health facility for treatment, care or observation and has the same rights as people receiving treatment for physical illness

Executive Summary

Electroconvulsive therapy (ECT) is considered an important and necessary form of treatment for some of the most severe psychiatric conditions and is, in many instances, a life-saving treatment, particularly for patients with severe depression.

This report provides information on the administration of Electroconvulsive Therapy by the five Health and Social Care Trusts (HSC) in Northern Ireland, in the period from 1 April 2010 to 31 March 2014.

The findings are based on information provided by the five HSC Trusts and data held by the RQIA Mental Health and Learning Disability Team in relation to requests for second opinions for ECT.
A total of 159 patients received ECT from 1 April 2013 to 31 March 2014. This compares with a figure of 156 during 2010/11, 128 in 2011/12 and 113 in 2012/13.
This is equivalent to a rate per 100,000 of the population of Northern Ireland of approximately 9 in 2010/11, 7 in 2011/12, 6 in 2012/13 and 9 in 2013/14.

Severe depression continues to be the diagnostic group which requires the majority of courses of ECT.

Overall 67% of patients receiving ECT were female and the age range for all patients varied from 22 to 95 years. A course of ECT ranged from 1 to 12 treatments. A small minority of patients had more than one course within the timescale of one year.

Treatment with ECT requires valid consent from the patient, where possible. Every effort is made to assist patients in this decision-making process. The percentage of patients receiving ECT on a voluntary basis and capable of giving valid consent, was 66%. Some patients commenced their course of ECT on a detained basis and completed it as a voluntary patient. The number of patients receiving ECT on an outpatient basis varied between trusts, and some patients who commenced ECT as an inpatient completed their course as an outpatient.

Two Adverse Incidents (AIs) in relation to the administration of ECT were reported to RQIA during the period of this review. The trust acted appropriately on the recommendations made for improvement.

The Royal College of Psychiatrists has promoted the ECT Accreditation Service, known as (ECTAS). Holywell Hospital (NHSCT) and Downe Hospital (SEHSCT) are accredited to ECTAS, which is voluntary, and subject to peer review.

In November and December 2013 RQIA inspected the ECT facilities in Northern Ireland that were not accredited to ECTAS. This report contains a

summary of the findings of these inspections.

The last report on the administration of ECT in Northern Ireland was completed in November 2013. RQIA has shared the findings with trusts. RQIA has also developed a template for the return of data from trusts on ECT administration to RQIA on a quarterly basis.

In addition, RQIA has revised their policy and procedures for the appointment of Part IV Medical Practitioners. The appointment and re-appointment of Part IV Medical Practitioners took place in 2014 and is on-going.

The Director of Mental Health and Learning Disability obtained permission from ECTAS in 2013 to use an adapted version of their Patient Experience Questionnaire in order to obtain the views of patients about their experience of ECT. It was agreed with trusts that patients, on completion of their treatment with ECT, would be given the patient questionnaire to complete. They were asked to return the questionnaire, if they wished, to RQIA. A trainee in Psychiatry, in conjunction with RQIA has collated the results and prepared a paper on the Patient Experience of ECT in Northern Ireland. It was found that the majority of patients who returned their questionnaire commented very positively on the quality of care that they received when undergoing electroconvulsive therapy. This included the process of giving consent and the way in which they were given information about the treatment.

RQIA would like to thank all staff involved in returning information on ECT and will continue to monitor and report on the administration of this treatment in 2014/15.

1.0 Introduction

Electroconvulsive therapy (ECT) is considered an important and necessary treatment for various serious psychiatric conditions, most commonly for severe depression.

This is the third report by the Mental Health and Learning Disability Directorate on the use of Electroconvulsive Therapy in Mental Health and Learning Disability hospitals in Northern Ireland.

Surveys in England have demonstrated a steady decline in the use of ECT since 1985[1]. The availability of a greater variety of safe alternative anti-depressants and other therapies are amongst the possible explanations for this downward trend.

There is robust scientific evidence that ECT is medically safe and effective. Many patients receiving ECT do so voluntarily and provide fully informed consent, based on an understanding of the treatment, the reasons why it is being offered and the possible risks and side effects.
In cases where this is not possible a second opinion of a Part IV medical practitioner is sought from RQIA. Part IV medical practitioners are Consultant Psychiatrists, appointed by RQIA, to give second opinions in relation to the administration of ECT.

This report provides an overview of the use of ECT from1 April 2010 to 31 March 2014 using data obtained by RQIA from the information made available by the five trusts.

The individual's right to privacy, dignity and autonomy, and the patient experience, is central to the work of the MHLD Directorate. Although patients were not interviewed as part of this review it was agreed that trusts would ask patients who had completed a course of ECT to complete a Patient Experience Questionnaire and return this to RQIA. ECTAS gave RQIA permission to use a slightly adapted version of their Patient Experience Questionnaire for this purpose.

1.1 Purpose of Review of ECT

A review of ECT has been undertaken by the Irish Mental Health Commission[2], by the Department of Health (London) and by the Mental Welfare Commission for Scotland[3]. This allows for some comparison of data in the administration of ECT across these jurisdictions.
It was agreed by RQIA that a baseline position on the administration of ECT in psychiatric facilities in Northern Ireland and annual returns would provide

[1] Trends in the Administration of ECT in England – Bickerton et al, The Psychiatrist, (2009) 33,61-63
[2] The Administration of Electroconvulsive Therapy in Approved Centres: Activity Report 2012
[3] Scottish ECT Accreditation Network Annual Report 2011

relevant information in respect of trends in the use of ECT and highlight any issues which require to be monitored in the future.

1.2 Information about the Administration of Electroconvulsive Therapy (ECT)

ECT is a medical procedure in which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalised seizure activity. The person receiving the treatment is placed under general anaesthetic and muscle relaxants are given to prevent muscle spasms. Repeated treatments induce several molecular and cellular changes in the brain that are believed to stimulate antidepressant mechanisms. Normally ECT is given twice a week up to a maximum of 12 treatments per course of ECT. The number of treatments administered within a course of ECT treatment varies depending on the clinical state of the patient.

ECT is usually provided to patients who have not responded to other treatments and for whom there are no other effective treatments. It is often considered as a life-saving treatment for those who are actively suicidal or refusing food and fluids or who are physically debilitated by depression. Guidelines produced by NICE[4],advise that ECT should be used when other treatments have failed, or in emergency situations.

Depressive disorders continue to be indicated as the diagnostic group who require the majority of ECT courses: treatment resistant mania and, in some circumstances, schizophrenia are occasional indications for treatment with ECT.

1.3 Issues Regarding Consent

When ECT is proposed as being the most appropriate treatment, patients, whether voluntary or detained, are asked to give their informed consent. In the case of a detained patient who is able to give valid consent to ECT, the Responsible Medical Officer (RMO) for the patient must validate this consent. A Form 22 must be signed indicating consent has been given and returned to RQIA. Patients, who either cannot give informed consent to ECT or who refuse ECT, are protected under the Mental Health Order (NI) 1986. Article 64 of the Order requires, in these situations, consent for ECT to be obtained or an independent second opinion to be sought from a Part IV Medical Practitioner.

[4] http://www.nice.org.uk/TA59

1.4 Procedure for Seeking a Part IV Medical Practitioner's Opinion for ECT

RQIA currently hold a list of 6 approved Part IV Medical Practitioners who are consultant psychiatrists with more than ten years' experience, who provide second opinions for ECT, arranged through RQIA.
The referring consultant contacts RQIA and requests a Part IV Medical Practitioner's opinion on their proposed treatment plan to administer ECT.

A Part IV Medical Practitioner who is available to take on the case is required to visit the patient and review the entire case history, interview the patient, discuss the treatment options with the referring consultant and provide an opinion on whether or not the treatment plan to administer ECT is appropriate. If the Part IV Medical Practitioner agrees with the treatment plan the decision is recorded on a Form 23. This form is subsequently returned to RQIA who records that the visit was made by a Part IV Medical Practitioner. If the Part IV Medical Practitioner disagrees with the plan to administer ECT he will discuss his reasons and other treatment options with the referring consultant. In this case the treatment plan to administer ECT will not proceed.

1.5 Timelines for Requesting a Part IV Medical Practitioner's Opinion

The timeline for the Part IV Medical Practitioner's opinion is determined by the referring consultant and relates to the urgency of the situation and the timing of the next ECT session. The time between referral and the Part IV Medical Practitioner seeing the patient is normally between one and seven days.

The referring consultant has the option of giving one emergency treatment before the Part IV Medical Practitioner's opinion takes place if treatment is deemed to be urgent, or if the Part IV Medical Practitioner is unable to see the patient before the next session of ECT.

1.6 Documentation Monitored by RQIA

RQIA checks each Form 23 containing details of the treatment plan to administer ECT, and ensures that the visit by the Part IV Medical Practitioner took place. The following information on Form 23 is checked for accuracy:

1) The name and professional address of the medical practitioner providing the Part IV opinion.
2) That he/ she is an RQIA appointed Part IV Medical Practitioner.
3) The name, professional address and status of persons consulted by the Part IV Medical Practitioner (these should be persons who are principally involved in the patient's care).
4) The Medical Practitioner has recorded that the patient is not capable of understanding the nature, purpose and likely effects of the treatment or that the patient has not consented to the treatment.
5) The proposed plan of treatment to administer ECT by the referring

consultant includes not more than twice weekly treatments and not more than a total number of 12 treatments.

6) The details of the treatment plan have been completed on the Form 23 and it has been signed and dated.

All of the Form 23s completed by Part IV Medical Practitioners between 1 April 2010 and 31 March 2014 were checked and found to be correctly completed, in line with the legislative requirements.

In the past there has not been any requirement to report to RQIA on the details of the outcome of treatment following the completion of a course of ECT.

A new template for the return of data on the administration of ECT by each trust on a quarterly basis, however, requires, from April 2013, that the outcome of ECT treatment for the patient is recorded in the form of the Clinical Global Impression Improvement Scale. This is a 7 point scale assessing how much the patient's illness has improved or worsened ranging from "very much improved to very much worse".[5]

1.7 ECT Accreditation Service

The voluntary ECT Accreditation Service (ECTAS)[6] is an initiative of the College Centre for Quality Improvement launched through the Royal College of Psychiatrists in 2003. The purpose of ECTAS is to assure and improve the quality of the administration of ECT. It engages staff in a comprehensive process of review, through which good practice and high quality care are recognised and services are supported to identify and address areas for improvement. Accreditation assures staff, service users, and referrers, commissioners and regulators of the quality of services being provided. Over 78% of ECT clinics in England and Wales participate in this accreditation programme and there are also members in Northern Ireland and the Republic of Ireland. It provides a peer review visit which will result in the Accreditation Committee awarding the following accreditation status – accredited as excellent, accredited, accreditation deferred, not accredited. Accreditation is valid for three years, subject to the satisfactory completion of an interim self-review.

In Northern Ireland ECT is available across all of the trusts. The facilities where it is administered are located in particular hospitals in each trust, as detailed in Table 1.

[5] Guy W. Clinical Global Impression (CGI) Scale. Modified from: Rush J.et al.: Psychiatric Measures, APA, Washington DC, 2000

[6] http://www.ectas.org.uk

Table 1

List of Hospitals in Northern Ireland and their accreditation status with ECTAS.

Trust	ECT Clinic	Status
Belfast Health and Social Care Trust	Mater Hospital, Belfast	Not a member
Northern Health and Social Care Trust	Causeway Hospital, Coleraine	Not a member
	Holywell Hospital, Co Antrim	Accredited to Feb 2014 – currently under review for re-accreditation
Southern Health and Social Care Trust	Craigavon Area Hospital, Craigavon	Not a member
South Eastern Health and Social Care Trust	Downe Hospital, Downpatrick	Accredited to Feb 2014 – currently under review for re-accreditation
Western Health and Social Care Trust	Tyrone County Hospital, Omagh	Not a member
	Altnagelvin Hospital, Londonderry	Not a member

1.8 Northern Ireland Regional Forum for ECT

A multidisciplinary Forum was established in Northern Ireland several years ago to improve the standard of administration of ECT. Representatives from all the trusts meet quarterly to discuss issues and agree standards which they base on those of ECTAS and the Scottish Electroconvulsive therapy Accreditation Network (SEAN)[7].

The Inspection of ECT suites by RQIA

The ECT suites that were not ECTAS accredited were selected for planned inspections in November/December 2013.
The standards chosen were selected from the ECTAS standards on the basis of patient safety and the quality of experience of ECT. The four RQIA inspectors met with key staff; the Lead Consultant Psychiatrist, the Lead Anaesthetist, Nursing Staff and others involved in the administration of ECT and examined a range of multi-disciplinary documentation, the clinical records of patients, the facilities and the equipment.

[7] Scottish Electroconvulsive Therapy (ECT) Accreditation Network (SEAN) Annual Report 2011

Results

One ECT suite was directed to cease administering ECT until appropriate governance arrangements were put in place to ensure patient safety and acceptable standards. These requirements were carried out satisfactorily and ECT administration resumed. In general, all the other suites were deemed to be very satisfactory and the inspectors were impressed by the enthusiasm of the staff and their level of expertise. The following is a summary of the results:

- ECT was administered by the Consultant Psychiatrist
- The anaesthetic was administered by a Consultant Anaesthetist
- The maintenance of equipment was excellent in all suites
- Policies and protocols were mainly satisfactory but had occasional errors
- Clinical preparation records had minor gaps and some lacked signatures
- The ECT Pathway had minor gaps in the documentation in some suites
- Clinical notes were occasionally incomplete and sometimes lacked signatures in some suites
- In some suites Incident records were incomplete (5 minor incidents reported to inspectors)
- Deficiencies were noted in some environments

In relation to Training in ECT, there was a general absence of Training Plans and no overview or dedicated budget for training for all staff involved with ECT.

Recommendations

The following were included in the recommendations that were made:

- Regular multi-disciplinary staff meetings for all involved in ECT
- Designated ECT staff to have dedicated time in their Job Plans/Timetable
- Integrated Training Plans for all staff
- A separate budget for ECT and Training
- All clinical records to be completed in full and clearly signed off with a legible signature and staff designation.
- ECTAS accreditation was encouraged

1.9 Data Limitations

RQIA accept the data returned by trusts. Any inconsistencies in the reporting of data by the trusts will affect the accuracy of the figures contained in this report.

The collation of the data is complicated by the fact that a patient could have had both detained and voluntary status during a course of ECT. For the purpose of this report, a patient who had both detained and voluntary status during a course of ECT was counted within the detained group only, to avoid them being counted twice.

The data returned for the years 2010-2011, 2011-2012, 2012-2013 was returned manually on a data sheet and concerned the number of patients receiving ECT.

1.10 Analysis of 2013/14 ECT Activity

The data for the year 1 April 2013 to 31 March 2014 was returned to RQIA via an online template developed by RQIA in conjunction with trust ECT leads. This recorded courses of ECT for patients for each quarter and included information on diagnosis, reason for the termination of treatment, and the outcome of ECT treatment using the Clinical Global Impression (CGI) scores. The Western Trust was not able to return data on the CGI because it was not included in their ECT pathway during this review period.

The following results present some comparative data in relation to the number of patients receiving ECT between 2010 and 2014 and additional data in respect of the number of courses of ECT received by patients during the period 1 April 2013- 31March 2014.

1.11 Requests for Part IV Medical Practitioner's Opinions for ECT (1 April 2010 to 31 March 2014)

RQIA analysed the requests for Part IV Medical Practitioners' opinions in relation to the administration of ECT from 1 April 2010 to 31 March 2014.

Table 2

Number of Requests to RQIA for Part IV Medical Practitioners' Opinions from 1 April 2010 – 31 March 2014

Trust	1 April 2010 – 31 March 2011	1 April 2011 – 31 March 2012	1 April 2012 – 31 March 2013	1 April 2013 – 31 March 2014
BHSCT	8	5	12	12
NHSCT	13	9	11	16
SHSCT	4	6	5	7
SEHSCT	11	8	10	8
WHSCT	8	8	7	12
TOTAL	**44**	**36**	**45**	**55**

This demonstrates a slight increase in the number of Part IV opinions during the period 1April 2013 to 31 March 2014.

Table 3

Number of Patients receiving ECT by Trust from 1 April 2010 – 31 March 2014

Trust	2010-2011	2011-2012	2012-2013	2013-2014
BHSCT	36	17	30	32
NHSCT	36	43	37	42
SHSCT	35	31	15	17
SEHSCT	14	13	13	42
WHSCT	35	24	18	26
TOTAL	**156**	**128**	**113**	**159**

These figures reveal an increase in the number of patients receiving ECT during 2013/14 compared with the previous two years.

1.12 ECT Administration to Voluntary and Detained Patients

The majority of patients receiving ECT are voluntary patients who have been assessed as being able to give their own valid consent to ECT. Table 3 details the number of voluntary and detained patients receiving ECT by Trust in the period 2010 – 2013. The overall percentage of patients receiving ECT during this period on a voluntary basis is 70%.

Table 4

Number of Voluntary and Detained Patients receiving ECT by Trust from 1 April 2010 - 31 March 2013

	2010/11			2011/12			2012/13		
Trust	**Voluntary**	**Detained**	**Total**	**Voluntary**	**Detained**	**Total**	**Voluntary**	**Detained**	**Total**
BHSCT	26	10	36	10	7	17	17	13	30
NHSCT	22	14	36	36	7	43	28	9	37
SHSCT	31	4	35	22	9	31	10	5	15
SEHSCT	7	7	14	3	10	13	7	6	13
WHSCT	27	8	35	19	5	24	13	5	18
TOTAL	**113**	**43**	**156**	**90**	**38**	**128**	**75**	**38**	**113**

Some detained patients received more than one second opinion. This can occur if their course of ECT is interrupted by a period of physical illness.

During the period 1 April 2013 – 31 March 2014 the percentage number of courses of ECT administered to voluntary patients was 66%.

Table 5

Number of Male and Female Patients Receiving ECT by Trust from 1 April 2010 – 31 March 2014

	2010-2011		2011-2012		2012-2013		2013-2014	
Trust	Male	Female	Male	Female	Male	Female	Male	Female
BHSCT	10	26	5	12	12	18	9	23
NHSCT	12	24	13	30	15	22	11	31
SHSCT	14	21	9	22	7	8	12	30
SEHSCT	4	10	6	7	7	6	6	11
WHSCT	7	28	8	16	6	12	8	18
TOTAL	**47**	**109**	**44**	**87**	**47**	**66**	**46**	**113**
	156		**128**		**113**		**159**	

Table 5 breaks down ECT administration by gender and demonstrates that 67% of patients receiving ECT are female and 33% are male during the period 2010- 2014.

Table 6

Number of patients treated as an outpatient with ECT, by Trust from 1 April 2010 - 31 March 2014

	2010/11	2011/12	2012/13	2013/14
Trust	Number	Number	Number	Number
BHSCT	10	1	1	0
NHSCT	11	28	16	23
SHSCT	10	11	2	9
SEHSCT	1	1	1	2
WHSCT	3	5	4	0
TOTAL	**35**	**46**	**24**	**34**

The practice of using ECT on an outpatient basis varied between Trusts. Some patients started their course of ECT as an inpatient and completed their treatment on an outpatient basis.

1.13 Mode of Administration of ECT by Trusts

It is accepted that ECT can cause temporary anterograde and retrograde amnesia which is monitored pre and post treatment within the care pathway. Whether ECT causes longer term memory problems is controversial. It is

often difficult to differentiate the memory difficulties due to ECT from the memory difficulties associated with the underlying psychiatric conditions of the patient.
Current research is clarifying the possibility and nature of more persistent memory loss[8]. Bilateral ECT seems to work more quickly and effectively but may cause more side effects. Unilateral ECT has fewer side effects, may not be as effective and is more difficult to administer properly.

The decision about whether treatment is administered using bilateral or unilateral electrode placement will depend on a number of factors, but is mostly dependent on the desire to lessen the cognitive side effects.

Table 7

Number of patients receiving unilateral ECT by Trust from 1 April 2010 to 31 March 2014

Trust	2010/11 Unilateral	2011/12 Unilateral	2012/13 Unilateral	2013/14 Unilateral
BHSCT	0	0	2	2
NHSCT	8	4	1	1
SHSCT	2	2	1	2
SEHSCT	1	0	1	0
WHSCT	5	3	0	5
TOTAL	**16**	**9**	**5**	**10**

Table 7 identifies the number of patients receiving unilateral ECT by trust and indicates that the vast majority of patients since 2010 received bilateral ECT. Patients may receive both unilateral and bilateral ECT during a course of ECT for clinical reasons.

ICD 10 Classification of Diagnosis for Patients receiving a Course of ECT from 1 April 2013 – 31 March 2014

The majority of patients had a diagnosis of severe depressive episode with or without psychotic symptoms (F32.3 and F32.2 respectively). The next commonest diagnosis was recurrent depressive episode with or without psychotic symptoms (F33.3 and F33.2 respectively) and depressive episode unspecified (F32.9).

[8] How Specialist ECT Consultants inform patients about memory loss", Hanna et al, The Psychiatrist 2009, 33,412-415

Table 8

ICD 10- Category for each Course of ECT by Trust 1 April 2013 – 31 March 2014

Trust	F20	F25	F31	F32	F33	F41	F43	F53	F60	Total
BHSCT	0	2	3	15	18	0	0	0	0	38
NHSCT	0	1	2	30	12	2	0	0	0	47
SHSCT	0	1	4	36	1	0	1	1	3	47
SEHSCT	0	2	0	7	9	0	0	0	0	18
WHSCT	4	4	1	17	5	0	0	0	1	32
TOTAL	**4**	**10**	**10**	**105**	**45**	**2**	**1**	**2**	**4**	**182**

F20 Schizophrenia
F25 Schizoaffective Disorder
F31 Bipolar Affective Disorder
F32 Depressive Episode
F33 Recurrent Depressive Disorder
F41 Other anxiety disorders
F43 Reaction to severe stress, adjustment disorders
F53 Mental and behavioural disorders associated with the puerperium
F60 Specific personality disorders

Emergency ECT 1 April – 31 March 2014

The Consultant Psychiatrist has the option to give one Emergency ECT to a patient prior to the Part IV Medical Practitioner's opinion. This option is used when a patient needs treatment very urgently or where there is an unavoidable delay in providing the second opinion. An Emergency ECT was given on 3 occasions within this period.

Number of Courses of ECT per Patient from 1April 2013 – 31 March 2014

During this period 16 patients had 2 courses of ECT, 2 patients had 3 courses and 1 patient had 4 courses.

Reasons for the Administration of a Course of ECT from 1 April 2013 – 31 March 2014.

The commonest indication for the administration of ECT was reported as the severity of the mental state of the patient (57%), followed by refractoriness to medication (34%), inadequate eating/drinking (8%) and other reasons not specified (1%).

Reasons for Termination of a Course of ECT from 1 April 2013 – 31 March 2014

The reasons for terminating a course of ECT have also been collated. Improvement in the mental state was cited as the reason for terminating the course in 82%, no improvement in 9%, the patient's withdrawal of consent in 4%, side-effects in 3% and Complications in 2%.

Outcome of ECT Treatment following a Course of ECT 1 April 2013 -31 March 2014

The outcome of ECT treatment was documented according to a 5-point scale ranging from "complete recovery" to "deterioration" immediately following the termination of the course. The outcome was not recorded for 1 course. The figures reveal that 93% of those patients who were rated on the scale showed improvement following their course of ECT.

Table 9

Outcome of Treatment immediately following a Course of ECT 1 April 2013 – 31 March 2014

Trust	Complete recovery	Significant improvement	Some improvement	No change	Deterioration
BHSCT	5	25	8	0	0
NHSCT	6	23	14	4	0
SHSCT	1	26	14	5	0
SEHSCT	0	6	10	2	0
WHSCT	0	26	4	2	0
Total	12	106	50	13	0
%	**7%**	**58%**	**28%**	**7%**	**0**

Clinical Global Impression Scores

The Clinical Global Impression scale was carried out by the Consultant responsible for the patient's treatment at follow-up. The CGI scores reveal that about two thirds (68%) of the courses of ECT result in "very much improvement" and "much improvement" in the mental state of the patient which is very encouraging. A further 25% of courses show minimal improvement and 7% are deemed to have not shown any change. No patient's mental state was reported to have been made worse. The CGI was not recorded for 1 course and was not recorded by the Western Trust.

Table 10

CGI Scores by Episode by Trust 1 April 2013 – 31 March 2014

Trust	Very Much Improved	Much Improved	Minimally improved	No Change	Minimally Worse	Much Worse	Very Much worse
BHSCT	10	23	5	0	0	0	0
NHSCT	12	19	13	3	0	0	0
SHSCT	9	18	14	5	0	0	0
SEHSCT	0	10	6	2	0	0	0
WHSCT	0	0	0	0	0	0	0
TOTAL	**31**	**70**	**38**	**10**	**0**	**0**	**0**
%	**21%**	**47%**	**25%**	**7%**	**0%**	**0%**	**0%**

1.14 Use of ECT Care Pathway by Trust

A care pathway for ECT is used for the majority of patients. The layout of the care pathway appears to vary between Trusts.

1.15 Rate of Administration of ECT per 100,000 of the Catchment Population

The approximate rate of administration of ECT by trust has been calculated and presented below in Table 11 as the number of patients receiving ECT per 100,000 of the catchment population of each Trust using estimated mid-year population figures from Northern Ireland Research and Statics Agency's (NISRA)[9] most recent report.

Table 11

Summary of rate of ECT per 100,000 of catchment population by Trust from 1 April 2010 to 31 March 2013

Trust	2010/11	2011/12	2012/13	2013/14
BHSCT	10	5	9	9
NHSCT	8	9	8	9
SHSCT	10	9	4	5
SEHSCT	4	4	4	12
WHSCT	12	8	6	9
TOTAL	8.64	7.05	6.19	8.68

Table 11 demonstrates a variation in the rate of the administration of ECT across the five trusts. A number of reasons may account for this variation. It should also be borne in mind when considering the disparity in these rates of

[9] www.nisra.gov.uk/demography

administration of ECT that under-use of ECT is as undesirable as over-use. In respect of some patients with severe depression, treatment with ECT can bring about improvement in their mental state within a month of starting their course of ECT whereas drug therapy may require a high dosage or a combination of drugs given over several months to effect improvement.

These factors may be extremely important in the management of an individual patient's illness when weighing up the risks and benefits of different treatments.

1.16 Comparisons with Other Jurisdictions

In 2012 the Irish Mental Health Commission[10] reported that 244 residents received ECT in the Republic of Ireland which represents a rate of 5.3 people per 100,000 total population and 6.8 courses of ECT per 100,000 of the total population.

Republic of Ireland	England & Wales	Scotland	N. Ireland
5.3	3	6.8	8.7

In 2012 ECTAS[11] undertook a national survey of the number of people receiving ECT in clinics in England and Wales. From data provided by 75% of the clinics, it is calculated that 1729 people received ECT: a rate of 3 people per 100,000 of the population of England and Wales.

In Scotland the Scottish ECT Accreditation Network[12] reported that 362 patients received ECT in 2012 which equates to 6.81 per 100,000 population. (434 courses = 8.16 per 100,000 total population) based on mid 2012 population estimates.

RQIA found it difficult to find accurate comparisons across the jurisdictions as the rates of ECT administration are not published on an annual basis.

2.0 Adverse Incidents (AIs)

ECT teams are advised by their trusts to have a meeting to discuss any incidents involving ECT, examine if it was preventable and identify actions required to minimise the risk of it occurring again. There were two Adverse Incidents reported to RQIA involving the administration of ECT between 1 April 2011 and July 2012. The trust had followed up appropriately on the recommendations and made the necessary improvements to their service.

[10] http://www.mhcirl.ie/File/The-Administration-of-ECT-in-Approved-Centres-Activity-Report-2012.pdf
[11] http://www.rcpsych.ac.uk/pdf/ECTAS%20Minimum%20Dataset%20Report%202012-13.pdf
[12] http://www.sean.org.uk/AuditReport/SEAN-Report-2013-web.pdf

3.0 Conclusions

This review by the MHLD Team provides information on ECT administration across Northern Ireland for the period 1 April 2010 to 31 March 2014.

More women than men received ECT (67% vs.33%) and the majority of patients were able to give valid consent to ECT.

The majority of ECT involved the bilateral placement of electrodes.

The Clinical Global Impression Improvement Score which is a measure of the outcome of ECT treatment for the patient is reported for the year 2013/14 and reveals that the majority of patients receiving ECT have a good outcome. Analysis of the Patient Experience Questionnaires returned to RQIA have shown that patients believe that the quality of care that they received was very satisfactory.

4.0 Next Steps

The MHLD Team will:

- Share this ECT report with trusts to inform them about current trends.
- Request that each Consultant responsible for ECT develops a system within their facility whereby they themselves are able to gather and return in full their own quarterly data on ECT to RQIA within the time-scales that are set out by RQIA each year.
- Seek a copy of the ECTAS audit reports for ECT suites which have ECTAS accreditation
- Inspect ECT suites which do not have ECTAS accreditation again over the next two years, based on the themes of quality and safety.
- Encourage the ECT suites not accredited by ECTAS to seek accreditation.
- Provide information to the HSC Board from the returns of trusts regarding the administration of ECT in order to monitor trend data and any emerging issues, themes or concerns.
- Continue to review the number of Part IV Medical Practitioners available to provide second opinions and encourage Consultants with more than 10 year's experience as a consultant psychiatrist to apply for Part IV status.

- Request that Patient Experience Questionnaires are given out to all patients receiving ECT so that RQIA can continue to monitor and review the quality of the patient experience.

- Submit a journal article for publication about the patient experience of ECT based on questionnaires that were by received by RQIA between 1 July 2013 and 30 June 2014.

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Date: 20 November 2014

Mr. Patrick Convery
Head of Programme Mental Health and Learning Disability

Date: 20 November 2014