The use of ECT and Seclusion declines for the fifth year in a row, according to the Mental Health Commission

Physical restraint remains relatively static, with a small decrease in 2012

Wednesday 12th March 2014. The use of ECT and Seclusion in the country’s inpatient mental health services has declined for the fifth consecutive year, according to the Mental Health Commission which published 2012 data on ECT and Seclusion today. The administering of ECT to patients who are unable or unwilling to give consent to treatment also declined for the fifth year in a row. Physical restraint remains relatively static with a decrease of nine episodes in 2012 when compared with cases reported in 2011.

Commenting on the newly published data Mr John Saunders, Chairman of the Mental Health Commission said, “The year on year decline in the use of ECT and seclusion, as well as the small decline in the use of restraint is very much welcomed and is a testament to the hard work undertaken by mental health practitioners and their commitment to building and delivering a truly modern mental health service for the Irish public.”

“However, further progress can still be made, for example while the number of those who do not consent to ECT treatment is in decline it is still the Commission’s view that it should not be possible to administer ECT to a patient who is unwilling to receive it. Furthermore while progress has been made on seclusion and restraint we would like to see that number reduced further. These are emergency measures and should only be used in exceptional circumstances and only when in the best interests of the patient.”

“The Commission will continue to advocate for minimising the use of restrictive intervention and for the elimination of ECT provision to those who are unwilling to receive it.”

ECT

There were 311 programmes (2,152 single treatments) of ECT administered to 244 patients during 2012. This represents a decrease of 6.3% on the number of programmes of ECT that were reported in 2011 (332). A programme of ECT refers to no more than 12 treatments prescribed by a consultant psychiatrist.

The majority of ECT was administered to patients with their consent. 27 patients were administered ECT without their consent, 4 of whom were considered to be unwilling to consent.

Patients receiving ECT ranged in age from 24 years to 92 years of age and more women (62.7%) than men (37.3%) were administered ECT. The treatment was mainly administered to individuals with depressive disorders (83.1% of programmes).
Some level of improvement was reported, by the treating consultant psychiatrist, for 92.6% of programmes of ECT, with 38.7% of programmes having an outcome of complete recovery, 36.5% showing significant improvement and 17.4% showing some or moderate improvement. No change or deterioration was recorded for 7.4% of programmes of ECT.

In 2012, 19 approved centres administered ECT and a further five referred one or more patients to another approved centre for ECT treatment.

**Seclusion & Restraint (mechanical & physical)**

There were 4,466 episodes of restrictive practice in 2012, 6.1% less than the number reported in 2011 (4,755). Physical restraint accounted for 68.6% (3,063) of interventions, seclusion accounted for 31.4% (1,403) and there were zero episodes of mechanical means of bodily restraint recorded in 2012.

As in previous years, the use of seclusion and physical restraint varied widely between approved centres. This is in line with findings from other countries and factors such as admission practices, ward design and staffing can all contribute to variation in use of seclusion and restraint.

**Seclusion**

Twenty-nine approved centres recorded 1,403 episodes of seclusion in 2012.

The use of seclusion decreased for the fifth year in a row, with 16.6% fewer episodes reported in 2012 in comparison to 2011. The majority (68.2%) of seclusion lasted less than eight hours and almost 70% of seclusion occurred between the hours of 8am and 8pm. A small number of seclusion episodes exceeded 72 hours.

The 1,403 episodes of seclusion involved 505 individual patients, with a higher percentage of males (65.3%) than females (34.7%). Over half (55.6%) of those placed in seclusion were between the ages of 18 and 39 years of age. Ten children were secluded in 2012.

St Joseph’s Intellectual Disability Service recorded the highest number of episodes of seclusion (231) in 2012, involving 15 individual patients. This was followed by the National Forensic Service – Central Mental Hospital – which had 133 episodes of seclusion involving 37 individuals. Both approved centres reported notable decreases in the use of seclusion for the year with St Joseph’s Intellectual Disability Service reporting a 37.4% decrease and the Central Mental Hospital reporting a 24% reduction.

**Restraint**

There were a total of 3,063 episodes of physical restraint reported by 52 approved centres in 2012. This represents a decrease of nine episodes on the number reported in 2011. A total of 993 individuals were physically restrained during the year with a higher proportion of males (56.3%) than females (43.7%). Almost half of those restrained were between 18 and 39 years of age. Forty-two children were physically restrained in 2012.
Almost three-quarters (74.1%) of physical restraint episodes lasted for five minutes or less, 18.9% of which lasted for one minute or less.

St Vincent’s Hospital in Fairview, reported the highest number of episodes of physical restraint, having 315 episodes involving 56 patients. St Joseph’s Intellectual Disability Services reported the second highest use of 244 episodes involving 17 individuals.

ENDS
Issued by Murray Consultants on behalf of The Mental Health Commission

For further information contact:
Murray Consultants 01 4980300
Aoibheann O’Sullivan 087 6291453
Mark Brennock 087 2335923

NOTES TO EDITOR

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

The Commission has produced Rules Governing the Use of Electro-convulsive Therapy (ECT) and a Code of Practice on the Use of Electro-convulsive Therapy (ECT) for Voluntary Patients, which regulate the administration of ECT in approved centres. In addition the Commission has produced Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint and a Code of Practice on the Use of Physical Restraint in Approved Centres, which regulate the use of seclusion and restraint in approved centres.

An Approved Centre: An “approved centre” is a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder that is registered pursuant to the Mental Health Act 2001. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the 2001 Act.

ECT: Electro-convulsive Therapy (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 treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses.

A programme of ECT refers to no more than 12 treatments prescribed by a consultant psychiatrist.

Mechanical restraint is defined in the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (MHC, 2009) as “the use of devices or bodily garments for the purposes of preventing or
limiting the free movement of a patient’s body”. Version 2 of the Rules specifies that “The use of cot sides or bed rails to prevent a patient from falling or slipping from his or her bed does not constitute mechanical means of bodily restraint under these rules.”

**Physical restraint** is defined in the *Code of Practice on the Use of Physical Restraint in Approved Centres* (MHC, 2009) as “the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident’s body when he or she poses an immediate threat of serious harm to self or others.”

**Restrictive interventions/restrictive practices** for the purposes of this report include the use of mechanical restraint, physical restraint and seclusion.

**Seclusion** is defined in the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (MHC, 2009) as “the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving.”