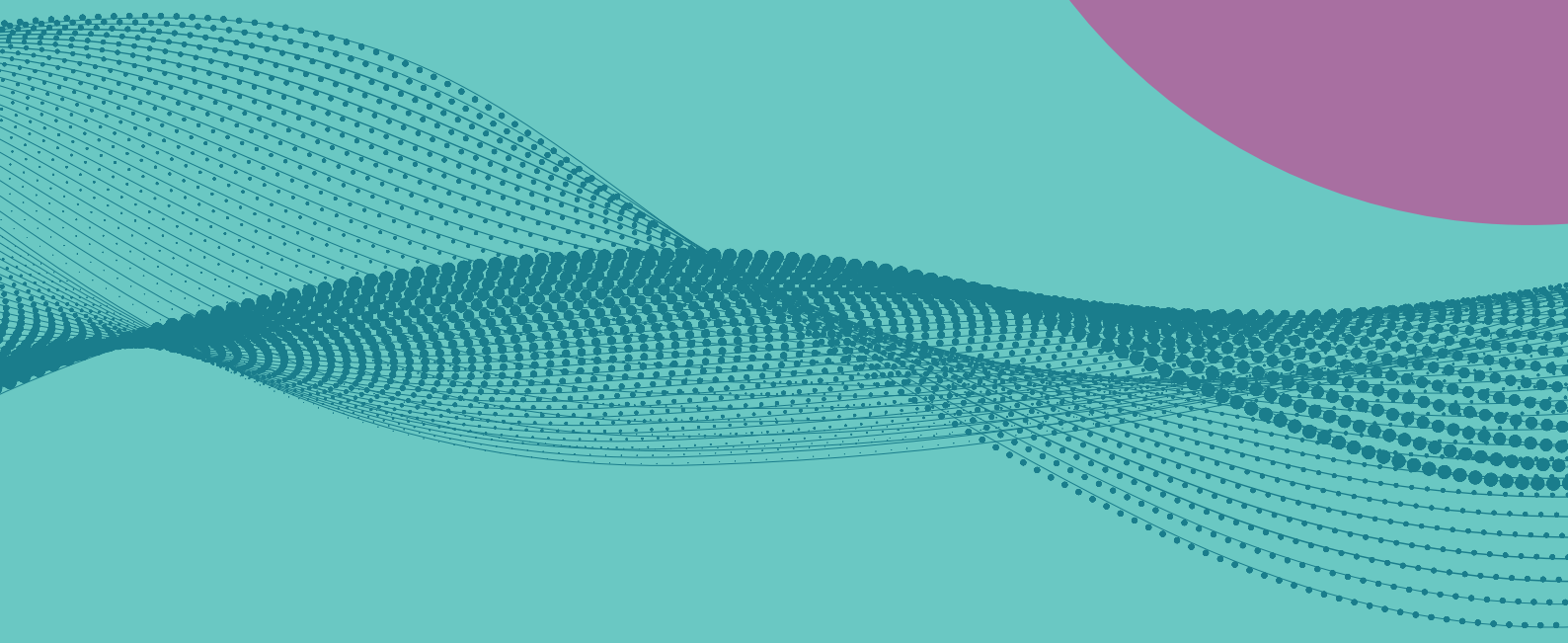
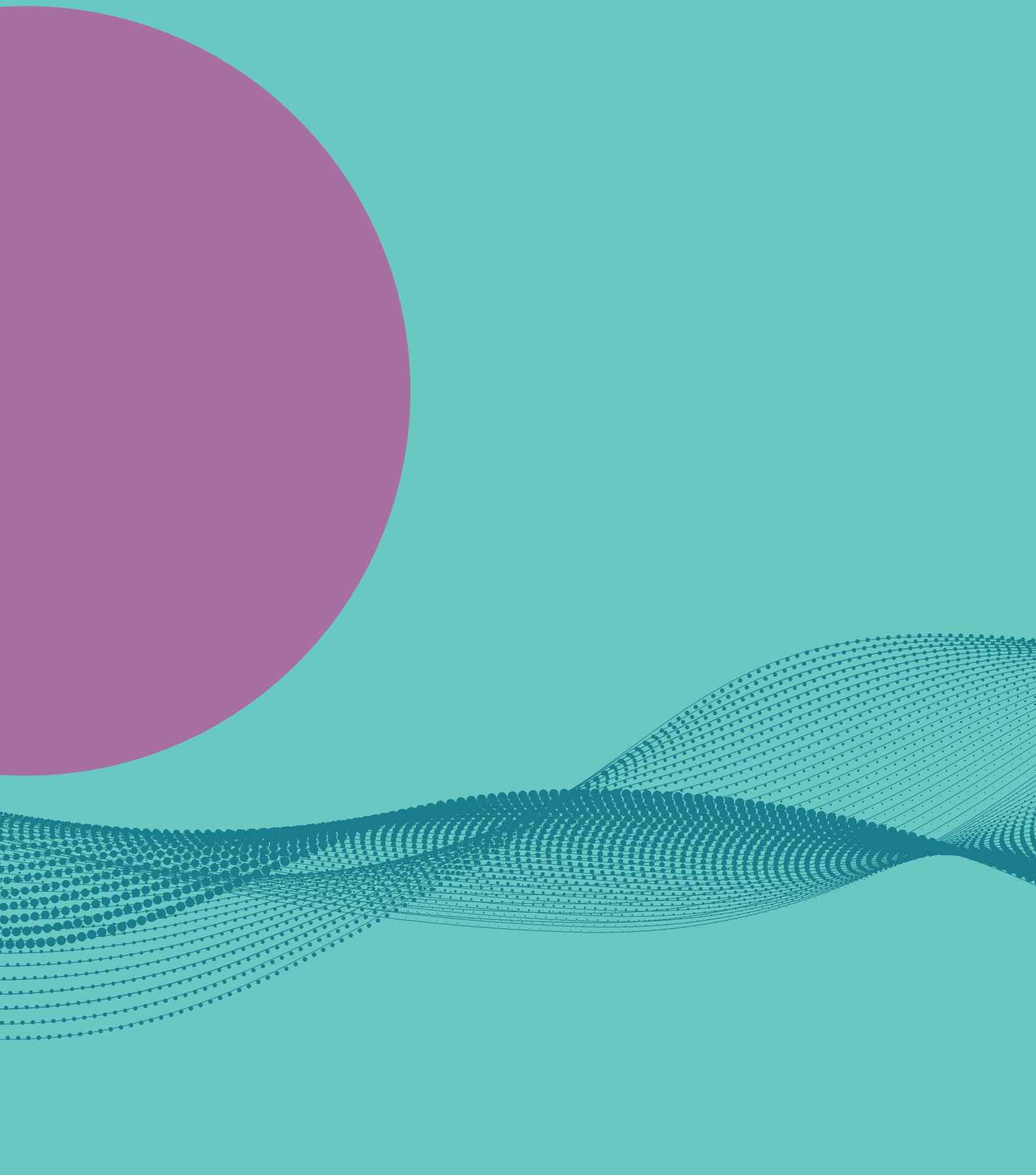
MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

THE ADMINISTRATION OF ELECTRO-CONVULSIVE THERAPY IN APPROVED CENTRES

DECEMBER 2020



ACTIVITIES REPORT 2019



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GLOSSARY

Approved centre is a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder, which is registered pursuant to the 2001 Act (as amended). The Mental Health Commission establishes and maintains the Register of Approved Centres pursuant to the 2001 Act (as amended).

Community Healthcare Organisations (CHOs) were established by the Health Services Executive in 2015 to deliver health services at a local level across both the statutory and voluntary sectors in the community setting, in partnership with the National Primary Care, Social Care, Mental Health and Health and Wellbeing Divisions. A list of approved centres by each of the nine CHOs is available in Table 7.

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.

Involuntary patient is a person to whom an admission or renewal order relates. The term patient is to be construed in accordance with Section 14 of the 2001 Act.

Maintenance ECT (also referred to as continuation ECT) is defined as ECT usually delivered at intervals of between one week and three months, that is designed to prevent relapse of illness. The purpose of maintenance ECT is to give the treatments as infrequently as possible, whilst preventing a relapse of symptoms (ECT Accreditation Service, 2017).

Mental illness means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person, to the extent that he or she requires care or medical treatment.

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

Resident means a person receiving care and treatment in an approved centre. For the purpose of this report, the term resident includes involuntary patients, voluntary patients and individuals who were administered ECT on an out-patient or day-patient basis in an approved centre.

Voluntary patient is a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order.

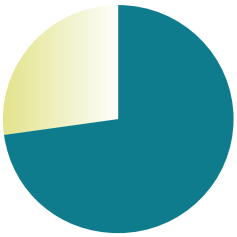
SUMMARY

All figures included in this summary are calculated across 2018 and 2019, unless otherwise indicated.

Programmes and treatments of ECT

Approved centres reported that **395 programmes of ECT** were administered to **286 residents** in 2019, as compared with **365 programmes** of ECT which were administered to **283 residents in 2018**.

The rate of ECT programmes per resident was **1.4 programmes per resident in 2019**, and **1.3 programmes per resident in 2018**.



In 2019, **73%** of residents who received ECT were administered one programme of ECT; this was a slight decrease from **74%** in 2018.

There was a total of

3,124

individual treatments of ECT administered in 2019, and

2,936

in 2018.

A programme of ECT may involve **up to 12 individual treatments of ECT**.

The average number of treatments per programme was **7.9 in 2019,** as compared with **8 in 2018**.

Services providing ECT

17 approved centres (26%) provided an ECT service in 2019, an increase from **15 approved centres** (23%) in 2018.

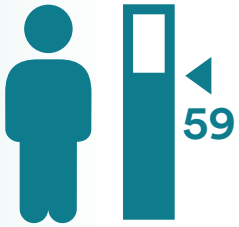
A further **twelve approved centres (18.5%)** referred residents to another approved centre for ECT treatment in 2019, as compared with **15 approved centres referring residents** to another approved centre (26.1%) for treatment in 2018.

In 2019, 61.1% of relevant services (those administering ECT to involuntary patients) were compliant with all aspects of the Rules Governing the Use of ECT; this was an increase from 58.3% compliance of relevant services in 2018.

People receiving ECT

In both 2018 and 2019, the **average age** of all residents who were administered ECT was **59 years of age**.

In 2019, residents receiving ECT ranged in age from **22 to 89 years of age**; in 2018, the age range was from **20 to 91 years of age**.



In **both 2018** and **2019**, **more females than males** received ECT, at a ratio of approximately two-thirds to one-third. In the case of both years, the **higher ratio of female to male** ECT recipients may be reflective of the **relatively higher incidence of depressive illness in women as compared with men**.

The **majority of programme**s of ECT were administered to residents who were admitted on a **voluntary basis** when they commenced their programme of ECT, accounting for **82% of programmes in 2019, and 78% in 2018**

ECT treatment without consent

16% of programmes of ECT (62) in 2019, and 19% (69) in 2018, involved one or more treatments without consent.

In 2019, **84% of ECT treatments** (2,621) were administered **with consent,** and **16%** (516) were administered **without consent**. In 2018, 82% of treatments (2,420) were administered with consent, and **18%** of treatments (516) were administered without.

3% of residents (13) **withdrew consent** during the course of their programme of ECT in 2019, **equal to 2018**, which saw **12 residents (3%) withdrawing consent** during the course of their programme.

Reasons for and outcomes of ECT

Depressive disorders[1] were reported as a diagnosis for **77% of residents** who were administered ECT in 2019, accounting for **63%** in 2018.

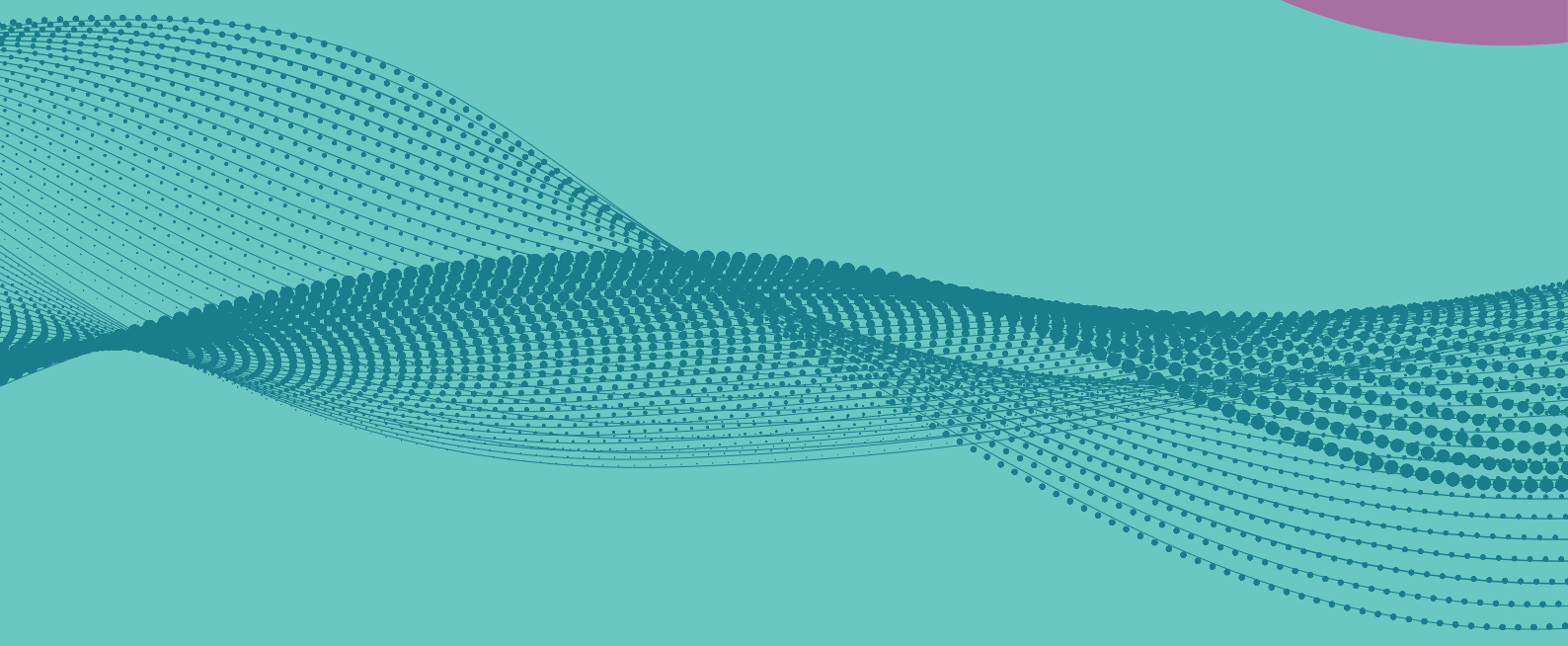
Refractory (resistance) to medication was the most common single indication for ECT, accounting for 66% of programmes (259) in 2019, and 67% (244) in 2018.

Improvement was reported as the outcome in **76% of programmes of ECT** (299) in 2019, and **81%** in 2018 (294).

[1] Depressive disorders are mental illnesses characterised by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.

1

INTRODUCTION



INTRODUCTION

The Mental Health Commission (the 'Commission') is the regulator for mental health services in Ireland. The Commission is an independent statutory body established in 2002. The Commission's main functions are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of persons admitted and detained under the Mental Health Act 2001 (the '2001 Act').

One of the core elements of the Commission's mission is to regulate and engage to promote, support and uphold the rights, health and well-being of all people who access mental health services. The use of electro-convulsive therapy (ECT) in Ireland is regulated by the 2001 Act. This report provides information on how often ECT is used, the people who receive it, the services providing it, and the quality and safety of the service.

This is the Commission's tenth annual activity report on the use of ECT in approved centres. *The Administration of Electro-convulsive Therapy in Approved Centres: Activity Report 2019* reports on 2019 data and includes previously published 2017 and 2018 data (Mental Health Commission, 2019). Data for previous years (2008 to 2018) are available at www.mhcirl.ie/publications.

Data in this report relate to the administration of ECT following the implementation of the Mental Health (Amendment) Act 2015, which came into effect on the 15th February 2016. Following implementation of the Mental Health (Amendment) Act 2015, ECT may only be administered to an involuntary patient without consent where it has been determined that the patient is unable to consent to the treatment.

The Commission issued revised (Version 3) *Rules Governing the Use of Electro-Convulsive Therapy* (Mental Health Commission, 2016b) and *Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients* (Mental Health Commission, 2016c) in February 2016 to reflect the legislative change and also to align with current best international practice.

This report describes the administration of ECT in 2019, nationally, by sector (by Community Healthcare Organisations (CHOs) and independent service providers) and by individual service.

The Commission would like to thank staff in approved centres for their ongoing co-operation in relation to the collation and return of ECT data which has enabled this report to be completed. For the majority of services using ECT, the collation of this data is a manual process and the Commission appreciates the local commitment required to report this data on an annual basis.

The Commission is in the process of rolling out its Comprehensive Information System (CIS) ECT function, which was initially piloted with two services, St Patrick's University Hospital and Acute Psychiatric Unit, Tallaght University Hospital. The implementation of the CIS ECT function alters the obligation on approved centres from providing an annual data return of all programmes of ECT, to a data entry contemporaneous with each ECT treatment.

For future ECT Activity Reports, annual data returns will no longer be required from approved centres.

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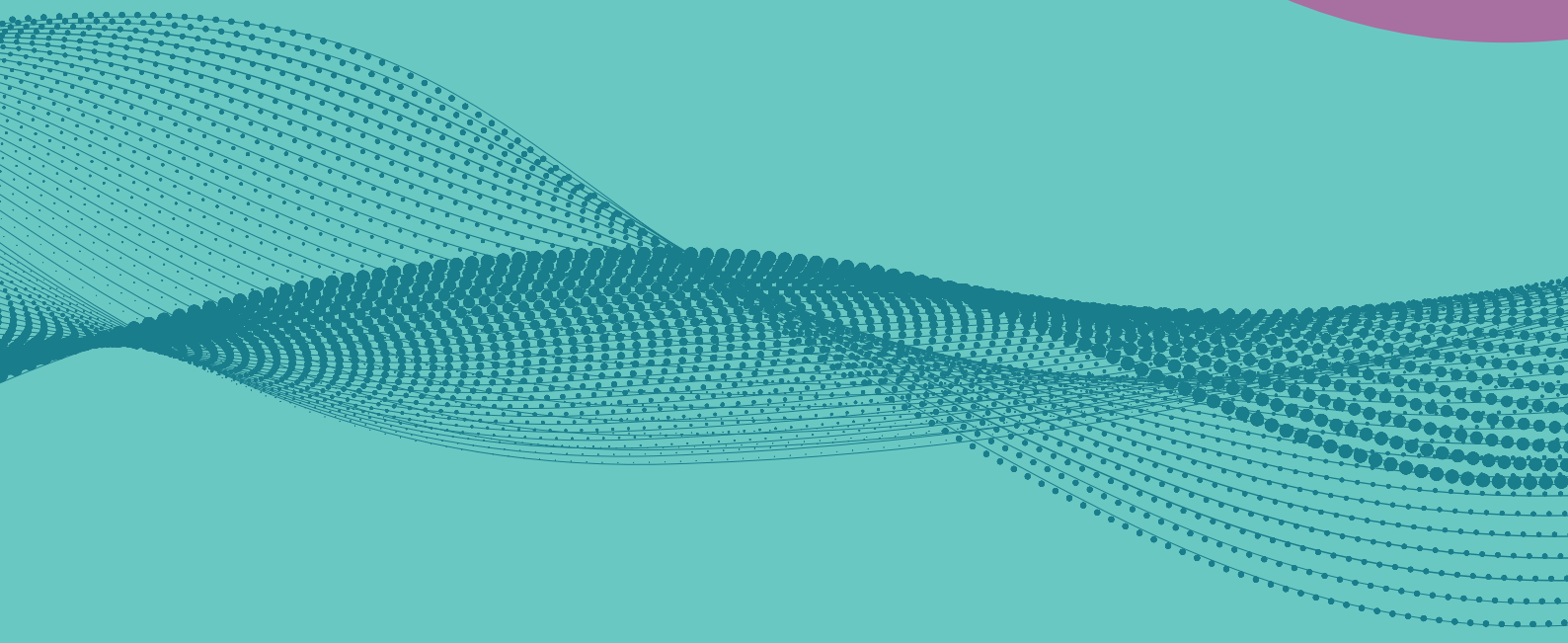
ABOUT THE DATA



2. ABOUT THE DATA

2.1 Data coverage

Data are presented for all approved centres that were entered on the Register of Approved Centres during 2017, 2018 and 2019. Table 1 reflects the number of approved centres on the Register at any time during the reporting year, including new registrations and closures.

Table 1: *Number of approved centres, 2017-2019*

	2017	2018	2019
Approved centres	64	65	**65**
Approved Centres using ECT	16	15	**17**
Approved centres referring residents for ECT	8	15	**12**

2.2 Data collection

The *Rules and Code of Practice Governing the Use of Electro-convulsive Therapy* require that the ECT Register must be completed for the resident on conclusion of a programme of ECT and a copy filed in the resident's clinical file. As a programme of ECT may have been commenced in one year and completed in another, each programme is counted in the year in which it was concluded, as this is when the ECT Register is completed in full.[2]

Data on administration of ECT were reported to the Mental Health Commission from approved centres via a form (*Form 16: Treatment without Consent Electro-convulsive Therapy Involuntary Patient (Adult)* and an annual data collection template, specified by the Commission (see *Appendix 1*).

A draft annual report, for each approved centre, based on information returned by approved centres, was sent to Clinical Directors in approved centres for verification before publication.

2.3 Data limitations

Data limitations as outlined below should be considered:

- Approved centres varied in relation to the number of beds and the type of service provided. Comparisons between programmes of ECT in individual approved centres, and in previous years, should be interpreted with caution. (For information regarding individual services, see Table 7, and the approved centre inspection reports, which can be accessed on our website.
- A high proportion of ECT was administered in approved centres operated by independent service providers, which provide a national service. Residents' home addresses were not collected; therefore, it was not possible to re-distribute data relating to those who received ECT treatment in independent approved centres to their own HSE CHO area. For these reasons, the rates of ECT administration per CHO were not included in the current report.
- Data on the administration of ECT were processed manually, initially by the relevant approved centres and subsequently by the Commission, which limited what could reasonably be requested from services and reported on. Due to the additional information reported on in the CIS ECT function, including the laterality of treatment, and the type of anaesthesia used, the ECT Activity Report 2020 will likely contain more detailed analysis of ECT programmes and treatments. This will result in a greater degree of granularity for future annual activity reports.
- Results may be skewed by a small number of residents with relatively high numbers of treatments and/or programmes.
- In the absence of a national individual health identifier, it is possible that residents may be counted more than once, if they were resident in more than one approved centre, such as within their CHO and laterally or subsequently in an independent service, within the same year. The exception to this is where residents have been referred from one approved centre to another for ECT, which is recorded and accounted for.

[2] A period of time may elapse between the date of last treatment and the date when the Register is completed in full, and in some cases these dates fall into different years. For example, the date of last treatment may have been in December 2016 but the information regarding reason for ending a programme of ECT and the outcome for that programme may not have been completed until January 2018. Some approved centres have indicated that they report such programmes of ECT in the year in which the Register was completed in full rather than the date of last treatment.

2.4 Admissions to approved centres

Information regarding admissions activity to approved centres nationally is included here to provide context in relation to the administration of ECT in approved centres. Table 2 shows that there were **16,710 admissions nationally** in 2019 and 17,000 in 2018. Data on involuntary admissions[3] (including admissions from the community and re-grades of patients from voluntary to involuntary) shows that **involuntary admissions** accounted for **14.3%** of admissions in both 2018 and 2019.

Table 2: *Total admissions and involuntary admissions, 2017-2019*

	2017	2018	2019
Total admissions[4]	16,743	17,000	16,710
Involuntary[5] admissions	2,337	2,435	2,390

The Health Research Board reported that in 2019, **depressive disorders** were the most common diagnoses recorded, accounting for **24.5%** of all admissions to in-patient mental health services. **Schizophrenia**, **schizotypal and delusional disorders** accounted for **21%** of all admissions. The Health Research Board reported that in 2018, depressive disorders were once against the most common diagnosis recorded, accounting for 24.3% of admissions, and with schizophrenia, schizotypal, and delusional disorders again accounting for 20.4%.

Approximately equal proportions of male and female service users were admitted in both 2018 and 2019 with 49.1% female admissions in 2019, and 49.9% female admissions in 2018. Females had a slightly higher rate of admission for depressive disorders than males, with women accounting for 55.6% in 2019, and 55.5% in 2018, of admissions with a primary diagnosis of depressive disorders (Daly and Craig, 2019 and 2020).

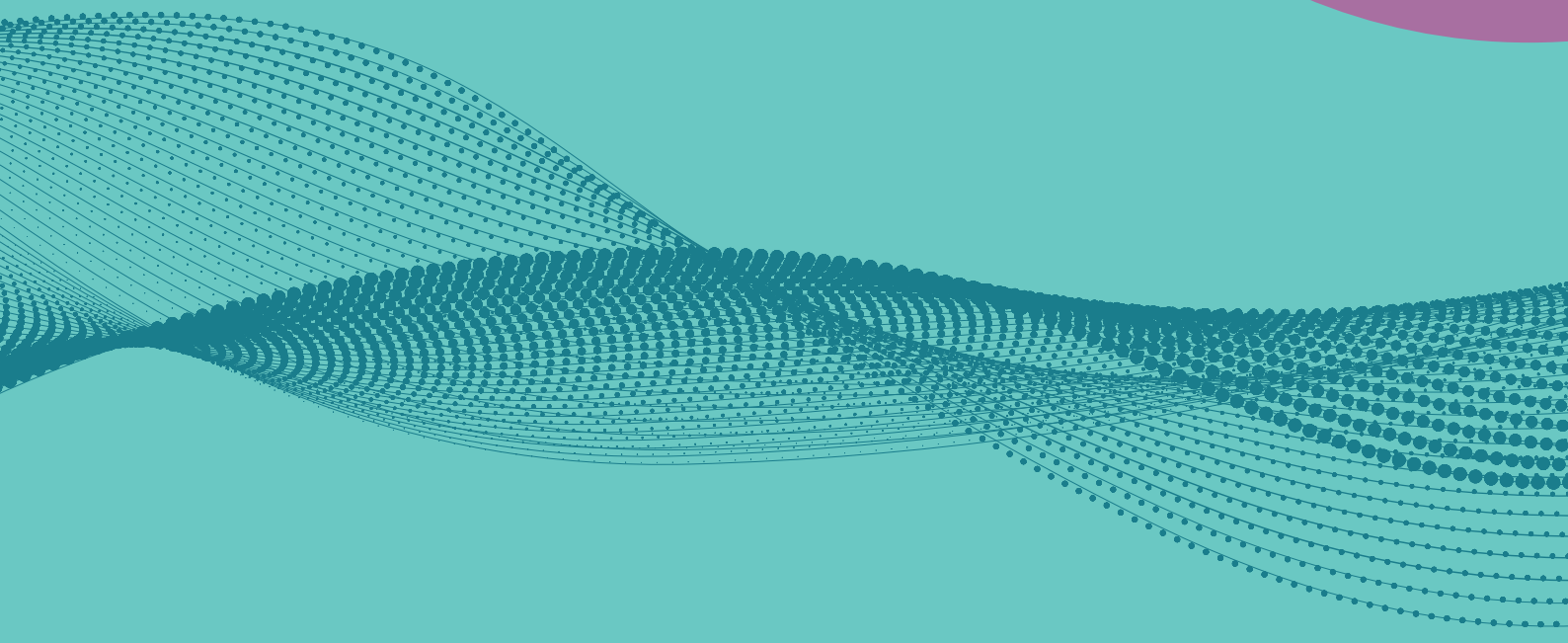
[3] Mental Health Commission data regarding involuntary admissions include Form 13 re-grades of voluntary patients, whereas the Health Research Board report on legal status as recorded on admission. The Health Research Board's figures for involuntary admissions may differ from the Commission's figures as they only capture legal status on admission and do not record any change in legal status during an admission.

[4] 'Total admissions' data are sourced from the Health Research Board's 'Activities of Irish Psychiatric Units and Hospitals 2017 (Daly and Craig, 2018), 'Activities of Irish Psychiatric Units and Hospitals 2018' (Daly and Craig, 2019), and 'Activities of Irish Psychiatric Units and Hospitals 2019' (2020).

[5] 'Involuntary admissions' data are sourced from the Mental Health Commission Annual Report 2017, 2018 and 2019.

3

ECT ACTIVITY DATA



3. ECT ACTIVITY DATA

3.1 Programmes and treatments

Data are presented for 2019 and 2018, with 2017 and 2016 data included for context where relevant. Data on the number of programmes of ECT administered are presented nationally, by sector (by CHO and independent service providers), and in relation to each individual approved centre.

Total residents, programmes and treatments

Table 3 provides an overview of the numbers of residents who were administered ECT, programmes and separate treatments (or sessions) of ECT. In 2019, **286** residents were administered **one or more programmes of ECT**. In total, **395 programmes** of ECT were administered. The number of treatments within a programme ranged from one to twelve treatments, with **3,124 treatments** of ECT being administered in total, resulting in an average of **7.9 treatments per programme**. In 2018, 283 residents were administered one or more programmes of ECT, for a total of 365 programmes. The number of treatments similarly ranged from one to twelve treatments, with 2,936 treatments being administered in total. The average number of treatments per programme in 2018 was 8.04.

Table 3: *Overview of ECT administration: residents, programmes and treatments, 2017-2019*

	2017	2018	2019
Residents administered ECT	257	283	**286**
Programmes of ECT administered	349	365	**395**
Total treatments of ECT administered	2,801	2,936	**3,124**

Programmes per resident

Figure 1 shows that the majority of residents were **administered one programme** of ECT (**72.7% in 2019** and 74.3% in 2018). In 2019, **15.7% of residents were administered two programmes** of ECT, followed by 11.5% being administered three or more programmes. In 2018, 18.6% of residents were administered two programmes of ECT, followed by 7.1% being administered three or more programmes.

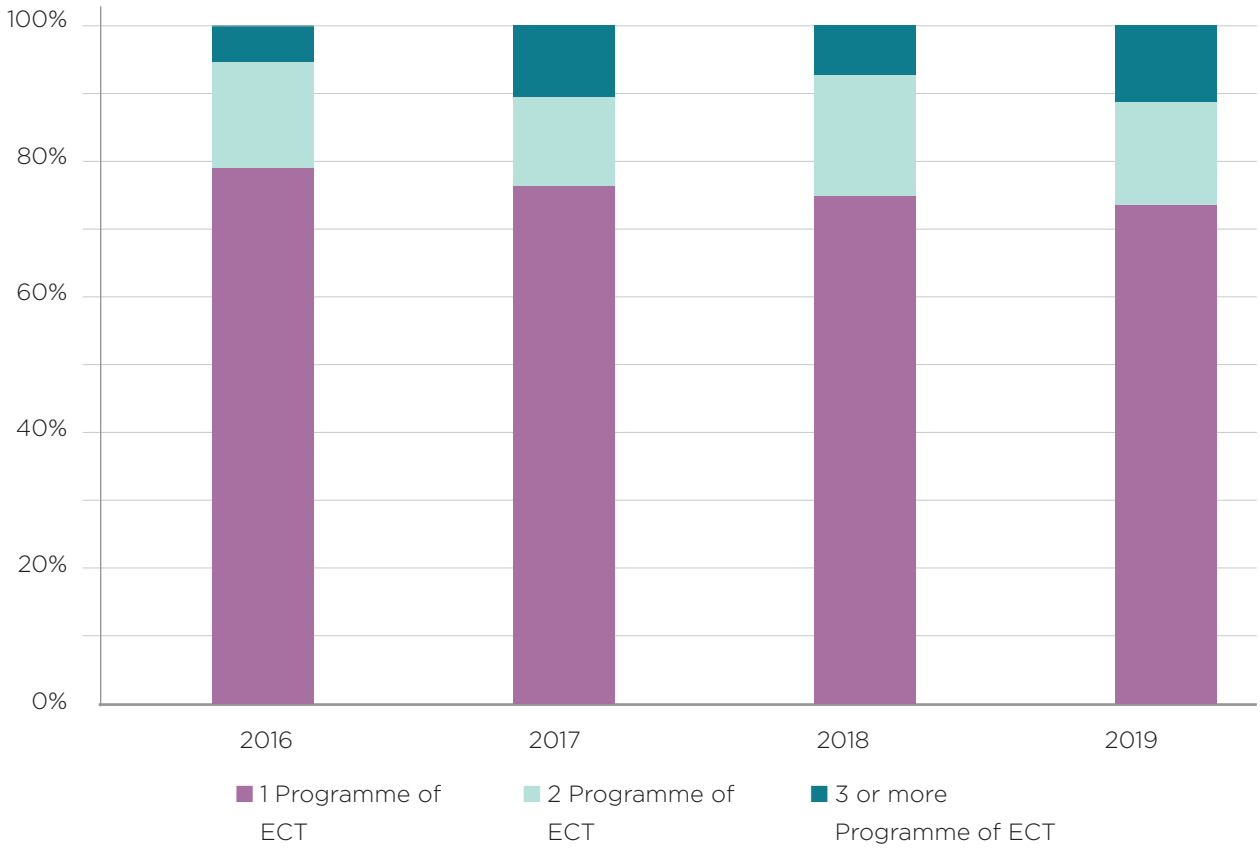


Figure 1: *Number of programmes of ECT administered to residents, 2016-2019* ¬

Treatments per programme of ECT

A programme of ECT refers to **no more than 12 treatments of ECT prescribed by a consultant psychiatrist**, with the total number of treatments administered in a programme of ECT varying from one to 12 treatments. Table 4 shows that the average number of treatments per programme was **approximately 8** in each of the years between 2017 and 2019.

Table 4: *Treatments per programme of ECT, 2017-2019*

	2017	2018	2019
Average number of treatments per programme	8.02	8.04	**7.91**
Programmes of 12 treatments	93	103	**105**
Programmes of 1 treatment	12	13	**11**

The majority of programmes of ECT (**97.2%** in 2019 and 96.4% in 2018) **involved more than one treatment**. The number of treatments prescribed, the resident's diagnosis, indications for ECT, response to treatment and outcome may all be factors that account for variation in the number of ECT treatments. The **most frequent number** of treatments per programme was the **maximum twelve**, which accounted for **26.1%** of all programmes in 2019, as compared with 28.2% in 2018. The distribution in the number of treatments per programme can be seen in Figure 2.

Duration of a programme of ECT

As previously discussed, the Rules and Code of Practice governing the use of ECT specify the maximum number of treatments in a programme of ECT, **but do not prescribe a timeframe or duration for a programme of ECT**. Data reported to the Commission indicate that the duration of time over which a programme of ECT is administered to a resident varies considerably.

Table 5 provides an overview of average ECT programme duration between 2017 and 2019, showing that the **average duration** of all ECT programmes was **44 days** in 2019, and 46 days in 2018. The average duration of programmes of **maintenance ECT** was **110 days** in 2019, and 120 days in 2018, while the average duration for ECT

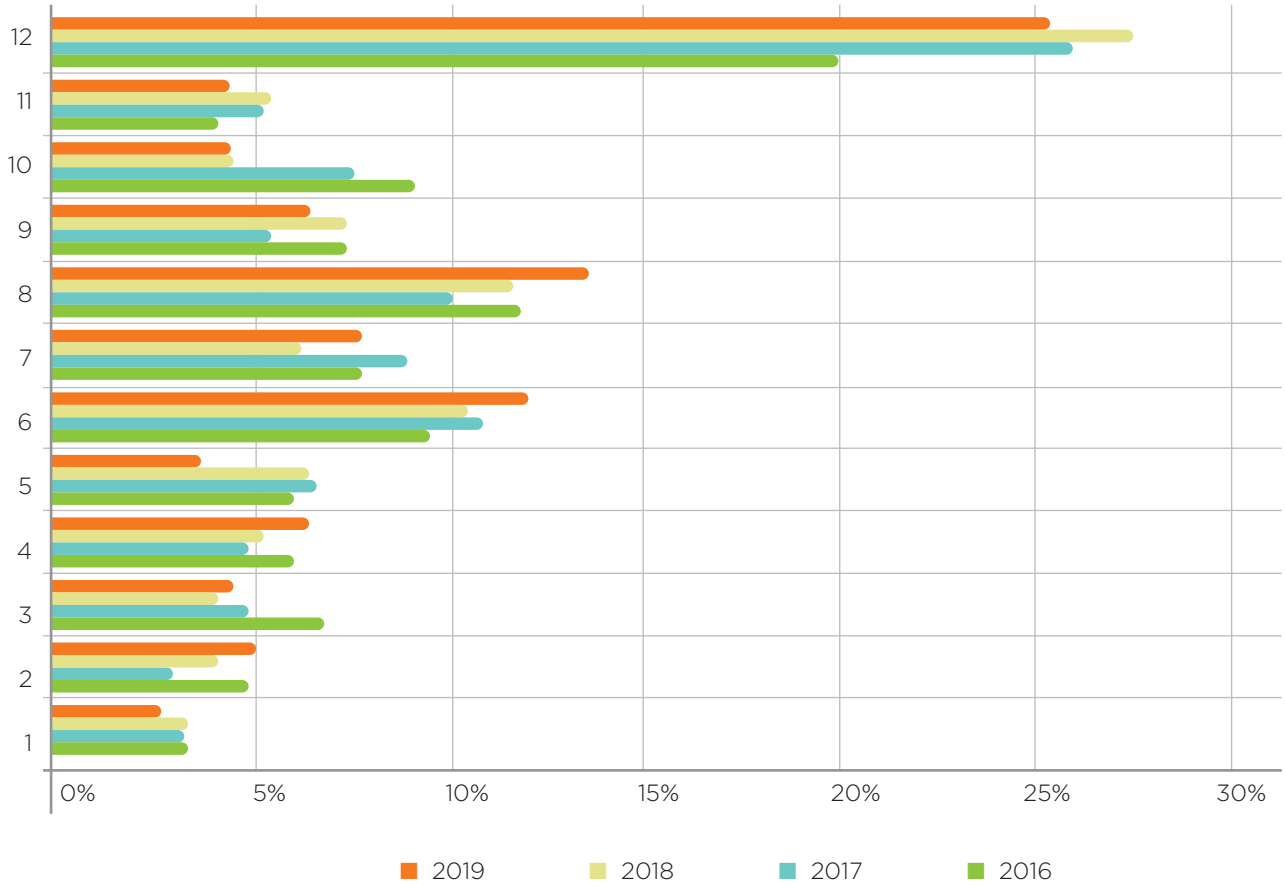


Figure 2: *Number of treatments per programme, 2016-2019*

programmes to treat **urgent or acute issues** was **35 days** in 2019, and 42 days in 2018. Given the distinct purposes of maintenance and acute ECT, the disparity in the average duration between maintenance and acute programmes (a ratio of approximately three-to-one) is explainable.

Table 5: Average ECT programme duration, 2017-2019

ECT programme type	Number of days		
	2017	2018	2019
All programmes	41	46	**44**
Maintenance ECT	96	120	**110**
Maintenance ECT excluded	32	42	**35**

3.2 ECT Services

ECT in approved centres

Table 6 provides an overview of the number of approved centres that administered ECT over the five-year period from 2015 to 2019. In 2019, **50.8%** of approved centres **did not provide an ECT service, 27.7%** of approved centres **provided an ECT service**, and **21.5%** of services **referred residents to other approved centres for ECT treatment**.

In 2018, 52.3% of approved centres did not provide an ECT service, 23.1% of approved centres provided an ECT service and 23.1% of services referred residents to other approved centres for ECT treatment.

Table 6: Overview of approved centres using ECT, 2017-2019

	Number of days				
	2015	2016	2017	2018	2019
ECT service	15	15	16	15	18
	23.4%	22.7%	25.0%	23.1%	27.7%
ECT service – not used	2	2	0	0	0
	3.1%	3.0%	0.0%	0.0%	0.0%
ECT service by referral	6	5	8	15	14
	9.4%	7.6%	12.5%	23.1%	21.5%
ECT service by referral – not used	0	1	0	0	0
	0.0%	1.5%	0.0%	0.0%	0.0%
No ECT service	41	43	40	35	33
	64.1%	65.2%	62.5%	53.8%	50.8%
Total approved centres	**64**	**66**	**64**	**65**	**65**

Administration of ECT by approved centre and CHO area

This section includes data in relation to the administration of ECT in individual approved centres. Data are presented nationally, by sector (by CHO or national provider) and by individual approved centre. Where a resident was referred by an approved centre to another approved centre for ECT treatment, this programme is reported under the referring approved centre. In other words, programmes of ECT are reported under the approved centre where the patient was a resident.

Table 7 shows the number of programmes of ECT reported by each approved centre in 2019, with 2017 and 2018 data included for context. The approved centres are ordered by sector (by CHO or national provider).

Approved centres in **eight out of the nine CHO areas** reported **one or more programmes of ECT** in the period spanning 2017 and 2019, with all nine CHO areas reporting one or more programmes of ECT in 2019. The national forensic mental health service, national intellectual disability service, and CAMHS did not report any programmes of ECT during the three-year period.

Acute Psychiatric Unit, Tallaght University Hospital reported the highest number of programmes of ECT in a HSE-operated service in 2019 and 2017, while the Acute Adult Mental Health Unit (formerly Department of Psychiatry), University Hospital Galway reported the highest number of programmes of ECT in a HSE operated service in 2018.

The Cluain Mhuire catchment area admits to St John of God Hospital; an approved centre in the independent sector. The HSE purchases in-patient places in this facility for Cluain Mhuire admissions. For the purpose of this report, St John of God Hospital and Cluain Mhuire data are presented together.

In 2019, **three approved centres accounted for 67% of all programmes**. They were St Patrick's University Hospital, St Edmundsbury (by referral to St Patrick's) and St John of God Hospital. St Patrick's University Hospital, a large 241-bed service, reported the highest number of programmes (197 in 2019, 166 in 2018 and 135 in 2017). St Patrick's University Hospital has an arrangement with the HSE for the admission of residents for ECT treatment. As part of this arrangement, residents are admitted to St Patrick's University Hospital, and therefore all such programmes are reported under this service's figures for 2017-2019.

In 2019, **seven of the approved centres (38%)** either using ECT or referring residents to other services for treatment reported fewer than five programmes, a reduction from eleven centres in 2018 (37%). Given the sensitive and potentially identifiable nature of the data, if **fewer than five programmes** of ECT were reported by an approved centre "<5" is used in the table.

Table 7: *Programmes of ECT reported by each approved centre, 2017-2019*

Approved centres by area / sector	Administration	2017*	2018º	2019
CHO Area 1 – Population 394,333 – Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan				
Acute Psychiatric Unit, Cavan General Hospital	ECT service	<5	<5	<5
Department of Psychiatry, Letterkenny University Hospital	ECT service	<5	11	11
Sligo/Leitrim Mental Health In-patient Unit	ECT service	8	<5	<5
CHO Area 2 – Population 453,109 – Galway, Roscommon, Mayo				
Acute Adult Mental Health Unit, University Hospital Galway	ECT service	20	22	24
Adult Mental Health Unit, Mayo University Hospital	ECT service	9	6	6
Department of Psychiatry, Roscommon University Hospital	By referral¬ºº º¬]	<5	0	<5
CHO Area 3 – Population 384,998 – Clare, Limerick, North Tipperary/East Limerick				
Acute Psychiatric Unit, Ennis Hospital	By referral¬ºº º	<5	<5	0
Acute Psychiatric Unit 5B, University Hospital Limerick	ECT service	18	17	24
CHO Area 4 – Population 690,575 – Kerry, North Cork, North Lee, South Lee, West Cork				
St Catherine's Ward, St Finbarr's Hospital, Cork	By referral¬ºº º	0	<5	0
Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	By referral¬ºº º	0	<5	0
Units 2, 3, 4, 5 and Unit 8 (Floor 2), St Stephen's Hospital, Cork	By referral¬ºº º¬]	0	<5	<5
CHO Area 5 – Population 510,333 – South Tipperary, Carlow/Kilkenny, Waterford, Wexford				
Department of Psychiatry, St Luke's Hospital	ECT service	10	<5	10
Department of Psychiatry, University Hospital Waterford	ECT service	14	17	<5
Haywood Lodge	By referral¬ºº¬]	0	0	<5
CHO Area 6 – Population 388,297 – Wicklow, Dun Laoghaire, Dublin South East				
Elm Mount Unit, St Vincent's University Hospital	ECT service	27	11	11
Avonmore & Glencree Units, Newcastle Hospital	ECT service	13	<5	<5
CHO Area 7 – Population 702,586 – Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West				
Acute Psychiatric Unit, Tallaght Hospital	ECT service	29	16	38
Jonathan Swift Clinic, St James's Hospital	ECT service	15	17	4
Lakeview Unit, Naas General Hospital	ECT service	14	17	11

CHO Area 8 – Population 616,229 – Laois/Offaly, Longford/Westmeath, Louth, Meath				
Department of Psychiatry, Midland Regional Hospital, Portlaoise	ECT service	5	9	6
Drogheda Department of Psychiatry	By referral	0	<5	0
St Loman's Hospital, Mullingar	ECT service	7	5	<5
Maryborough Centre, St Fintan's Hospital	By referral[¬ºº º]	<5	<5	0
St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre	ECT service	<5	0	<5
CHO Area 9 – Population 621,405 – Dublin North, Dublin North Central, Dublin North West				
Ashlin Centre	By referral	0	<5	0
Department of Psychiatry, Connolly Hospital	By referral[¬]	0	<5	<5
O'Casey Rooms	By referral[¬ºº º¬1]	<5	<5	<5
St Vincent's Hospital, Fairview	By referral[¬ºº º¬1]	<5	<5	<5
Forensic Service – National Coverage				
Central Mental Hospital	By referral	0	0	0
Independent – National Coverage				
St Edmundsbury Hospital	By referral[¬ºº º1]	14	26	29
St John of God Hospital & Cluain Mhuire	ECT service	39	43	41
St Patrick's University Hospital[b]	ECT service	135	166	197
Total all approved centres		**349**	**365**	**395**

Note: population figures taken from 2016 census population, CSO.ie

º In 2017: (i) St Edmundsbury Hospital referred residents to St Patrick's University Hospital; (ii) Acute Psychiatric Unit, Ennis to Acute Psychiatric Unit 5B, University Hospital Limerick; (iii) O'Casey Rooms to St Patrick's University Hospital; (iv) Newcastle Hospital to Elm Mount Unit, St Vincent's University Hospital; (v) Jonathan Swift Clinic, and Connolly Norman Ward, St James's Hospital to St Patrick's University Hospital; (vi) Maryborough Centre, St Fintan's Hospital to Department of Psychiatry, Midlands Regional Hospital, Portlaoise; (vii) St Vincent's Hospital, Fairview to St Patrick's University Hospital; and (viii) Department of Psychiatry, Roscommon Hospital to Acute Adult Mental Health Unit (Formerly Department of Psychiatry), University Hospital Galway.

¬º In 2018: Ashlin Centre, Department of Psychiatry, Connolly Hospital, Drogheda Department of Psychiatry, Jonathan Swift Clinic, St James's Hospital, Lakeview Unit, Naas, O'Casey Rooms, St Vincent's Hospital, Fairview, St Edmundsbury Hospital, and St Finbarr's Hospital, Cork all referred residents to St Patrick's University Hospital; and Sliabh Mis Mental Health Admission Unit, University Hospital Kerry and Acute Psychiatric Unit, Ennis University Hospital to Acute Unit 5B, University Hospital Limerick.

1 In 2019: (i) Acute Mental Health Unit, Cork University Hospital, Department of Psychiatry, Connolly Hospital, St Aloysius, Mater Misericordiae Hospital, O'Casey Rooms, Fairview, St Edmundsbury Hospital, St Stephen's Hospital, Cork, St Vincent's Hospital, Fairview, and Department of Psychiatry, Waterford University Hospital all referred residents to St Patrick's University Hospital for ECT treatment; (ii) Department of Psychiatry, Roscommon University Hospital referred residents to AAMHU Galway; (iii) Haywood Lodge referred residents to Department of Psychiatry, St Luke's Hospital; and (iv) Newcastle Hospital referred residents to Elm Mount Unit.

b This figure includes 22 programmes in 2017, 39 programmes in 2018, and 1 programme of ECT in 2019 where residents were referred from HSE services and admitted to St. Patrick's University Hospital for the duration of the programme of ECT.

3.3 People receiving ECT

This section provides information about the residents to whom ECT was administered in 2019, with data from 2017 and 2018 provided for context where relevant, including age, gender and legal status.

Demographics: Age and gender

Approximately **two-thirds** of residents in 2018 and 2019 were **female**[6]. Figure 3 shows the gender of residents who were administered ECT between 2017 and 2019.

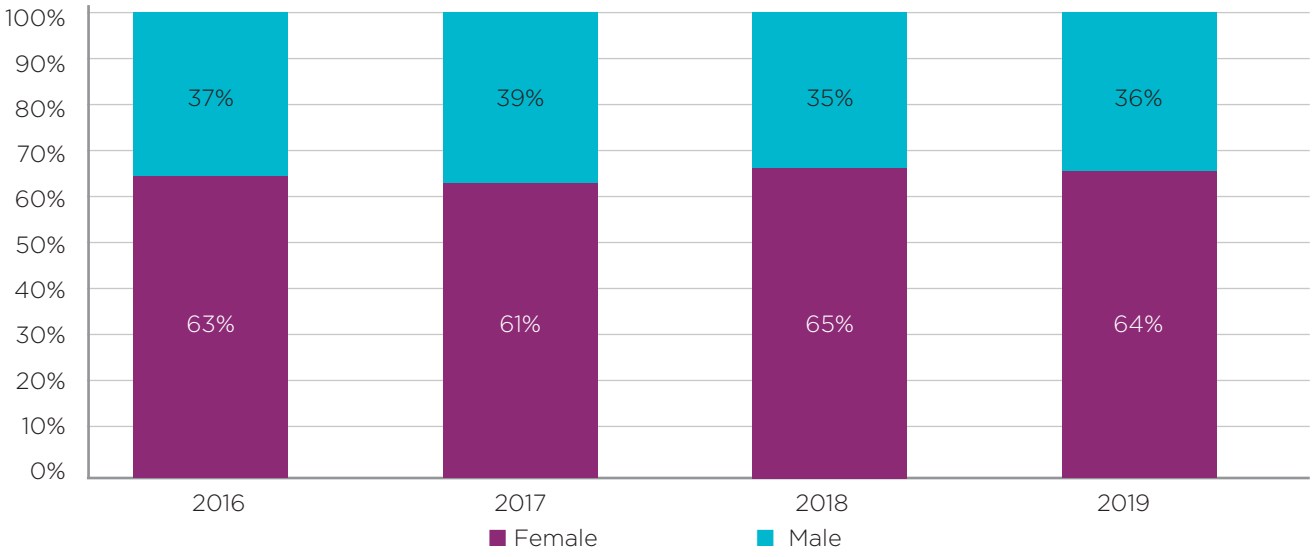


Figure 3: *Gender of residents who were administered ECT, 2017-2019*

The average age of residents who were administered ECT in 2019 was 59 years of age in both 2018 and 2019, ranging from 23 to 89 years in 2019, and from 20 to 91 years in 2018.

Figure 4 shows the age range distribution by gender of residents receiving ECT.

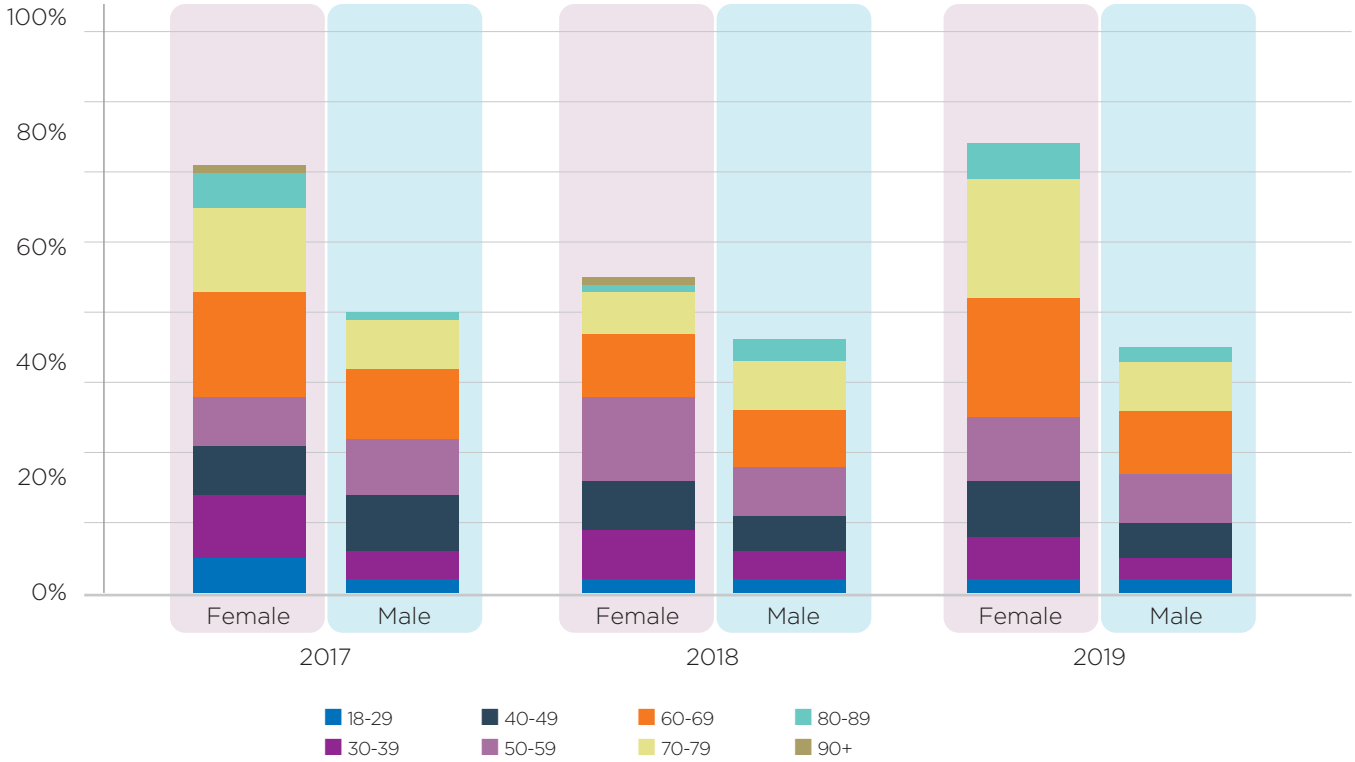


Figure 4: *Age range by gender of residents who were administered ECT (percentage of total year), 2017-2019*

[6] This is consistent with comparable jurisdictions (ECT Accreditation Service, 2017; Scottish ECT Accreditation Network, 2017; Scottish ECT Accreditation Network, 2019).

Legal status

Legal status as recorded on the ECT Register relates to residents' legal status when they commenced the programme of ECT: voluntary, involuntary, ward of court or outpatient.

Table 8 shows that in 2019, **82%** of programmes of ECT were administered to residents who were **admitted on a voluntary basis** when they commenced their programme of ECT, an increase from 78.4% in 2018. In 2019 **17.5%** of programmes were commenced when the legal status of the patient was **involuntary**, a decrease from 21% in 2018.

Table 8: *Programmes of ECT by residents' legal status, 2017-2019*

Legal Status	2017	2018	2019
Voluntary	79%	78.4%	**82%**
Involuntary	21%	21.1%	**17.5%**
Outpatient	-	0.5%	**-**
Ward of Court	-	-	**0.5%**

A programme of ECT may run over a number of weeks or months, meaning that there is potential for a resident's legal status to change during the course of the programme. Table 10 shows that a **change in legal status** was reported in relation to **16 programmes of ECT** in 2019, as compared with 12 in 2017 and 19 in 2018. **A change from involuntary to voluntary legal status was the most common change** in each of the three years.

Table 9: *Programmes of ECT with change in legal status, 2017-2019*

			2017	2018	2019
Change	Involuntary to voluntary	Number	8	13	**14**
		% of total	2.3%	3.6%	**3.5%**
	Voluntary to involuntary	Number	4	6	**1**
		% of total	1.1%	1.6%	**0.3%**
	Involuntary to Ward of Court	Number	-	-	**1**
		% of total	-	-	**0.3%**
Totals	Total changes to legal status	Number	12	19	**16**
		% of total	3.4%	5.2%	**4.1%**
	Total programmes		349	365	**395**

3.4 Administration of ECT Treatment without consent

ECT cannot be administered without consent to a voluntary patient.

Section 59 of the 2001 Act provides that two consultant psychiatrists can authorise and approve a treatment of ECT to an involuntary patient who has been assessed as being unable to consent to the treatment.[7] The two consultants must be satisfied, following assessment, that the patient is not capable of understanding the nature, purpose and likely effects of the proposed treatment.[8] The authorisation and approval is made on a specified statutory form (Form 16)[9], which includes the capacity assessment and intended benefit of the treatment.

Treatments without consent

Informed consent must be sought prior to the commencement of a programme of ECT, and also in advance of every ECT treatment. The capacity of a patient to consent may change over the duration of the programme and must also be assessed in advance of every treatment. A programme of ECT may therefore involve one or more treatments of ECT without consent. Table 10 **shows that 16% of programmes had one or more treatments without consent** in 2019, down from 19% in both 2017 and 2018.

Table 10: *Programmes of ECT with one or more treatment without consent, 2017-2019*

		2017	2018	2019
Programmes without consent	Number	66	69	63
	% of total	*19.0%*	*19.0%*	*15.9%*
Treatments without consent	Number	540	516	516
	% of total	*19.3%*	*17.6%*	*16.5%*

In both 2018 and 2019, a total of **516 individual treatments of ECT were administered without consent** (comprising 17.6% and 16.5% of all treatments respectively). In 2017, a total of 540 treatments were administered without consent (17.6% of all treatments).

[7] Section 59 Mental Health Act 2001.

[8] Section 60 Mental Health Act 2001.

[9] Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent.

3.5 Reasons for and outcomes of ECT use

This section provides information on the diagnoses of residents who are administered ECT, indications for ECT use, outcomes of the treatment and the reasons for ending a programme of ECT.

Diagnosis

In 2019, **77%** of programmes of ECT (304) were administered to residents with a **diagnosis of depressive disorders**, followed by 11.1% with a diagnosis of **schizophrenia, schizotypal, and delusional disorders** (44), and 7.6% with a diagnosis of mania (30). In 2018, roughly two-thirds (62.5%) of programmes of ECT were administered to residents with a diagnosis of depressive disorders, followed by 17.3% with a diagnosis of mania, and 13.2% with a diagnosis of schizophrenic, schizotypal, and delusional disorders.

This is in keeping with other jurisdictions, as **depressive disorders are the most common indication for ECT internationally** (ECT Accreditation Service, 2017; Scottish ECT Accreditation Network, 2017 and 2019).

Other diagnoses in 2019 included neuroses, organic disorders and developmental disorders. For a small number of programmes in 2018 (13 programmes, or 3.6%), diagnostic information was not available.

Figure 5 shows the breakdown of diagnoses between the years of 2017 and 2019.

Indications for ECT

Table 11 shows the breakdown of indications for programmes of ECT between 2017 and 2019. **Refractory (resistance) to medication was the most common single indication for ECT**, accounting for **66%** of indications in 2019, and 67% in 2018. **Rapid response required** accounted for the **second most common indication** in 2019 (13%), while **maintenance ECT** was **third most common indication** (12%).

Table 11: *Indications for ECT, 2017-2019*

Indications	2017	2018	2019
Refractory to medication	212	243	259
	61%	*67%*	*66%*
Multiple or 'other' indications°	7	3	8
	2%	*1%*	*2%*
Maintenance ECT	*53*	*55*	*47*
	15%	*15%*	*12%*
Rapid response required	*48*	*45*	*52*
	14%	*12%*	*13%*
Acute suicidality	*13*	*12*	*13*
	4%	*3%*	*3%*
Physical deterioration	*16*	*7*	*14*
	5%	*2%*	*4%*
Total Programmes	**349**	**365**	**395**

° Indications labelled as 'other' in 2019 included 'agitation', 'responded well in the past' and 'at risk of imminent death due to not eating or drinking'

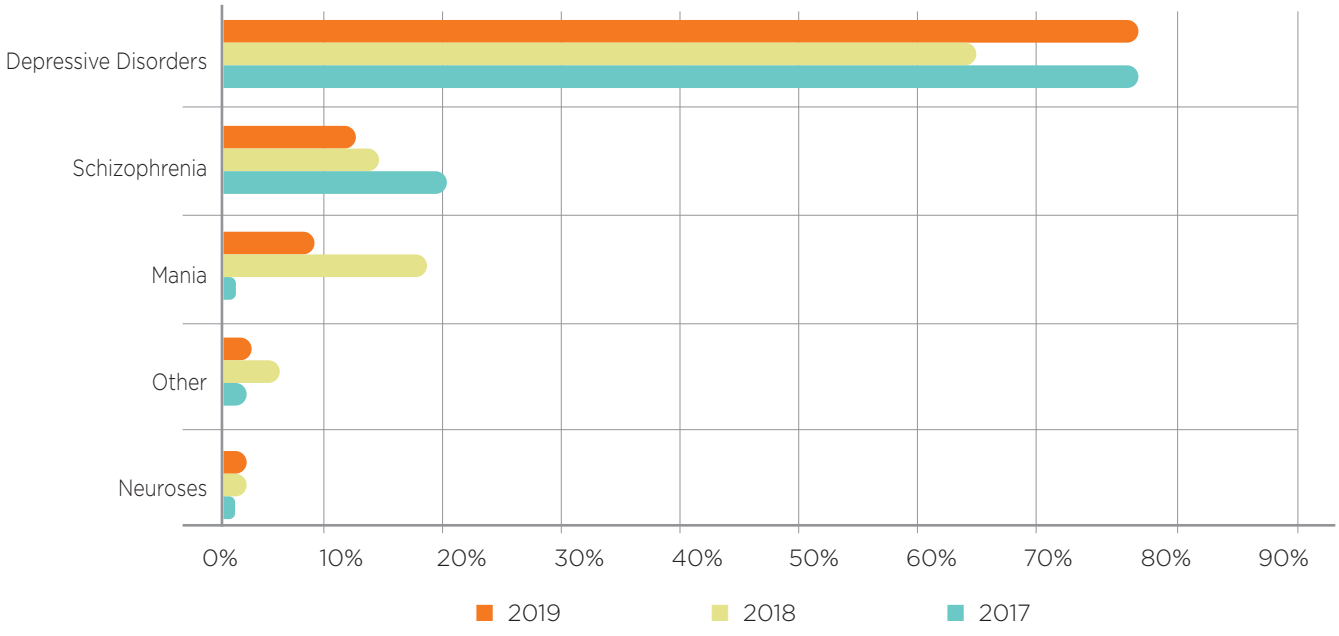


Figure 5: *Programmes of ECT by diagnosis, 2017-2019*

Reason for ending a programme of ECT

The consultant psychiatrist responsible for the care and treatment of the resident must record the reason for ending a programme of ECT on the ECT Register. Table 12 provides a breakdown of each reason for terminating a programme of ECT between the years 2017 and 2019.

Improvement was reported as the reason for ending the majority of programmes of ECT, accounting for **over three-quarters** (76% in 2019 and 81% in 2018) **of programmes**. Programmes of ECT ended because the **resident withdrew consent** in **3%** of programmes in both 2018 and 2019, while **no improvement or complications were the reasons for ending in 5% and 2% of programmes respectively in 2019**, and, in 2018, in 4% and 2% of programmes respectively. 'Other' reasons for ending programmes of ECT accounted for 14% and 8% of programmes in 2019 and 2018 respectively.

Table 12: Reason for ending programme of ECT, 2017-2019

Reason for ending ECT	2017	2018	2019
Improvement	282	294	299
	82%	*81%*	*76%*
Other°	17	28	53
	5%	*8%*	*13%*
No improvement	*17*	*16*	*18*
	5%	*4%*	*5%*
Resident withdrew consent	*15*	*12*	*13*
	4%	*3%*	*3%*
Complications	*7*	*7*	*9*
	2%	*2%*	*2%*
Register not completed	*7*	*7*	*2*
	2%	*2%*	*1%*
Total programmes	**349**	**365**	**395**

° 'Other' reasons for ending programmes of ECT included: underlying medical conditions, ECT treatment not concluded and was continuing to a new programme.

Outcome at the end of a programme of ECT

Improvement was reported as the **outcome in 87%** of programmes of ECT in 2019, a slight reduction from 92% in 2018. (This may be reflective of the fact that the register was not completed for an increased number of programmes in 2019 [18 or 5% in 2019, as compared with 3 or 1% in 2018]). Table 13 presents the outcome at the end of programmes of ECT administered from 2017 to 2019.

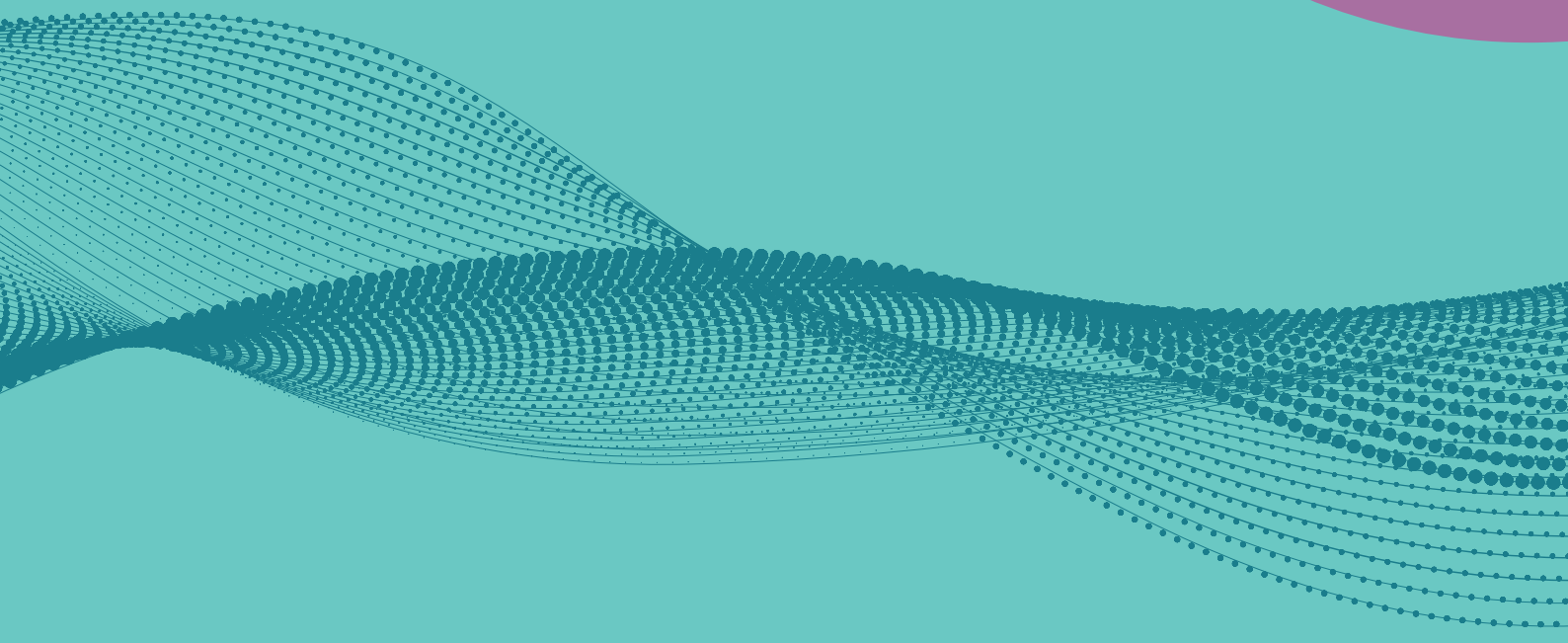
Complete recovery or significant improvement was reported as the outcome at the end of the programmes of ECT for **63% of programmes** of ECT in 2019, and 73% in 2018. Some or moderate improvement accounted for the outcome of another 26% of programmes in 2019, and 19% in 2018, while 5% of programmes reported no change in both 2018 and 2019. In 2019, **2% of programmes reported deterioration** in the condition of a person receiving ECT, and 1% in 2018.

Table 13: Outcome at end of ECT programme, 2017-2019

Outcome	2017	2018	2019
Complete recovery	89	104	95
	26%	*28%*	*24%*
Significant improvement	148	163	153
	43%	*45%*	*39%*
Moderate improvement	*25*	*26*	*50*
	7%	*7%*	*13%*
Some improvement	*44*	*45*	*52*
	13%	*12%*	*13%*
No change	*29*	*20*	*21*
	8%	*5%*	*5%*
Deterioration	*8*	*4*	*6*
	1%	*1%*	*2%*
Register not completed	7	3	18
	2%	*1%*	*5%*
Total	**344**	**365**	**395**

COMPLIANCE WITH ECT RULES & CODE OF PRACTICE

4



3. COMPLIANCE WITH ECT RULES & CODE OF PRACTICE

The Inspector of Mental Health visits and inspects every approved centre at least once a year. As part of this inspection, the Inspector rates compliance against the Rules and Code relating to ECT, as applicable.

In 2018 and 2019, the Inspector of Mental Health Services inspected 15 and 16 approved centres respectively for which the *Rules Governing the Use of Electro-convulsive Therapy* and/or the *Code of Practice on the Use of Electro-convulsive Therapy for Voluntary Patients* were applicable.

In 2019, of those 16 approved centres, the Rules were **not applicable for five centres**, as they had only voluntary patients in receipt of ECT. The Code was not applicable to two approved centres, as they had no voluntary patients receiving ECT between the time of the inspection and the previous inspection. In 2018, of the 15 approved centres using ECT, the Rules were not applicable to three approved centres, and the Code was not applicable to one approved centre.

Reasons for non-compliance for both the Rules and Code were similar, and included **patients not being informed of their right to access an advocate, cognitive assessments** not having been completed in relation to each programme of ECT, and not all staff having up-to-date **training**. Further details on approved centres' compliance can be found at: https://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/AC_IRs/.

Figure 6 shows the numbers of approved centres compliant with the Rules governing ECT in 2019. Of the 11 approved centres for which the Rules were applicable, **five were compliant**, while **six were non-compliant**. Of the six non-compliant approved centres, **one had a low risk rating, four had a moderate risk rating, and one was risk rated as critical.**

Figure 6: *Relevant approved centre compliance with Rules Governing the Use of Electro-convulsive Therapy, 2019*

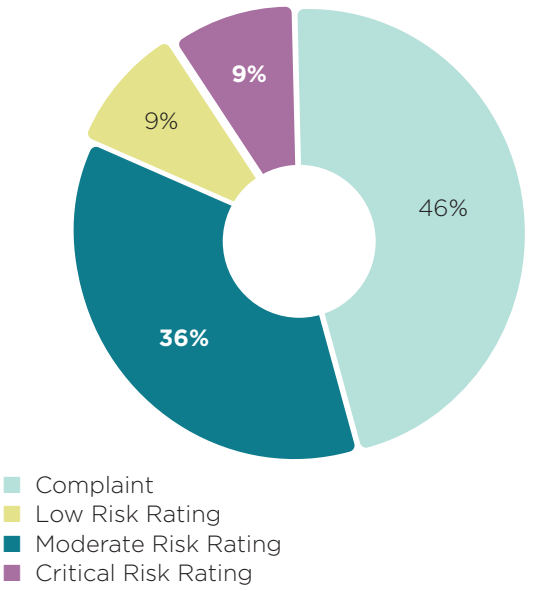


Figure 7 shows the numbers of approved centres compliant with the Rules governing ECT in 2018. Of the twelve approved centres for which the Rules were applicable, seven were compliant, while five were non-compliant. Of the five non-compliant approved centres, two had a low risk rating, two a moderate risk rating, and one a high-risk rating.

Figure 7: *Relevant approved centre compliance with Rules Governing the Use of Electro-convulsive Therapy, 2018*

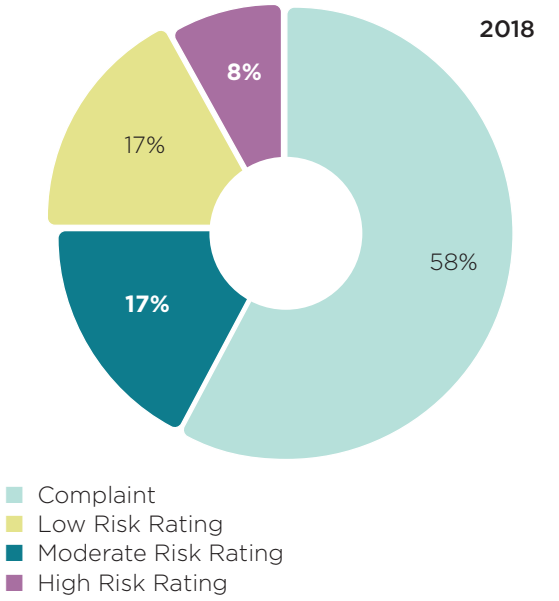


Figure 8 shows the numbers of approved centres compliant with the Code governing ECT in 2019. Of the 16 approved centres for which the Code was applicable, **thirteen were compliant, and three were non-compliant**. All three non-compliant centres had a **moderate risk rating**.

Figure 8: *Relevant approved centre compliance with Code of Practice on the Use of Electro-convulsive Therapy for Voluntary Patients, 2019*

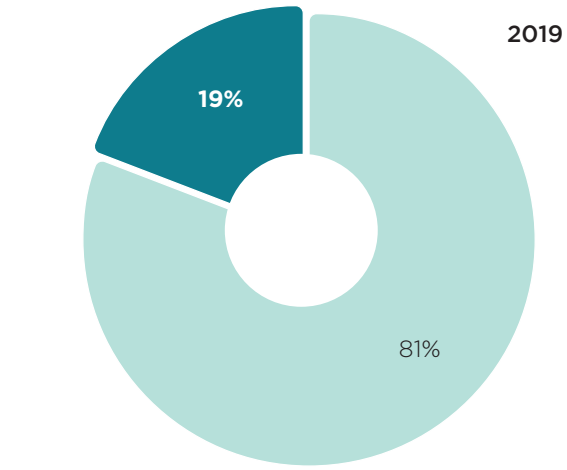
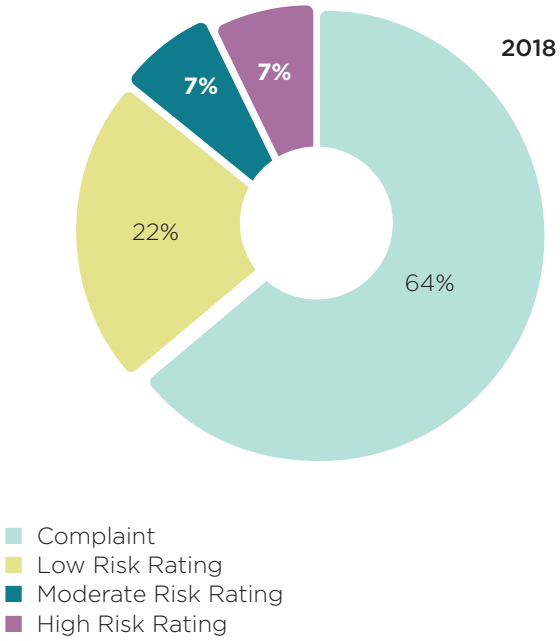


Figure 9 shows the number of approved centres compliant with the Code governing ECT in 2018. Of the 14 approved centres for which the Codes were applicable, nine were compliant, and five non-compliant. Of the five non-compliant, three had a low risk rating, one a moderate risk rating, and one a high-risk rating.

Figure 9: *Relevant approved centre compliance with Code of Practice on the Use of Electro-convulsive Therapy for Voluntary Patients, 2018*



DISCUSSION

DISCUSSION

This report is being issued eleven years after the publication of the first annual *Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008* (2009). In light of this, a comparison and trend visualisation in the use of ECT in approved centres between 2008 and 2019 is outlined in the following graphs in relation to:

i. the number of residents who underwent ECT;
ii. the number of programmes and treatments administered per year;
iii. outcomes of ECT treatment;
iv. the gender balance of residents who were administered ECT;
v. indications for the use of ECT treatment;
vi. the percentage of residents who were diagnosed with a depressive disorder prior to undergoing ECT treatment;
vii. the outcomes observed from ECT treatments from 2008-2018; and
viii. the average age of residents undergoing ECT treatment.

Figures 10 and 11 indicate that in relation to the number of residents undergoing ECT treatment and the number of programmes of ECT, there has been an overall decrease since 2008, but a general increase since 2015. The number of treatments of ECT has increased considerably since 2015, which may indicate that more residents are undergoing the full complement of treatments per programme than in previous years.

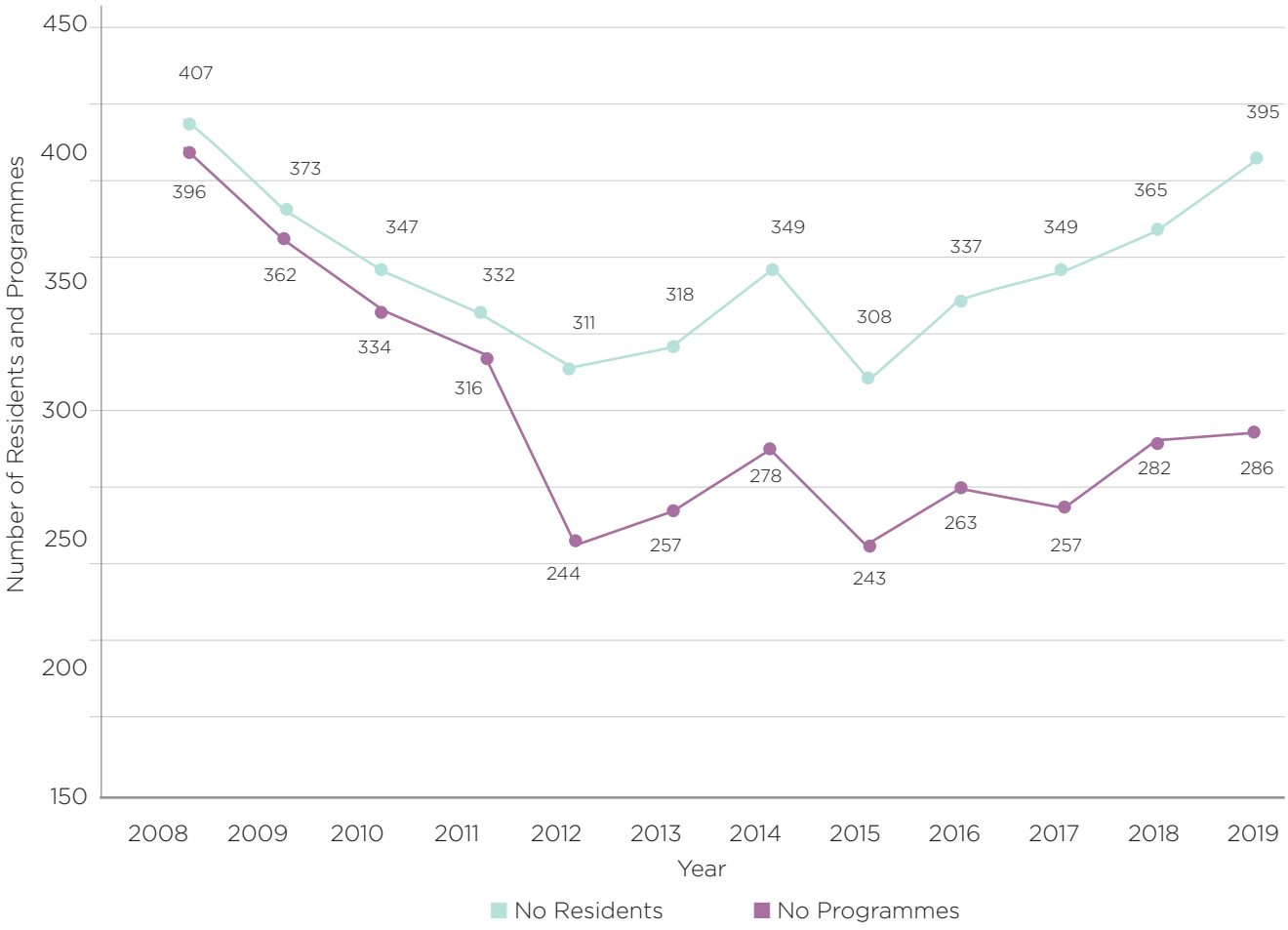


Figure 10: *Comparison of number of residents and programmes in approved centres, 2008-2019*

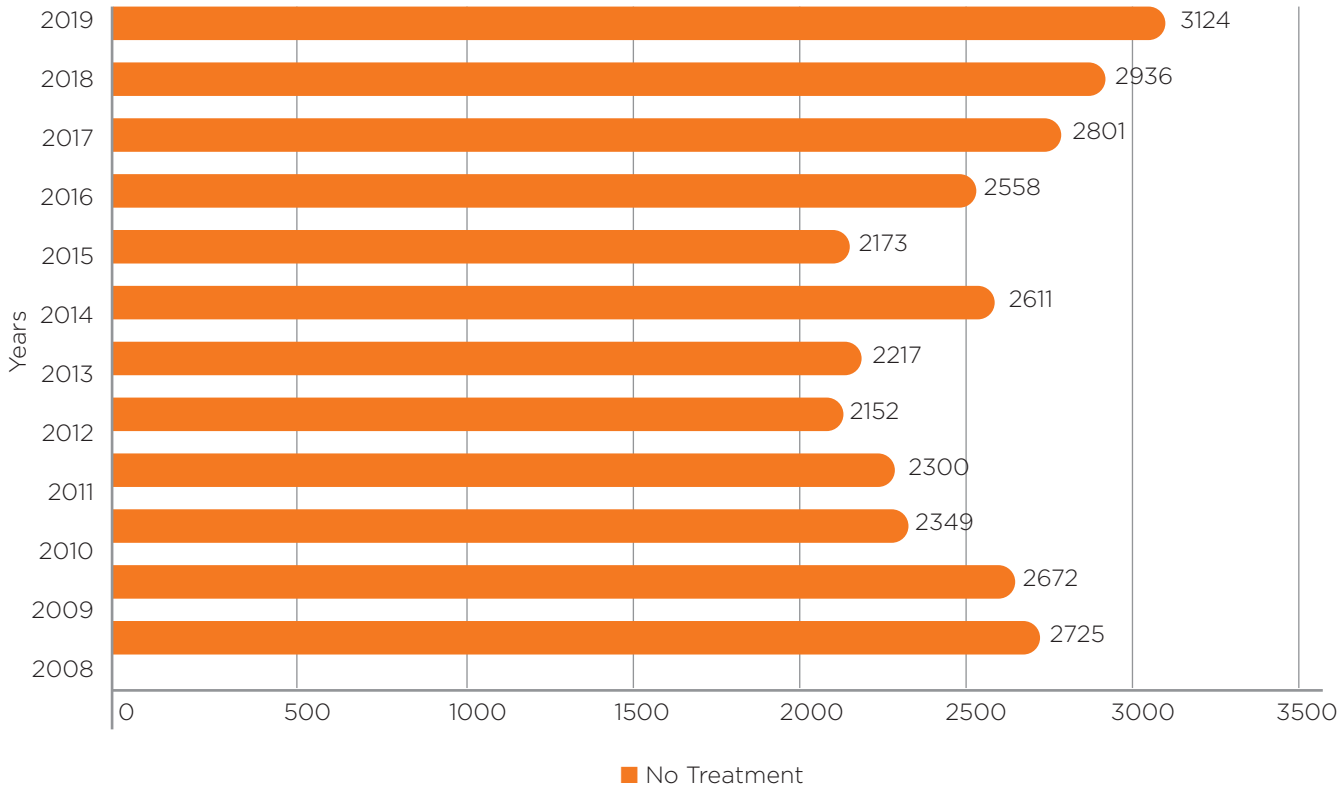


Figure 11: *Comparison of number of ECT treatments per year, 2008-2019*

Figure 12 outlines the total in-patient mental health service admissions recorded by the Health Research Board between the years 2008 and 2019, compared with the numbers of patients involuntarily admitted to in-patient mental health services over the same period of time. Involuntary admissions have increased year-on-year from **2,004 to 2,390** over the eleven-year period, while total admissions have fallen considerably, from **20,752 at the highest in 2008 to 16,710 at the lowest in 2019**.

Figure 12: *Comparison of total admissions as compared with involuntary admissions, 2008-2019*

Figure 13 shows that the ratio of female to male residents remained fairly static (approximately two-to-one) over the eleven-year period. As previously discussed, this may be as a result of the relatively higher rate of diagnosed depressive disorders in women than men in Ireland.

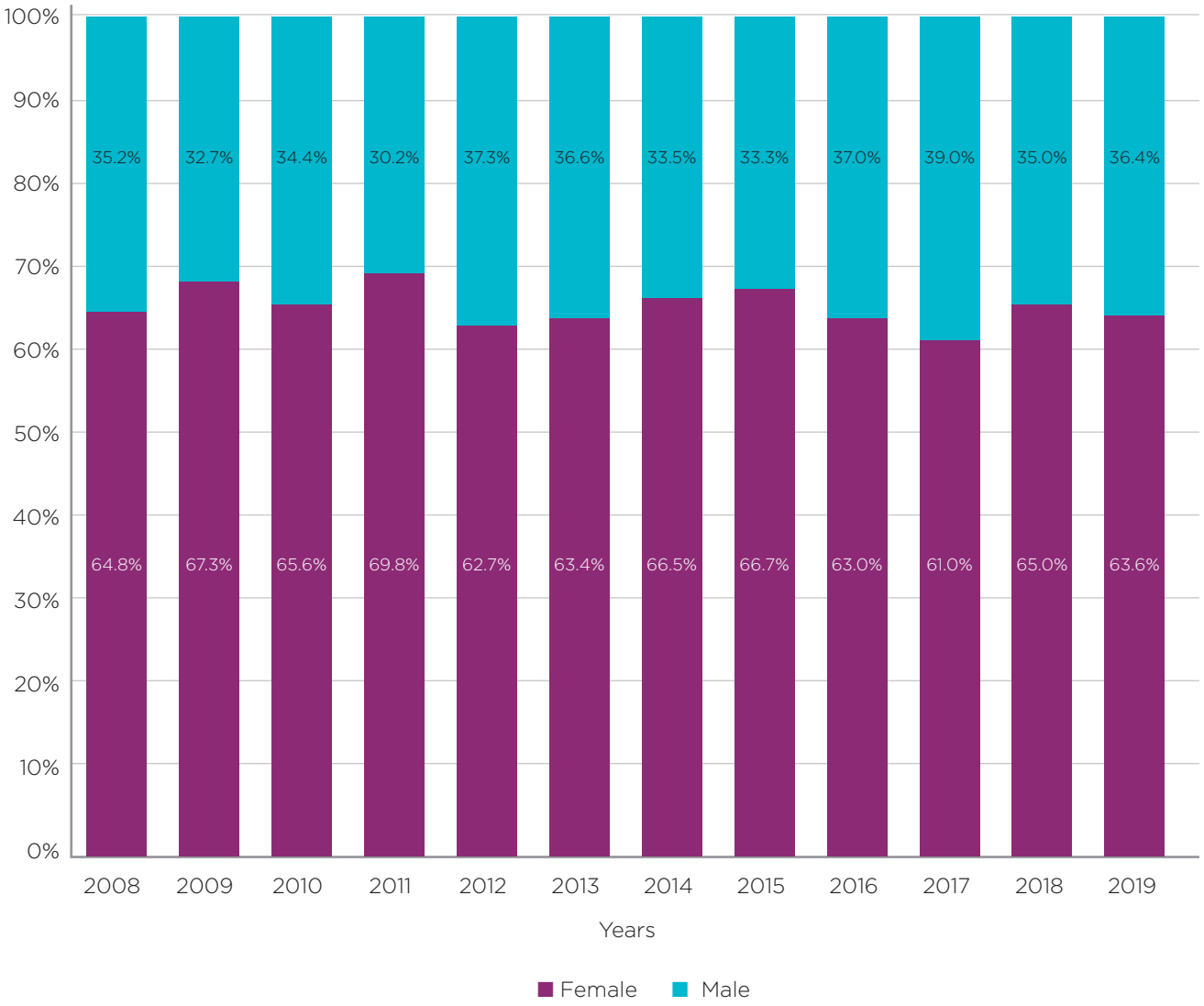


Figure 13: *Comparison of gender of residents who were administered ECT, 2008-2019*

Figure 14 shows that since 2008, the most common indication for the use of ECT treatment has consistently been that the residents are refractory, or resistant, to medication.

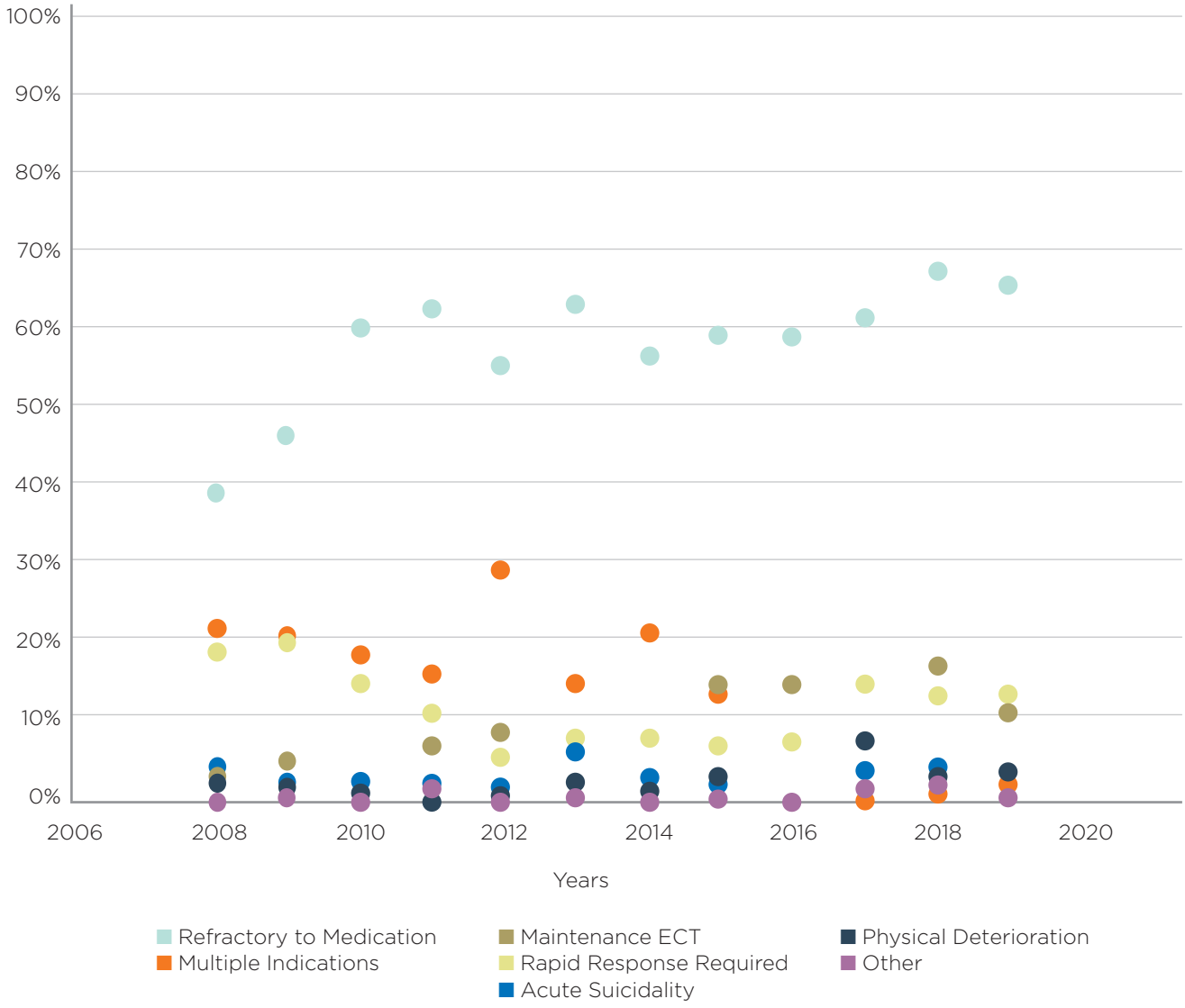


Figure 14: *Comparison of indications for use of ECT, 2008-2019*

Figure 15 indicates that, between 2008 and 2019, the most common diagnosis for residents undergoing ECT treatment has consistently been depressive disorders (between 63% and 84.3% per annum), followed by schizophrenic, schizotypal, and delusional disorders. The least common diagnoses have tended to be personality and behavioural disorders, and neuroses.

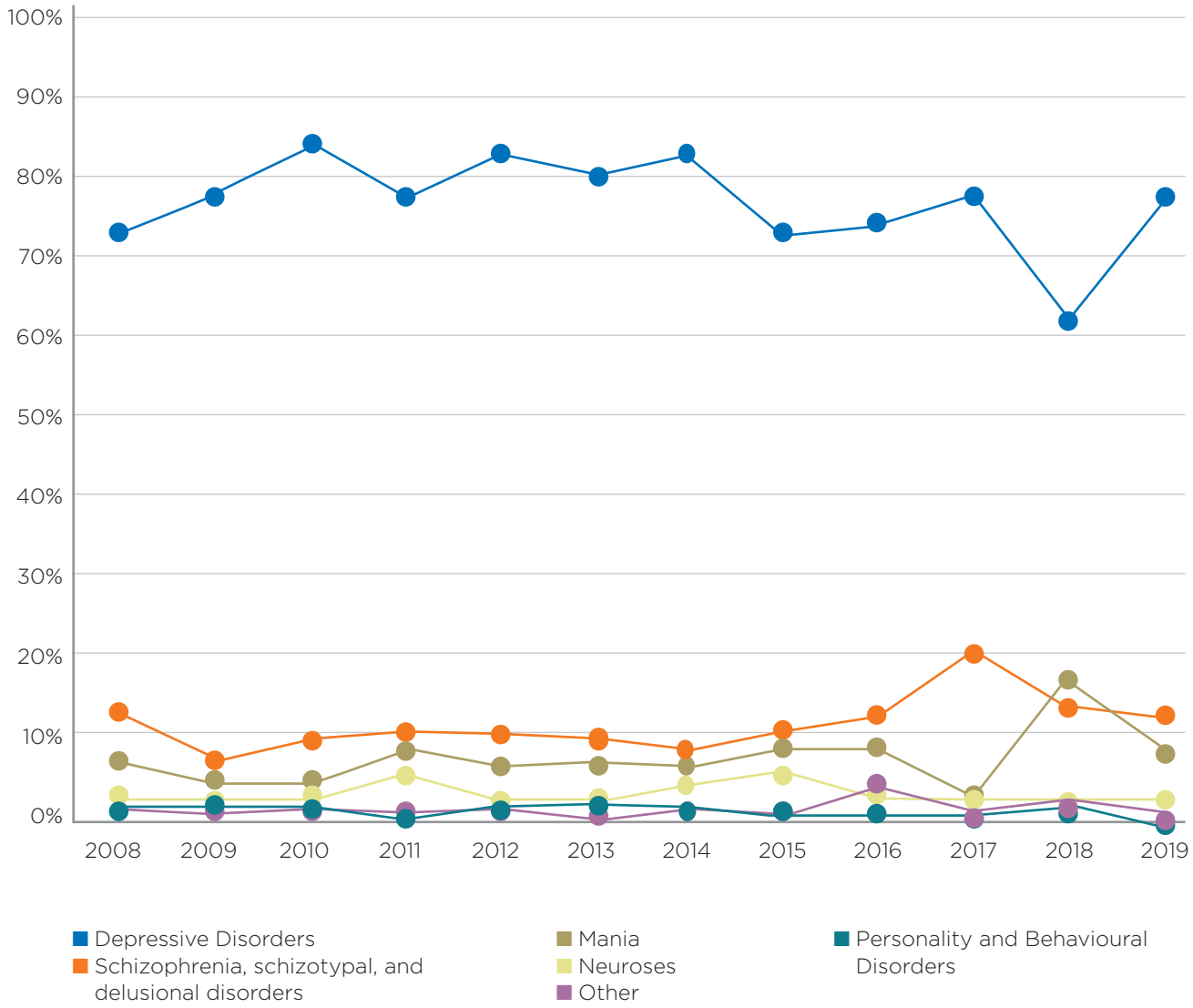


Figure 15: *Comparison of programmes of ECT by diagnosis, 2008-2019*

Figure 16 shows that significant improvement and complete recovery have consistently been the two most common outcomes of a programme of ECT treatment since 2008, with 'Deterioration' and 'No Change' consistently being the two least common outcomes. This trend would indicate that ECT treatment generally has a positive effect on those being treated. However, it is not clear what weight external factors, such as diagnosis, age, and acuity, have on the aggregate effectiveness of the treatment, and how ECT weighs up against traditional medication or alternative methods.

Figure 17 indicates that the average age of residents receiving ECT rose considerably between 2010 (the first year that the age of ECT residents was collected from approved centres) from 57 years of age, to 60 years of age in 2013. The average age between 2017 and 2019 was 58 years of age. A reason suggested for the elevated average age of ECT users, as opposed to the average age of residents admitted to Irish hospitals generally (including approved centres) (45 years of age in 2017[10], 2018[11], and 2019[12]) is that ECT tends for the vast majority of cases, as outlined in Figure 13 above, to be a last resort treatment for people suffering from mental disorders who have been unresponsive or refractory to alternative treatments and medication for a considerable period of time.

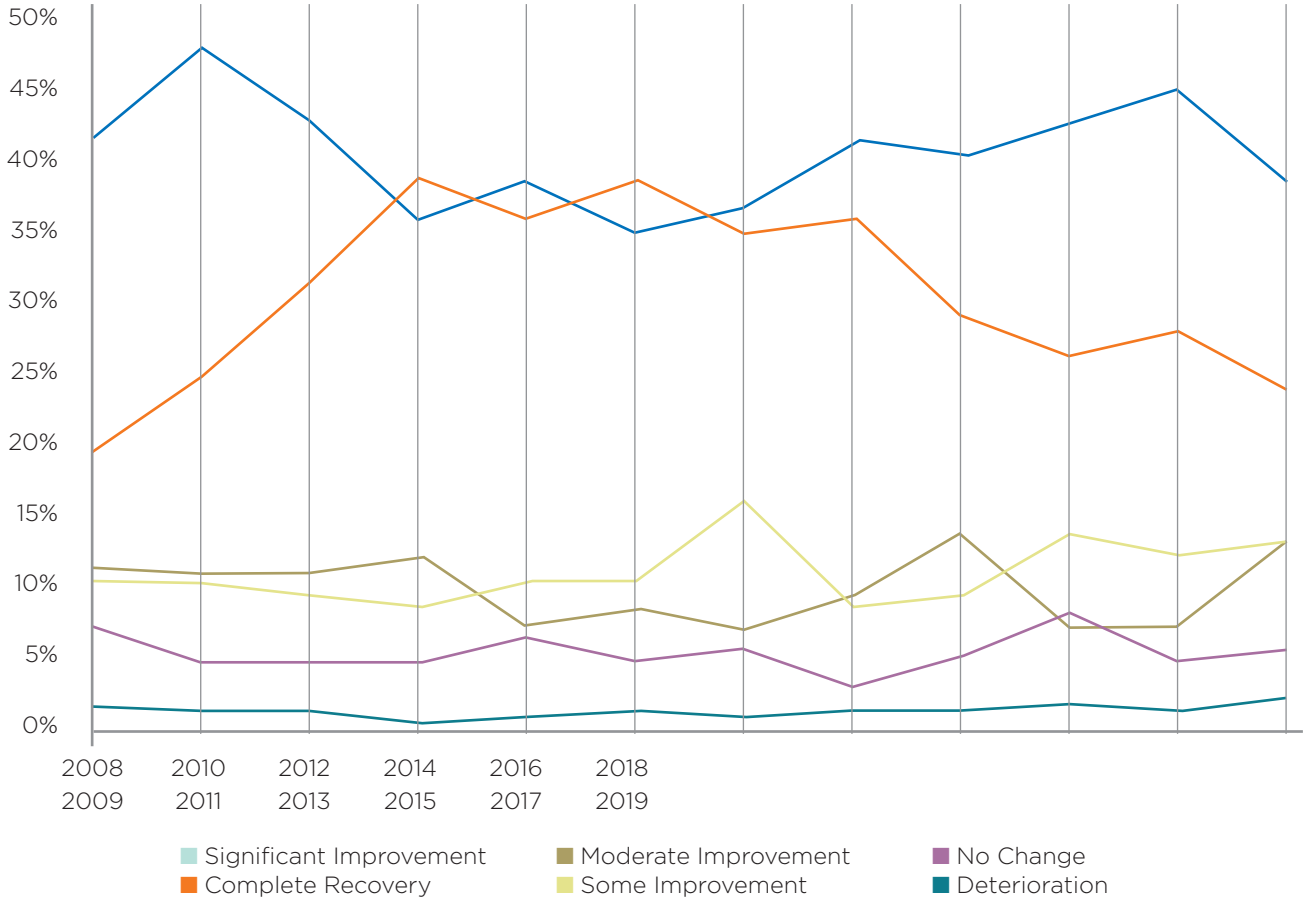


Figure 16: *Comparison of outcomes of ECT treatment, 2008-2019*

[10] Daly A, Craig S (2017), HRB Statistics Series 35 *Activities of Irish Psychiatric Units and Hospitals 2016. Health Research Board.* (Dublin).

[11] Daly A, Craig S (2018), HRB Statistics Series 38 *Activities of Irish Psychiatric Units and Hospitals 2017. Health Research Board.* (Dublin).

[12] Daly A, Craig S (2020), HRB Statistics Series 41 *Activities of Irish Psychiatric Units and Hospitals 2019. Health Research Board.* (Dublin)

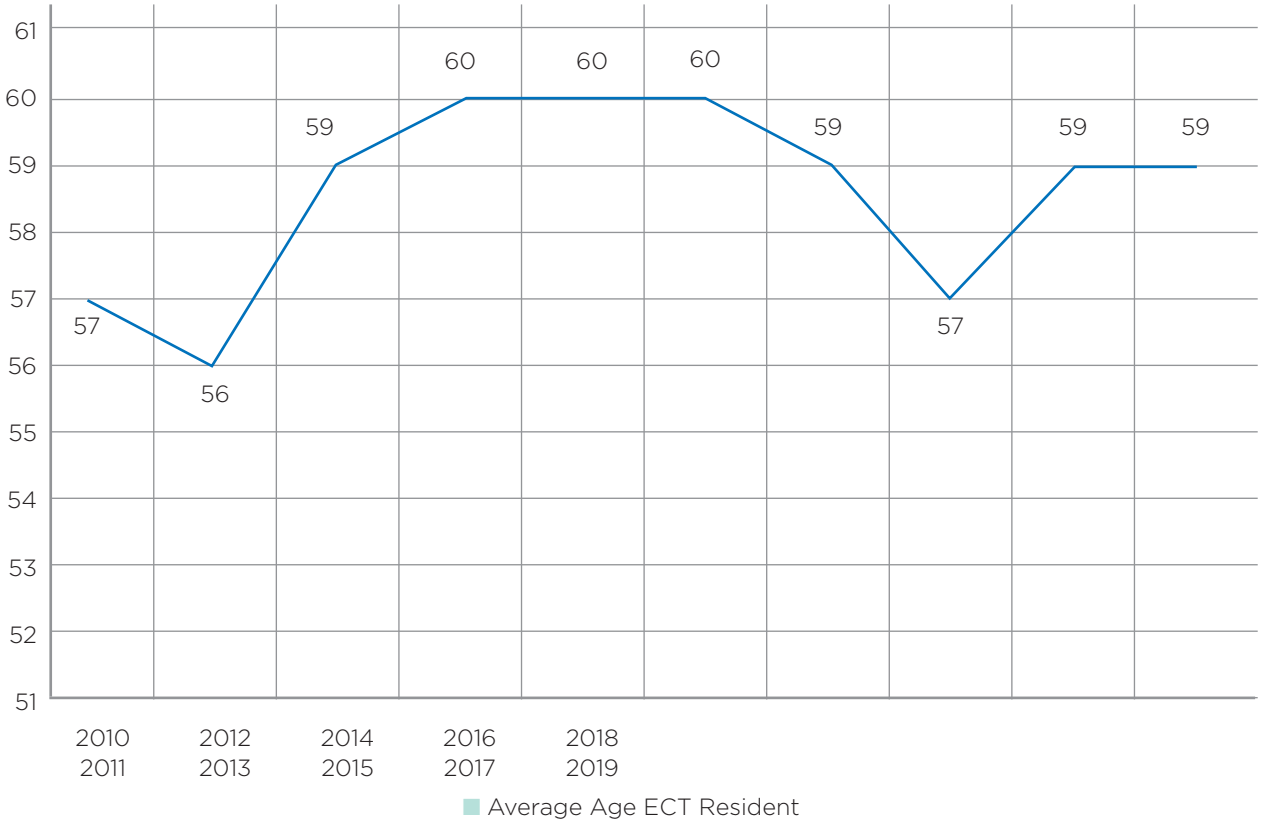
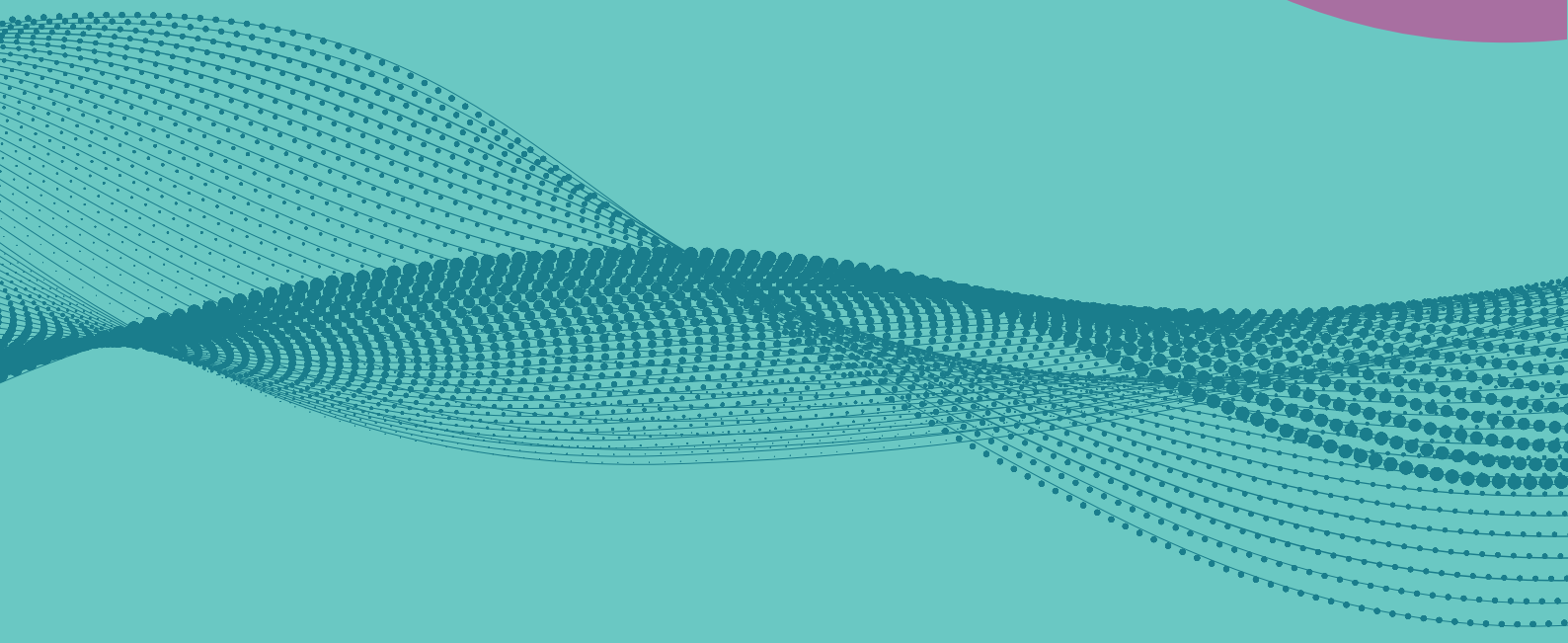


Figure 17: *Comparison of average age of ECT residents, 2008-2019*

CONCLUSION



CONCLUSION

The aim of collecting data in relation to the use of ECT in approved centres was to report on the administration of ECT as captured in the register. There are limitations, on the basis of data protection, which restrict the amount of information that can legally be requested, and which could, in theory, make a comparative analysis more useful. This might include: geographic area or address collection, as the majority of ECT is administered in national services and data on the location of residents is not included; long-term recovery or improvement statistics collected from residents who underwent ECT treatments, at 6-month, 1-year, and 5-year increments. In light of these limitations, it is neither useful nor practicable to offer recommendations based on the results of the data collected, nor to make either a positive or negative statement about the impact and usefulness of ECT treatment.

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REFERENCES

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APPENDICES

APPENDIX 1: ECT DATA COLLECTION TEMPLATE, CIS215: ECT FUNCTION NEW PROGRAMME NOTIFICATION SCREEN AND FORM 16S

AC Name **Year:**

NB: if a form is void or both copies removed from the book please enter the form ID number and enter 'void' or 'missing' under patient initials

21. Date of sign off												
20. Additional info Outcome												
19. Outcome at termination of ECT												
18. Additional info RFT												
17. Reason for termination												
16. Number treatments without consent												
15. Number treatments with consent												
14. Number of treatments												
13. Date of last treatment												
12. Date of first treatment												
11. Additional info Indications												
10. Indications for ECT												
9. ICD 10												
8. Details of change in legal status												
7. change in legal status												
6. Legal status												
5. Gender												
4. Date of Birth												
3. Patient Initials												
2. Referring AC name												
1. Form ID												

CIS215 - ECT

Home » ECT » New ECT

Guidance on this notification

1. About the service

Approved Centre	Please select... *	Ward/Unit	
Responsible Consultant Psychiatrist			
MCRN			
Name			

2. About the resident

Identifier		Gender	Please select...
Initials		Date of Birth	
Legal Status		Date of capacity assessement	
Resident Service Status	Please select...	ICD 10 diagnosis code	Please select...
		Reason for administering ECT	Please select...

3. About the programme

New ECT Treatment

Date of Treatment	Was Capacity Assessment Performed	With Consent	Legal Status	Laterality	Action
					Clear

Records 0 to 0 of 0

Page 1 / 1

4. Outcome of programme

Total number of treatments		Stimulus dosing used	○ Yes ○ No
With Consent	0	Reason for ending	Please select...
Without Consent	0	Programme complete and awaiting submission	☐
Outcome of the programme	Please select...		

5. Additional Information

Additional information applicable to notification		Query	
		Response	
		History	

6. Submitted by (Automatically populates when the notification is submitted)

Role		Date Submitted	
MCRN		Date Entered	
Name		Who Entered	

Submit Save Printable View Cancel

Form 16: *Treatment Without Consent Electro-convulsive Therapy Involuntary Patient (Adult)* forms relating to patients who were unable to consent to ECT treatment. Effective from 15th February 2016

MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

Revised February 15th 2016

ELECTROCONVULSIVE THERAPY INVOLUNTARY PATIENT (ADULT) – UNABLE TO CONSENT

FORM 16
MENTAL HEALTH ACT 2001 (AS AMENDED)
SECTION 59
PAGE 1 OF 3

To be completed by the consultant psychiatrist responsible for the care and treatment of the Patient:

BLOCK CAPITALS **(Before completing this form, please read the notes overleaf)**

1. Full Name of Patient

2. Date of Birth ☐☐/☐☐/☐☐☐☐ **Gender** M ☐ F ☐

was involuntarily admitted to

3. Name and Address of Approved Centre to which the patient was admitted

Ward.

on

4. Date ☐☐/☐☐/☐☐☐☐

5. Full Name of Responsible Consultant Psychiatrist (and Professional Address if other than Section 3 above)

I have examined the above named patient on (date) ☐☐/☐☐/☐☐☐☐
and I am of the opinion that it would be to the benefit of the patient to be administered electroconvulsive therapy for the following reasons

6. Give details of how this treatment will benefit the patient

7. Give details of discussion with and views expressed by the patient

8. Give details of assistance, if any, provided to the patient in relation to discussion

9. Give details of your assessment of the patient's ability to consent to treatment

SIGNATURES REQUIRED ON PAGE 3 >

For use only in accordance with the Mental Health Act 2001 (as amended). Penalties apply for giving false or misleading information.

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Revised February 15th 2016

ELECTROCONVULSIVE THERAPY INVOLUNTARY PATIENT (ADULT) – UNABLE TO CONSENT

FORM 16
MENTAL HEALTH ACT 2001 (AS AMENDED)
SECTION 59
PAGE 3 OF 3

To be completed by the consultant psychiatrist responsible for the care and treatment of the Patient:

This patient is unable to give consent to this treatment.
I approve this programme of electroconvulsive therapy. ☐

Signed: _____ **MCRN:** _____

(Responsible Consultant Psychiatrist**)**

Date: ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐
(24 hour clock e.g. 2.41p.m. is written as 14.41)

This part to be completed by another consultant psychiatrist following referral by the first-mentioned psychiatrist.

10. Full Name of Consultant Psychiatrist (and Professional Address if other than Section 3 above)

I have examined the above named patient on DATE: ☐☐/☐☐/☐☐☐☐
and I am of the opinion that it would be to the benefit of the patient to be administered electroconvulsive therapy for the following reasons

11. Give details of how this treatment will benefit the patient

12. Give details of discussion with and views expressed by the patient

13. Give details of assistance, if any, provided to the patient in relation to discussion

14. Give details of your assessment of the patient's ability to consent to treatment

This patient is unable to give consent to this treatment.
I authorise this programme of electroconvulsive therapy. ☐

Signed: _____ **MCRN:** _____

(Consultant Psychiatrist**)**

Date: ☐☐/☐☐/☐☐☐☐ **Time:** ☐☐:☐☐
(24 hour clock e.g. 2.41p.m. is written as 14.41)

For use only in accordance with the Mental Health Act 2001 (as amended). Penalties apply for giving false or misleading information.

Form 16 Confirmation of ECT without consent proceeding template.

Form 16 Treatment Without Consent Electro-convulsive Therapy involuntary patient (adult)

Please complete the information below electronically in relation to the attached Form 16 and return by email: mentalhealthdata@mhcirl.ie

1. Approved Centre Name	
2. Form ID number:	
3. Did this programme of ECT without consent proceed? (if no you do not need to complete the remaining questions)	Yes ☐ No ☐
4. Was this patient (please select response **a** or **b** or **c**) **a)** A patient of this Approved Centre who was administered ECT in this Approved Centre? **Or** **b)** A patient of another Approved Centre who was referred here for ECT treatment? (if yes please specify name of other Approved Centre) **Or** **c)** A patient of this Approved Centre who was referred to another Approved Centre for ECT treatment? (if yes please specify the name of the other Approved Centre)	☐ ☐ _____ ☐ _____

APPENDIX 2: ICD 10 CODES AND DIAGNOSTIC GROUPS

ICD-10 diagnostic groups	ICD-10 Code
1. Organic disorders	F00-F09
2. Alcoholic disorders	F10
3. Other drug disorders	F11-F19, F55
4. Schizophrenia, schizotypal and delusional disorders	F20-F29
5. Depressive disorders	F31.3, F31.4, F31.5, F32, F33, F34.1, F34.8, F34.9
6. Mania	F30, F31.0, F31.1, F31.2, F31.6, F31.7, F31.8, F31.9, F34.0
7. Neuroses	F40-F48
8. Eating disorders	F50
9. Personality and behavioural disorders	F60-F69
10. Intellectual disability	F70-F79
11. Development disorders	F80-F89
12. Behavioural and emotional disorders of childhood	F90-F98
13. Other diagnosis	F38, F39, F51-F54, F59, F99

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www.twitter.com/mhcireland