MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

THE ADMINISTRATION OF ELECTRO-CONVULSIVE THERAPY IN APPROVED CENTRES

February 2020

Activity Report **2017 & 2018**

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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.

2017
KEY FINDINGS

257
RESIDENTS RECEIVED ECT

349
PROGRAMMES OF ECT ADMINISTERED

16
APPROVED CENTRES PROVIDED AN ECT SERVICE

57
AVERAGE AGE
RANGING FROM 22-90

3 IN 4
WERE DIAGNOSED WITH DEPRESSION

82%
REPORTED IMPROVEMENT

81%
TREATMENTS ADMINISTERED WITH CONSENT

3 IN 5
WERE FEMALE

2018
KEY FINDINGS

283
RESIDENTS RECEIVED ECT

365
PROGRAMMES OF ECT ADMINISTERED

15
APPROVED CENTRES PROVIDED AN ECT SERVICE

59
AVERAGE AGE
RANGING FROM 20-91

2 IN 3
WERE DIAGNOSED WITH DEPRESSION

81%
REPORTED IMPROVEMENT

82%
TREATMENTS ADMINISTERED WITH CONSENT

2 IN 3
WERE FEMALE

Summary

All figures included in this summary are calculated across 2017 and 2018, unless otherwise indicated.

Programmes and treatments of ECT

- Approved centres reported **349** programmes of ECT were administered to **257** residents in 2017, while **365** programmes of ECT were administered to **283** residents in 2018.
- The rate of ECT programmes per resident was 1.36 programmes per resident in 2017, and 1.29 programmes per resident in 2018.
- In 2017, 70% of residents who received ECT were administered one programme of ECT; in 2018, this rose to 74% of residents.
- A programme of ECT may involve up to 12 individual treatments of ECT. The average number of treatments per programme was 8 in both 2017 and 2018.
- There was a total of **2,801** individual treatments of ECT administered in 2017, and **2,936** in 2018.

Services providing ECT

- **16** approved centres (25%) provided an ECT service in 2017, decreasing to **15** approved centres (23%) in 2018.
- A further eight approved centres referred residents to another approved centre for ECT treatment in 2017, with **15** approved centres referring residents to another approved centre for treatment in 2018.
- In 2017, **69.2%** of relevant services (those services administering ECT to involuntary patients) were compliant with all aspects of the Rules Governing the Use of ECT; in 2018, this fell to **58.3%** of relevant services.

People receiving ECT

- In 2017, the average age of all residents who were administered ECT was **57** years of age, and **59** years of age in 2018. In 2017, residents receiving ECT ranged in age from **22** to **90** years of age, and in 2018, from **20** to **91** years of age.
- In 2017, more females than males received treatment, approximately three-fifths to two-fifths. In 2018, this ratio was roughly two-thirds to one-third. In both cases, the higher ratio of female residents to male residents may be reflective of the relatively higher incidence of depressive illness in women compared to men.
- The majority of programmes of ECT were administered to residents who were admitted on a voluntary basis when they commenced their programme of ECT, accounting for 79% of programmes of ECT in 2017, and 78% in 2018.

ECT treatment without consent

- **19%** of programmes (66) in 2017, and **19%** (69) in 2018, of ECT involved one or more treatments without consent.
- **81%** of treatments (2,261) were administered with consent, and **19%** (540 treatments) without, in 2017. In 2018, **82%** of treatments (2,420) were administered with consent, and **18%** of treatments (516) were administered without.
- **4%** of residents (15) withdrew consent during the course of their programme of ECT in 2017, falling to **3%** of residents (12) in 2018.

Reasons for and outcomes of ECT

- Depressive disorders[1] were reported for **77%** of residents who were administered ECT in 2017, and accounted for **63%** in 2018.
- Refractory (resistance) to medication was the most common single indication for ECT, accounting for **61%** of programmes (212 programmes) of ECT in 2017, and **67%** (244) in 2018.
- Improvement was reported as the reason for ending a programme of ECT in **81%** of programmes in 2017, and **81%** in 2018.

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

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 ninth annual report on the use of ECT in approved centres. *The Administration of Electro-convulsive Therapy in Approved Centres: Activity Report 2017 & 2018* reports on 2017 and 2018 data, and includes previously published 2016 data (Mental Health Commission, 2018a). Data for previous years (2008 to 2016) are available at www.mhcirl.ie/publications.

Data in this report relate to the administration of ECT both prior to and following the implementation of the Mental Health (Amendment) Act 2015, which came into effect on the 15th February 2016. This report includes ECT that was administered in advance of this Act, in accordance with the *Rules Governing the Use of Electro-convulsive Therapy* (Mental Health Commission, 2009a) and the *Code of Practice on the Use of Electro-convulsive Therapy for Voluntary Patients* (Mental Health Commission, 2009b), which regulated the administration of ECT in approved centres at the time.

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 2017 and 2018, nationally, by sector (by Community Healthcare Organisations (CHOs) and independent service providers) and in individual services.

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. In the absence of a national mental health information system, 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.

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 2016, 2017 and 2018. 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

	2016	2017	2018
Approved centres	66	64	65
Approved Centres using ECT	15	16	15
Approved centres referring residents for ECT	5	8	15

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.

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 at www.mhcirl.ie/inspectorate _of_mental_health_services).
- 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.

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.

- 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.

2.4 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 16,743 admissions nationally in 2017 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% and 14.3% of admissions in 2017 and 2018 respectively.

Table 2: Total admissions and involuntary admissions

	2016	2017	2018
Total admissions*	17,290	16,743	17,000
Involuntary admissions**	2,414	2,337	2,435

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

** 'Involuntary admissions' *data are sourced from the Mental Health Commission Annual Report (2017) and (2018)*

The Health Research Board reported that in 2017, depressive disorders were the most common diagnoses recorded, accounting for 24.7% of all admissions to in-patient mental health services. Schizophrenia, schizotypal and delusional disorders accounted for 20.4% of 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 years, with 50.2% female admissions in 2017, and 49.9% female admissions in 2018. Females had a slightly higher rate of admission for depressive disorders than males, with women accounting for 54.5% in 2017, and 55.5% in 2018, of admissions with a primary diagnosis of depressive disorders (Daly and Craig, 2018 and 2019).

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.

3. ECT activity data

3.1 Programmes and treatments

Data are presented for 2017 and 2018, with 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 2017, 257 residents were administered one or more programmes of ECT. In total, 349 programmes of ECT were administered. The number of treatments within a programme ranged from one to twelve treatments, with 2,801 treatments of ECT being administered in total, resulting in an average of 8.03 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.

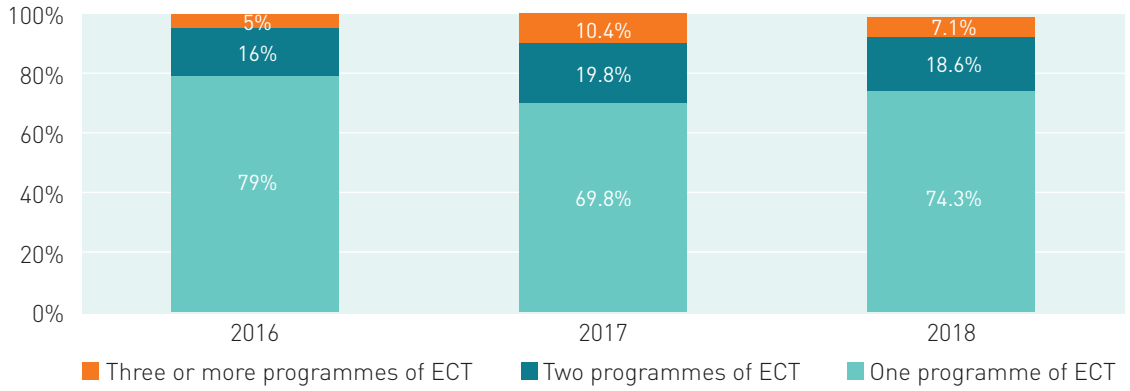
Table 3: Overview of ECT administration: residents, programmes and treatments

	2016	2017	2018
Residents administered ECT	263	257	283
Programmes of ECT administered	337	349	365
Total treatments of ECT administered	2,558	2,801	2,936

PROGRAMMES PER RESIDENT

Figure 1 shows that the majority of residents were administered one programme of ECT (69.8% in 2017 and 74.3% in 2018). In 2017, 19.8% of residents were administered two programmes of ECT, followed by 10.3% 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



TREATMENTS PER PROGRAMME OF ECT

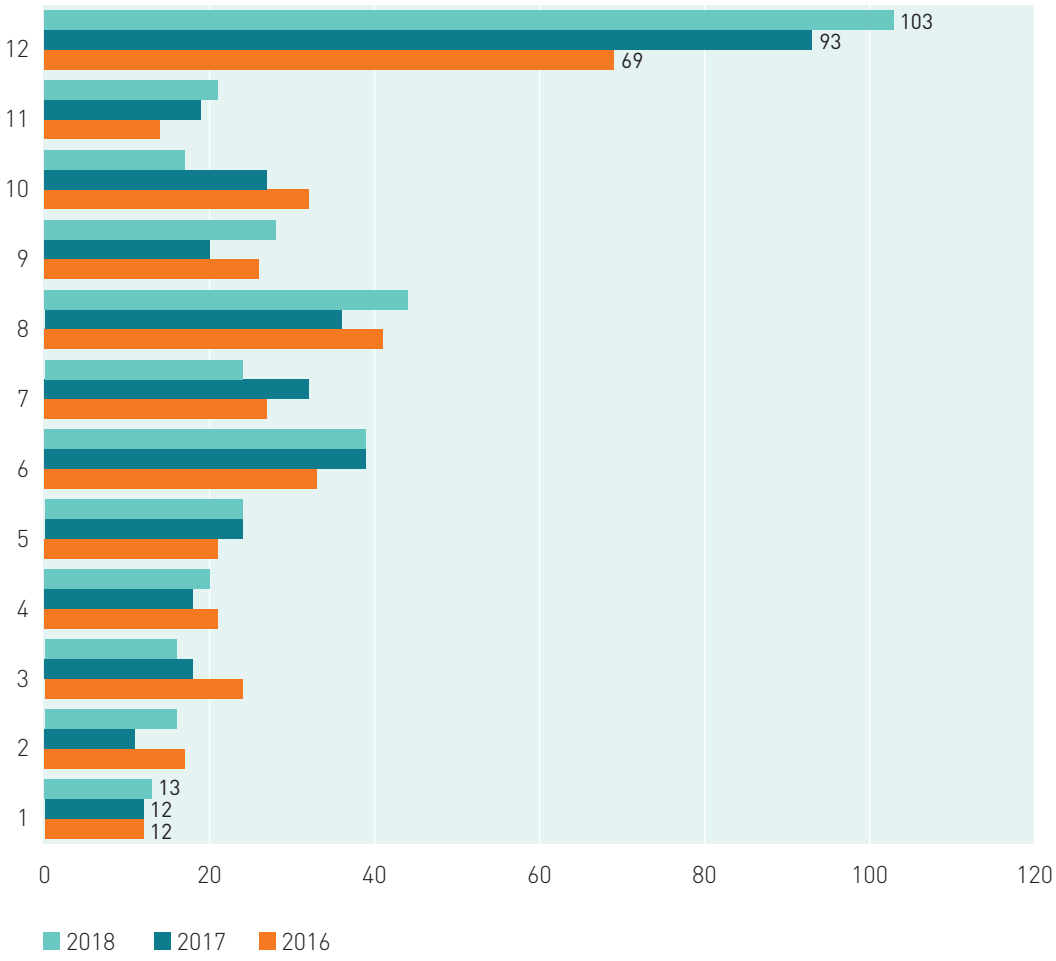
A programme of ECT refers to no more than 12 treatments of ECT prescribed by a consultant psychiatrist, with the total number of treatments administered in a programme of ECT varying from one to 12 treatments. Table 4 shows that the average number of treatments per programme was 8 in both 2017 and 2018.

Table 4: Treatments per programme of ECT

	2016	2017	2018
Average number of treatments per programme	8	8	8
Programmes of 12 treatments	69	93	103
Programmes of 1 treatment	12	12	13

The majority of programmes of ECT (96.6% in 2017 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 12, which accounted for 26.6% of all programmes in 2017, and 28.2% in 2018. The distribution in the number of treatments per programme can be seen in Figure 2.

Figure 2: Number of treatments per programme



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 shows that the average duration of all ECT programmes was 41 days in 2017, and 46 days in 2018. The average duration of programmes of maintenance ECT was 96 days in 2017, and 120 days in 2018, while the average duration for ECT programmes to treat urgent or acute issues was 32 days in 2017, 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

	Number of days		
ECT programme type	**2016**	**2017**	**2018**
All programmes	38	41	46
Maintenance ECT	99	96	120
Maintenance ECT excluded	28	32	42

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 2014 to 2018. In 2017, 61.5% of approved centres did not provide an ECT service, 24.6% of approved centres provided an ECT service, and 12.3% of services referred residents to other approved centres for ECT treatment. In 2018, 53.1% of approved centres did not provide an ECT service, 23.4% of approved centres provided an ECT service and 23.4% of services referred residents to other approved centres for ECT treatment.

Table 6: Overview of approved centres using ECT

	2014	2015	2016	2017	2018
ECT service	18	15	15	16	15
ECT service – not used	0	2	2	0	0
ECT service by referral	5	6	5	8	15
ECT service by referral – not used	0	0	1	0	0
No ECT service	41	41	43	40	35
Total approved centres	**64**	**64**	**66**	**64**	**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 2017 and 2018, with 2016 data included for context. The approved centres are ordered by sector (by CHO or national provider).

Approved centres in eight out of nine CHO areas reported one or more programmes of ECT in the period spanning 2016 and 2017, with all nine CHO areas reporting one or more programmes of ECT in 2018. CHO 4 did not report any programmes in 2017. Acute Psychiatric Unit, Tallaght Hospital reported the highest number of programmes (29) of ECT in a HSE operated service in 2017. In 2018, Acute Adult Mental Health Unit (formerly Department of Psychiatry), University Hospital Galway reported the highest number of programmes (22).

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 2017, three approved centres in the independent sector accounted for over half (54%) of all programmes. They were St Patrick's University Hospital, St Edmundsbury Hospital (by referral) and St John of God Hospital. St Patrick's University Hospital, a large 241-bed service reported the highest number of programmes (135 in 2017, and 166 in 2018). 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 2016-2018.

The national forensic service, national intellectual disability service and CAMHS services did not report any programmes of ECT.

In 2017, five of the approved centres using or referring to other services for ECT (22%) reported fewer than five programmes. Given the sensitive nature of the data, if fewer than five programmes of ECT were reported by an approved centre "<5" is used in the table; in 2018, this rose to eleven approved centres (37%).

Table 7: Programmes of ECT reported by each approved centre

Approved centres by area / sector	Administration	2016	2017*	2018†
CHO Area 1 – Population 394,333 – Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan				
Acute Psychiatric Unit, Cavan General Hospital	ECT service	0	<5	<5
Department of Psychiatry, Letterkenny University Hospital	ECT service	13	<5	11
Sligo/Leitrim Mental Health In-patient Unit	ECT service	<5	8	<5
CHO Area 2 – Population 453,109 – Galway, Roscommon, Mayo				
Acute Adult Mental Health Unit (Formerly Department of Psychiatry), University Hospital Galway	ECT service	18	20	22
Adult Mental Health Unit, Mayo University Hospital	ECT service	<5	9	6
Department of Psychiatry, Roscommon University Hospital	By referral*†† †	<5	<5	0
CHO Area 3 – Population 384,998 – Clare, Limerick, North Tipperary/East Limerick				
Acute Psychiatric Unit, Ennis Hospital	By referral*†† †	<5	<5	<5
Acute Psychiatric Unit 5B, University Hospital Limerick	ECT service	24	18	17
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*†† †	0	0	<5
Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	By referral*†† †	0	0	<5
Units 2, 3, 4, 5 and Unit 8 (Floor 2), St Stephen's Hospital, Cork	By referral*†† †	0	0	<5
CHO Area 5 – Population 510,333 – South Tipperary, Carlow/Kilkenny, Waterford, Wexford				
Department of Psychiatry, St Luke's Hospital	ECT service	8	10	<5
Department of Psychiatry, University Hospital Waterford	ECT service	13	14	17
CHO Area 6 – Population 388,297 – Wicklow, Dun Laoghaire, Dublin South East				
Elm Mount Unit, St Vincent's University Hospital	ECT service	7	27	11
Newcastle Hospital	By referral*†† †	13	13	<5
CHO Area 7 – Population 702,586 – Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West				
Acute Psychiatric Unit AMNCH (Tallaght) Hospital	ECT service	12	29	16
Jonathan Swift Clinic, and Connolly Norman Ward, St James's Hospital	By referral*†† †	10	15	17
Lakeview Unit, Naas General Hospital	ECT service	9	14	17
CHO Area 8 – Population 616,229 – Laois/Offaly, Longford/Westmeath, Louth, Meath				
Department of Psychiatry, Midland Regional Hospital, Portlaoise	ECT service	16	5	9
Drogheda Department of Psychiatry	By referral	0	0	<5
St Loman's Hospital, Mullingar	ECT service	<5	7	5
Maryborough Centre, St Fintan's Hospital	By referral*†† †	<5	<5	<5
St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre	ECT service	<5	<5	0

Approved centres by area / sector	Administration	2016	2017*	2018†
CHO Area 9 – Population 621,405 – Dublin North, Dublin North Central, Dublin North West				
Ashlin Centre	By referral	0	0	<5
Department of Psychiatry, Connolly Hospital	By referral	0	0	<5
O'Casey Rooms	By referral*†† ‡	0	<5	<5
St Vincent's Hospital, Fairview	By referral*†† ‡	0	<5	<5
Forensic Service – National Coverage				
Central Mental Hospital	By referral	0	0	0
Independent – National Coverage				
St Edmundsbury Hospital	By referral*†† ‡	19	14	26
St John of God Hospital & Cluain Mhuire	ECT service	27	39	43
St Patrick's University Hospital[b]	ECT service	121	135	166
Total all approved centres		**337**	**349**	**365**

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

a *In 2016, Department of Psychiatry, Roscommon University Hospital referred residents to Department of Psychiatry, University Hospital Galway; Acute Psychiatric Unit, Ennis to Acute Psychiatric Unit 5B, University Hospital Limerick; Newcastle Hospital to Elm Mount Unit, St Vincent's University Hospital; Jonathan Swift Clinic, St. James's Hospital to St Patrick's University Hospital and the Acute Psychiatric Unit, Tallaght Hospital; and St Edmundsbury Hospital to St Patrick's University Hospital.*

* *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.*

‡ *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.*

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

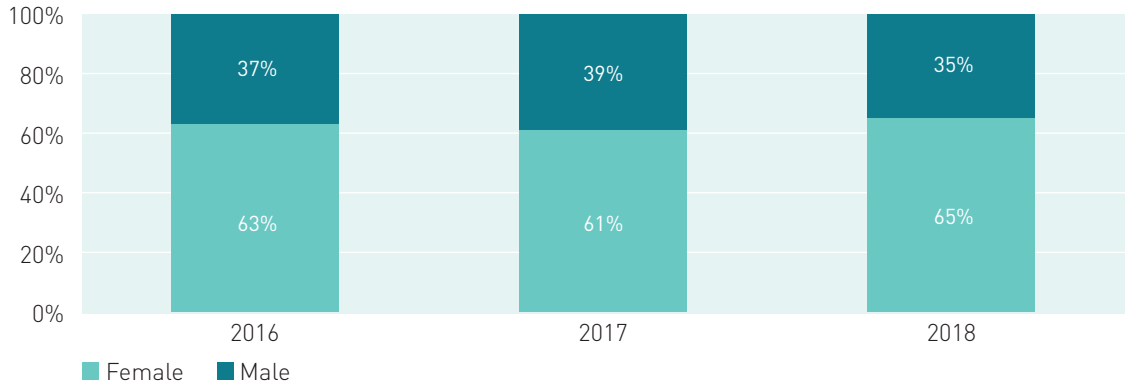
3.3 People receiving ECT

This section provides information about the residents to whom ECT was administered in 2017 and 2018, including age, gender and legal status.

DEMOGRAPHICS: AGE AND GENDER

Approximately three-fifths of residents in 2017, and two-thirds in 2018, were female[4]. Figure 3 shows the gender of residents who were administered ECT between 2016 and 2018.

Figure 3: Gender of residents who were administered ECT



The average age of residents who were administered ECT in both 2017 was 57 years of age, and 59 years of age in 2018, with ages ranging from 22 to 90 years in 2017, and from 20 to 91 years in 2018. Figure 4 shows the age range distribution by gender.

4 This is consistent with comparable jurisdictions (ECT Accreditation Service, 2017; Scottish ECT Accreditation Network, 2017).

Figure 4: Age range by gender of residents who were administered ECT

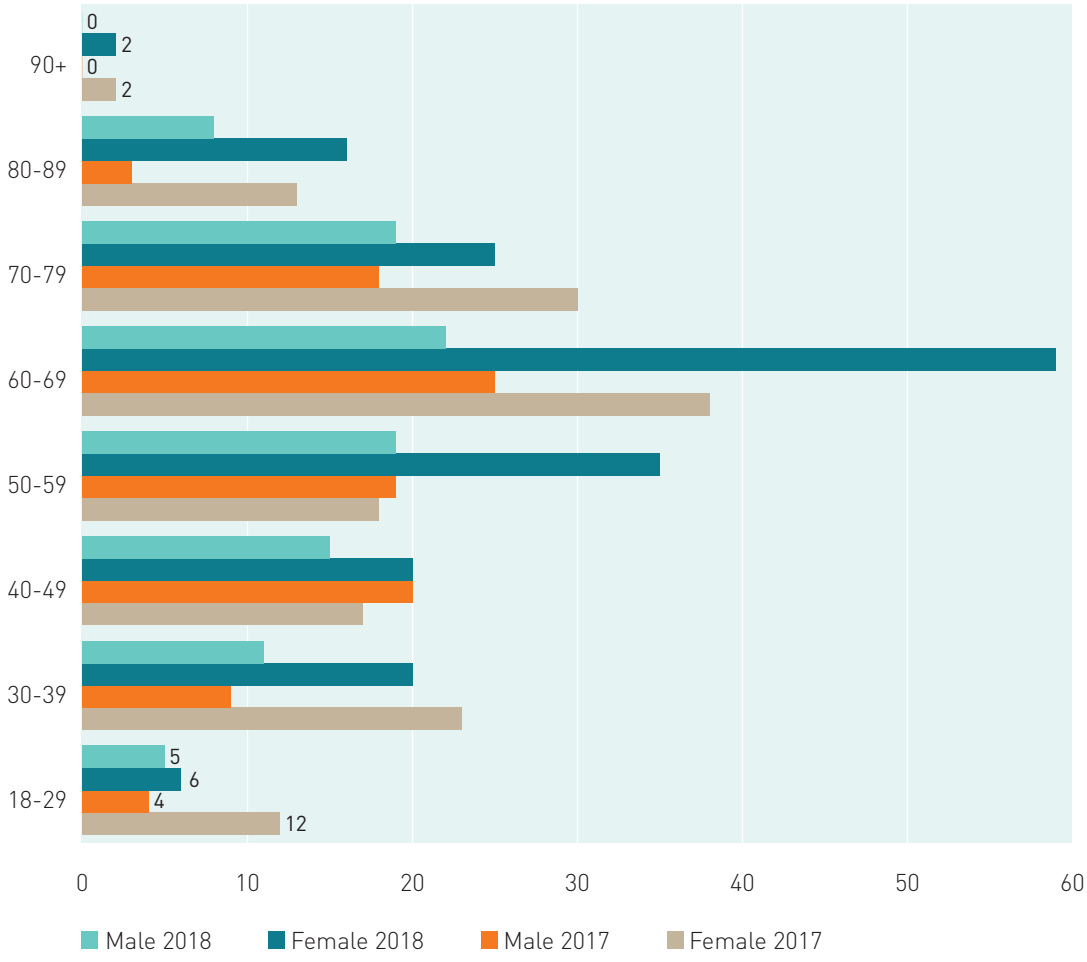


Figure 4 shows the age range distribution by gender of residents receiving ECT.

LEGAL STATUS

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

Table 8 shows that in 2017, 79% of programmes of ECT were administered to residents who were admitted on a voluntary basis when they commenced their programme of ECT, falling to 78.4% in 2018. In each year, over one-fifth (21%) of programmes were commenced when the legal status of the patient was involuntary.

Table 8: Programmes of ECT by residents' legal status

Legal Status	2016	2017	2018
Voluntary	84%	79%	78.4%
Involuntary	16%	21%	21.1%
Outpatient	-	-	0.5%

A programme of ECT may run over a number of weeks or months, meaning that there potential for a resident's legal status to change during the course of the programme. Table 9 shows that a change in legal status was reported in relation to twelve programmes of ECT 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

		2016	2017	2018
Change	Involuntary to voluntary	17	8	13
	Voluntary to involuntary	-	4	6
Totals	Total changes to legal status	17	12	19
	Total programmes	337	349	365

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.[5] 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.[6] The authorisation and approval is made on a specified statutory form (Form 16)[7], 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 nearly one-fifth (19%) of programmes had one or more treatments without consent in both 2017 and 2018.

Table 10: Programmes of ECT with one or more treatment without consent

		2016	2017	2018
Programmes without consent	Number	48	66	69
	% of total	14%	19%	17.6%

In 2017, a total of 540 individual treatments of ECT were administered without consent; 19.3% of all treatments. In 2018, a total of 516 individual treatments of ECT were administered without consent; 17.6% of all treatments.

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.

5 Section 59 *Mental Health Act 2001*.

6 Section 60 *Mental Health Act 2001*.

7 Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent.

DIAGNOSIS

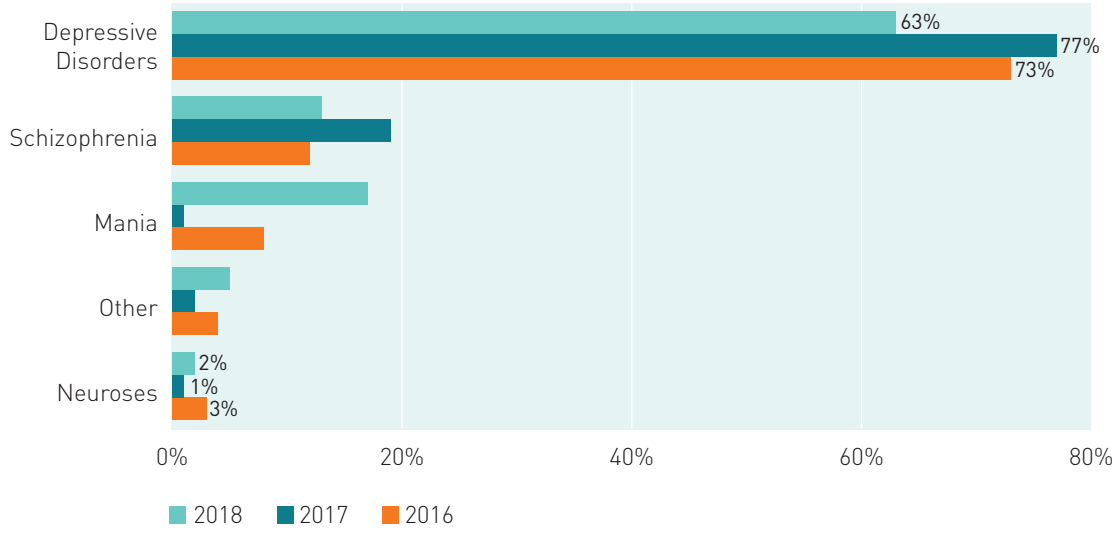
In 2017, more than three-quarters (77.4%) of programmes of ECT were administered to residents with a diagnosis of depressive disorders, followed by 18.9% with a diagnosis of schizophrenia, schizotypal, and delusional disorders, and 1.1% with a diagnosis of neuroses. In 2018, roughly two-thirds (62.5%) 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).

Other diagnoses included personality and behavioural disorders, and organic disorders. For a small number of programmes (6 programmes, or 1.7%, in 2017, and 13 programmes, or 3.6% in 2018), diagnostic information was not available. Figure 5 shows the breakdown of diagnoses from 2016 to 2018.

Figure 5 shows the breakdown of diagnoses between the years 2016 and 2018.

Figure 5: Programmes of ECT by diagnosis



INDICATIONS FOR ECT

Table 11 shows the breakdown of indications for programmes of ECT between 2016 and 2018.

Refractory (resistance) to medication was the most common single indication for ECT, accounting for 61% of indications in 2017, and 67% in 2018. Maintenance ECT and rapid response required accounted for the second and third most common indications respectively.

Table 11: Indications for ECT

Indications	2016	2017	2018
Refractory to medication	200 *59%*	212 *61%*	243 *67%*
Multiple indications**	48 *14%*	0 *0%*	0 *0%*
Maintenance ECT	46 *14%*	53 *15%*	55 *15%*
Rapid response required	22 *7%*	48 *14%*	45 *12%*
Acute suicidality	7 *2%*	13 *4%*	12 *3%*
Physical deterioration	8 *2%*	16 *7%*	7 *2%*
Other*	6 *2%*	7 *2%*	3 *1%*
Total Programmes	**337**	**349**	**365**

* *'Other' indications included 'pharmacological treatment contraindicated', 'side effects from medication', as well as a number of cases of the register not being completed.*

*** Approved centres in 2017 and 2018 did not record multiple indications for ECT.*

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 ending a programme of ECT between the years 2016 and 2018.

Improvement was reported as the reason for ending the majority of programmes of ECT, accounting for over four-fifths (82% in 2017 and 81% in 2018) of programmes. Programmes of ECT ended because the resident withdrew consent in 4% and 3% of programmes in 2017 and 2018 respectively, while no improvement or complications were the reasons for ending in 2017 in 5% and 2% of programmes respectively, and in 2018 in 4% and 2% of programmes respectively. 'Other' reasons for ending programmes of ECT accounted for 5% and 8% of programmes in 2017 and 2018 respectively.

Table 12: Reason for ending programme of ECT

Reason for ending ECT	2016	2017	2018
Improvement	281 *83%*	282 *82%*	294 *81%*
Other*	16 *5%*	17 *5%*	28 *8%*
No improvement	17 *5%*	17 *5%*	16 *4%*
Resident withdrew consent	13 *4%*	15 *4%*	12 *3%*
Complications	8 *2%*	7 *2%*	7 *2%*
Register not completed	2 *0.6%*	7 *2%*	7 *2%*
Total programmes	**337**	**349**	**365**

* *'Other' reasons for ending programmes of ECT included: underlying medical conditions and ECT course not having been completed.*

Note: a number of programmes' reasons for ending were left blank, resulting in a lower total number.

OUTCOME AT THE END OF A PROGRAMME OF ECT

Improvement was reported as the outcome in 89% of programmes of ECT in 2017, and 92% in 2018.

Table 13 presents the outcome at the end of programmes of ECT administered from 2016 to 2018.

Complete recovery or significant improvement was reported as the outcome at the end of the programmes of ECT for 69% of programmes of ECT in 2017, and 73% in 2018. Some or moderate improvement accounted for another 20% in 2017, and 19% in 2018, while 8% and 5% of programme reported no change in 2017 and 2018 respectively, and 1% reported a deterioration in both years.

Table 13: Outcome at end of ECT programme

Outcome	2016	2017	2018
Complete recovery	99 *29%*	89 *26%*	104 *28%*
Significant improvement	137 *41%*	148 *43%*	163 *45%*
Moderate improvement	43 *13%*	25 *7%*	26 *7%*
Some improvement	34 *10%*	44 *13%*	45 *12%*
No change	17 *5%*	29 *8%*	20 *5%*
Deterioration	4 *1%*	8 *1%*	4 *1%*
Register not completed	3 *1%*	7 *2%*	3 *1%*
Total	**337**	**349**	**365**

Note: a number of programmes' outcomes were left blank, resulting in a lower total for 2017

4. Compliance with ECT Rules & Code of Practice

Table 14: Compliance with ECT Rules and Codes of Practice, 2017-18

	2017		2018	
Centres	16	100.0%	15	100.0%
Applicable to Rules	13	81.3%	12	80.0%
Compliant with Rules	9	69.2%	7	58.3%
Applicable to Code	12	68.8%	14	86.7%
Compliant with Code	8	66.7%	9	64.3%

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 2017 and 2018, the Inspector of Mental Health Services inspected 16 and 15 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 2017, of those 16 approved centres, the *Rules* were not applicable for three centres, as they had only voluntary patients in receipt of ECT. The Code was not applicable for four approved centres, as they had no voluntary patients receiving ECT at the time of 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 lack of specific documentation, not all staff having up to date training and policies not being reviewed annually. 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 2017. Of the 13 approved centres for which the Rules were applicable, nine were compliant, while four were non-compliant. Of the four non-compliant approved centres, two had a low risk rating, and two a high risk rating.

Figure 6: Relevant approved centre compliance with Rules Governing the Use of Electro-convulsive Therapy, 2017

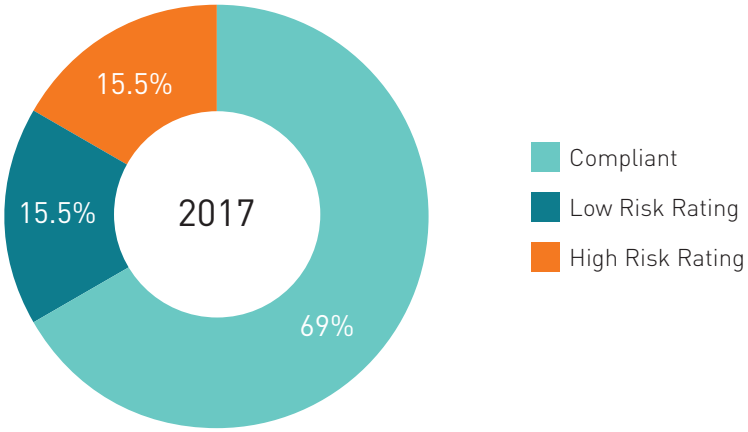


Figure 7 shows the numbers of approved centres compliant with the Rules governing ECT in 2018. Of the twelve approved centres for which the Rules were applicable, seven were compliant, while five were non-compliant. Of the five non-compliant approved centres, two had a low risk rating, two a moderate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

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

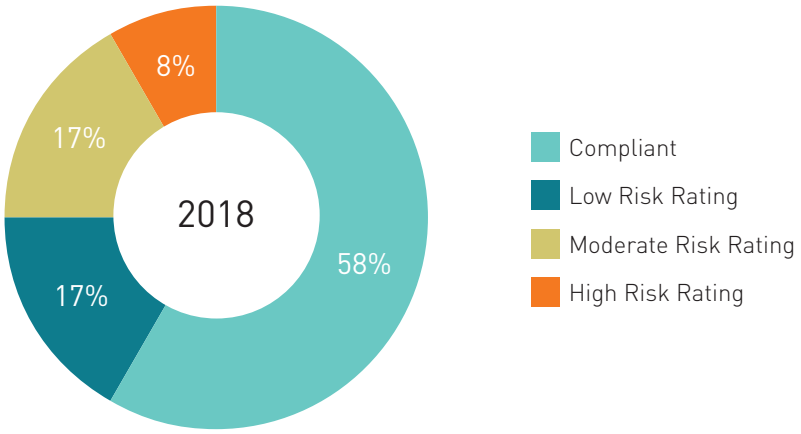


Figure 8 shows the numbers of approved centres compliant with the Code governing ECT in 2017. Of the twelve approved centres for which the *Codes* were applicable, eight were compliant, and four non-compliant. Of the four non-compliant centres, two had a low risk rating, and two a high risk rating.

Figure 8: Relevant approved centre compliance with Code of Practice on the Use of Electro-convulsive Therapy for Voluntary Patients, 2017

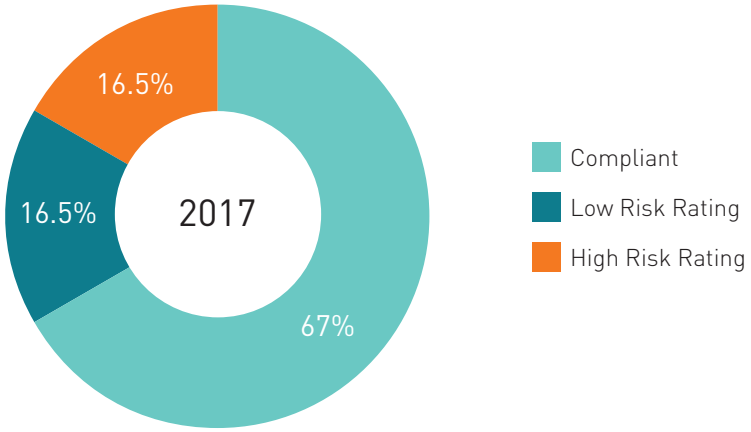
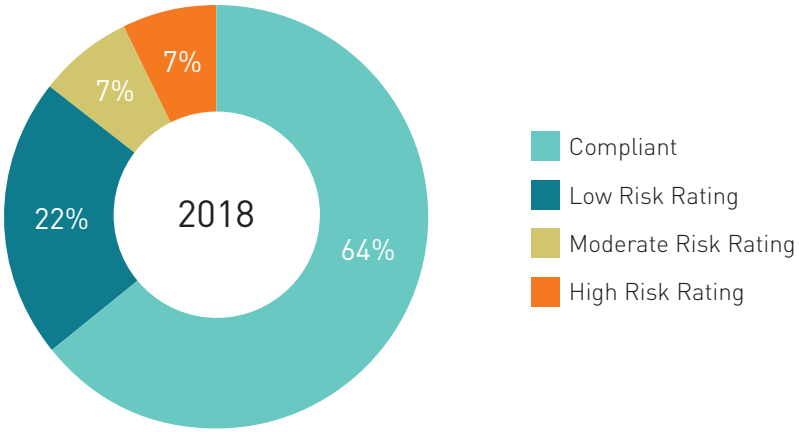


Figure 9 shows the number of approved centres compliant with the *Code* governing ECT in 2018. Of the 14 approved centres for which the Codes were applicable, nine were compliant, and five non-compliant. Of the five non-compliant, three had a low risk rating, one a moderate risk rating, and one a high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

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



Discussion

This report is being issued ten 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 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 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 greatly increased since 2015, which may indicate that more residents are undergoing the full complement of treatments per programme than in previous years.

Figure 10: Ten-year comparison of number of residents and programmes in approved centres

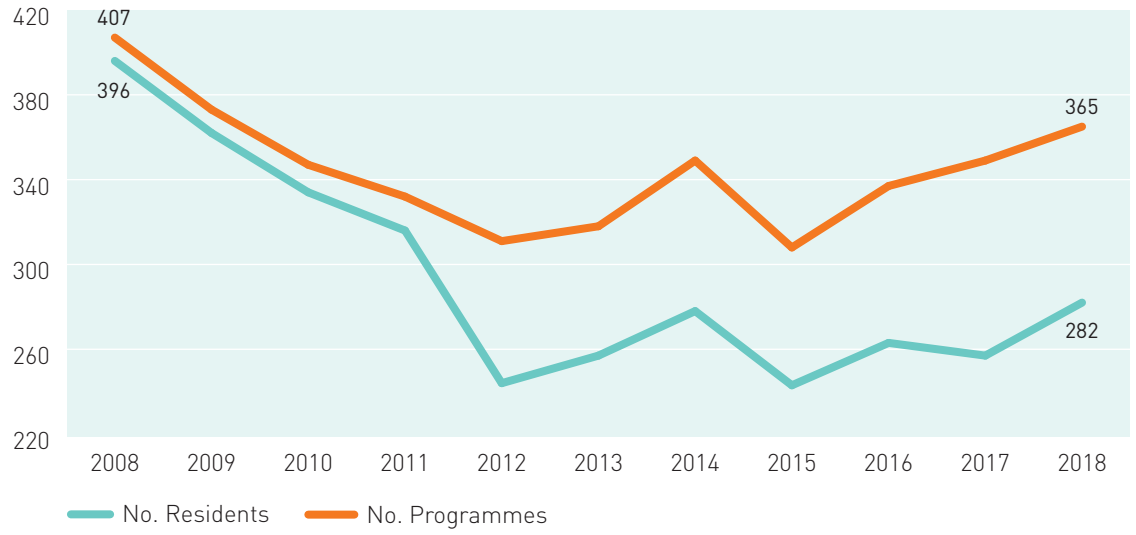


Figure 11: Ten-year comparison of number of ECT treatments per year

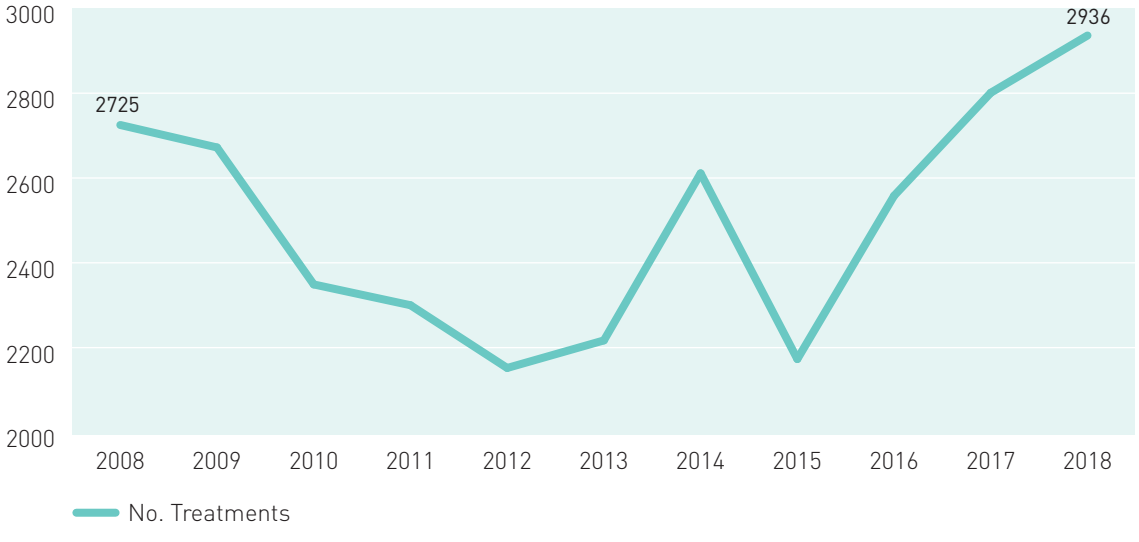


Figure 12 outlines the total admissions recorded by the Health Research Board between the years 2008 and 2018, compared with the numbers of patients involuntarily admitted to in-patient mental health services over the same period of time.

Figure 12: Ten-year comparison of total admissions as compared with involuntary admissions

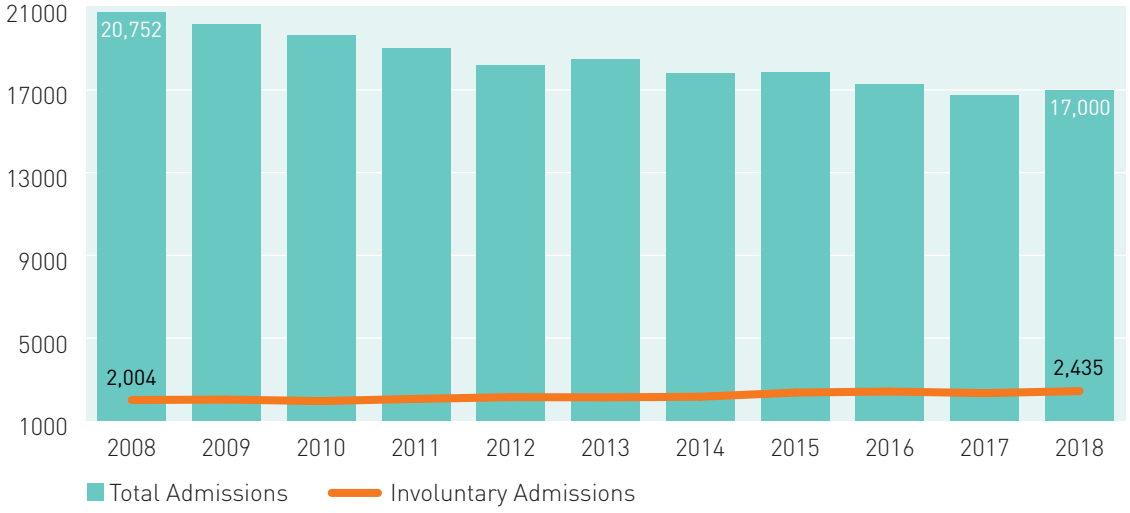


Figure 13 shows that the ratio of female to male residents remained fairly static (approximately two-to-one) over the ten-year period. As previously discussed, this may be as a result of the relatively higher rate of diagnosed depressive disorders in women than men in Ireland.

Figure 13: Ten-year comparison of gender of residents who were administered ECT

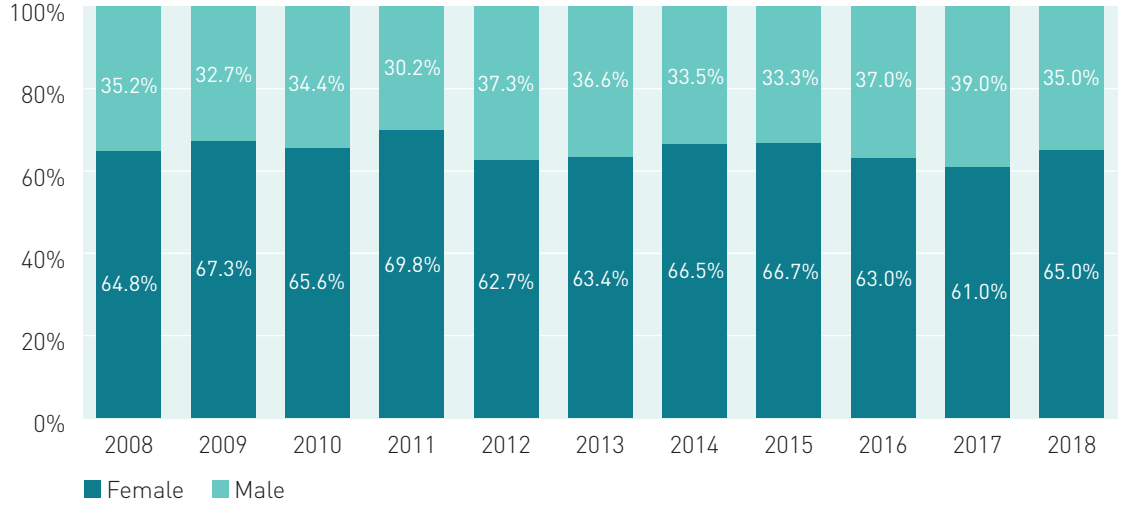


Figure 14 shows that the most common indication for the use of ECT since 2008 has consistently been that the residents are refractory, or resistant, to medication.

Figure 14: Ten-year comparison of indications for use of ECT

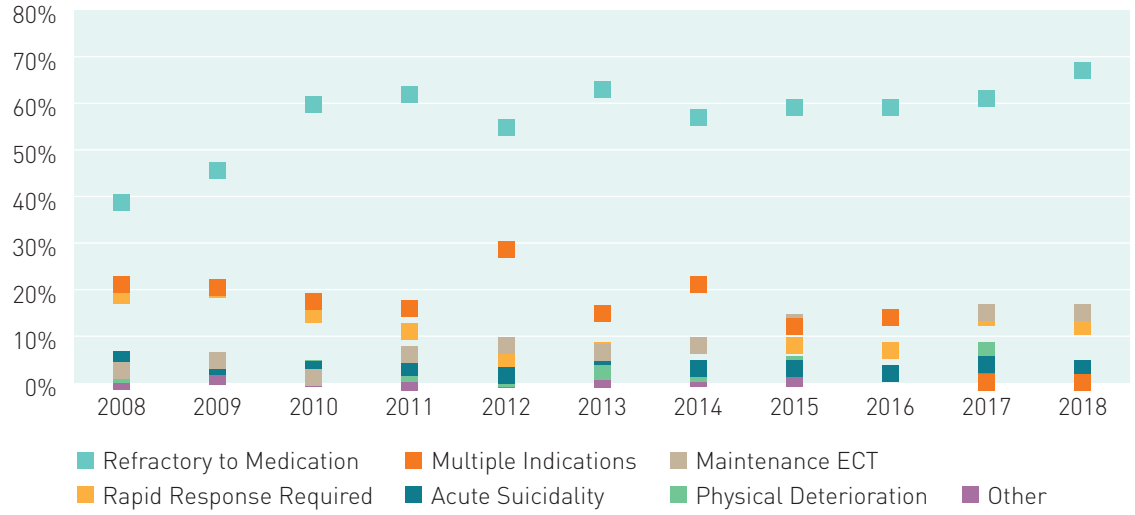


Figure 15 shows that, over the ten-year period since 2008, the most common diagnosis for residents undergoing ECT treatment has consistently been depressive disorders (between 70% and 80% per annum), followed by schizophrenic, schizotypal, and delusional disorders. The least common diagnoses have tended to be personality and behavioural disorders, and neuroses.

Figure 15: Ten-year comparison of programmes of ECT by diagnosis

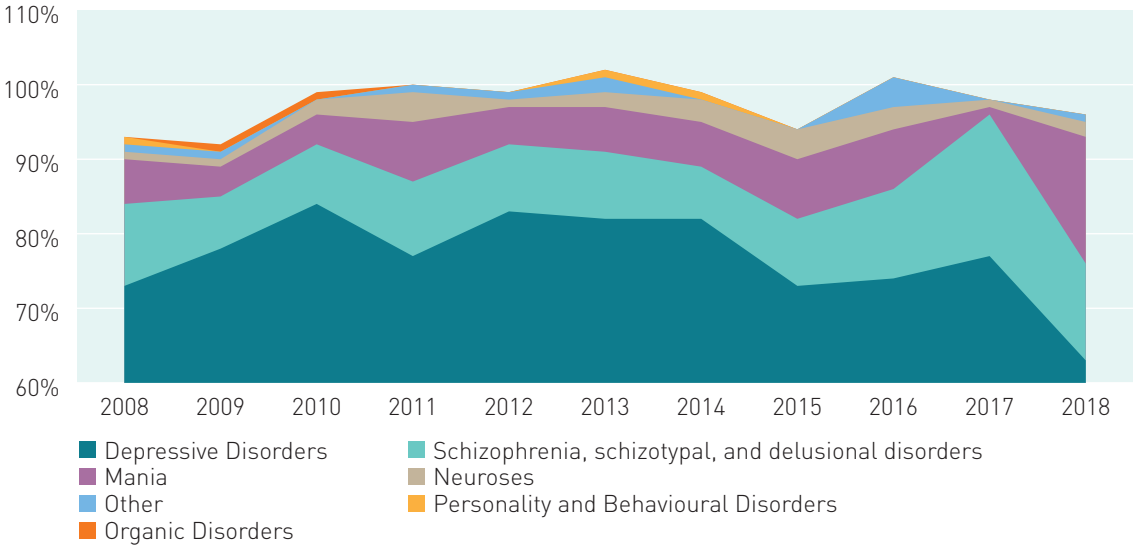


Figure 16 shows that significant improvement and complete recovery have consistently been the two most common outcomes of a programme of ECT treatment since 2008, with deterioration and 'No Change' consistently being the two least common outcomes. This trend would indicate that ECT treatment generally 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 alternative methods such as traditional medication or alternative methods.

Figure 16: Ten-year comparison of outcomes of ECT treatment

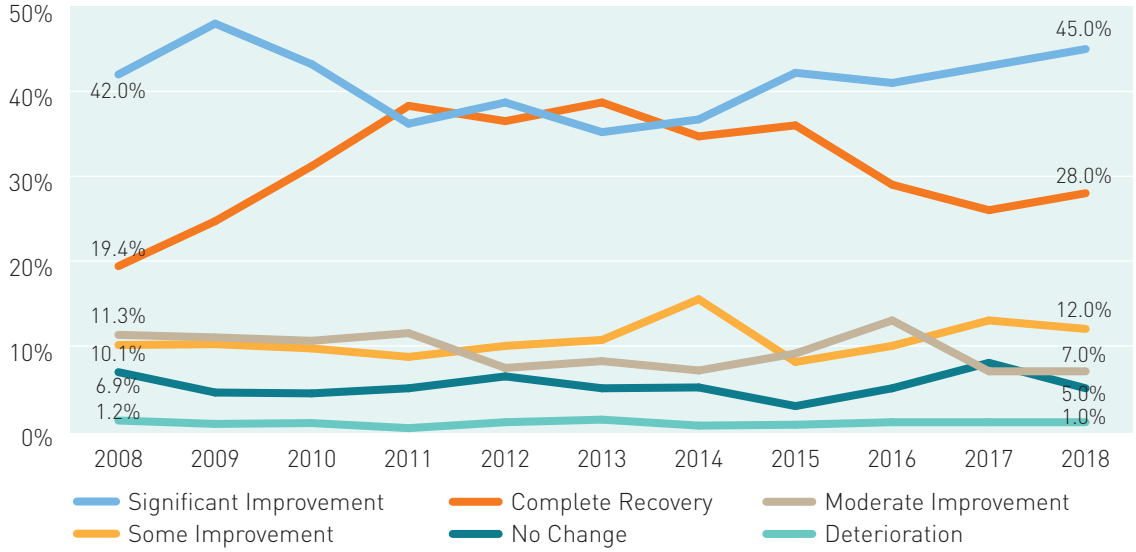
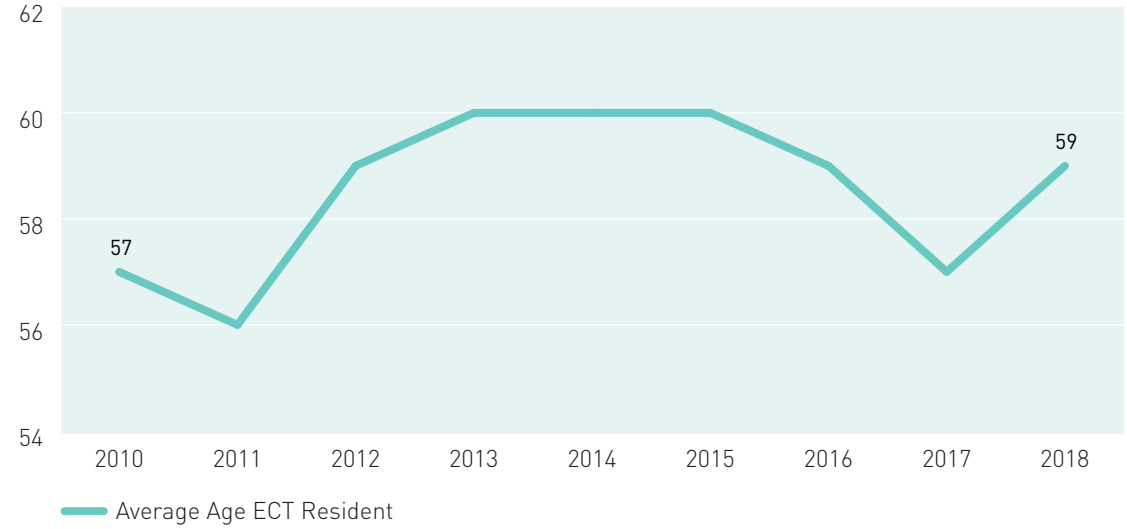


Figure 17 indicates that the average age of residents receiving ECT rose considerably between 2010 (the first year that the age of ECT residents was collected from approved centres) (57 years of age), to 60 years of age in 2013. The average age between 2017 and 2018 was 58 years of age. A reason suggested for the elevated average age of ECT users, as opposed to the average age of residents admitted to Irish hospitals generally (including approved centres) (45.4 years of age in 2017[8], and 45 years of age in 2018[9]) 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 medication.

Figure 17: Ten-year comparison of average age of ECT residents



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

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

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.

References

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

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

Daly A, Craig S (2019) HRB *Statistics Series 39 Activities of Irish Psychiatric Units and Hospitals 2018*. Health Research Board. (Dublin).

Department of Health (2001), *Mental Health Act 2001*. (Dublin Stationery Office).

Department of Health (2015), *Mental Health Amendment Act 2015*. (Dublin Stationery Office).

ECT Accreditation Service (ECTAS) (2017), *ECT Minimum Dataset 2016-17, Activity Report – England, Wales, Northern Ireland & Republic of Ireland*. Royal College of Psychiatrists. (London).

Mental Health Commission (2009a), *Rules Governing the Rules Governing the Use of Electro-Convulsive Therapy*. Version 2. (Dublin).

Mental Health Commission (2009b), *Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients*. Version 2. (Dublin).

Mental Health Commission (2016a), *The Administration of Electro-convulsive Therapy in approved centres: Activity Report* 2014/2015. (Dublin).

Mental Health Commission (2016b), *Rules Governing the Rules Governing the Use of Electro-Convulsive Therapy*. Version 3. (Dublin).

Mental Health Commission (2016c), *Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients*. Version 3. (Dublin).

Mental Health Commission (2017), *Annual Report including the Report of the Inspector of Mental Health Services* 2016. (Dublin).

National Institute for Health and Care Excellence (2009), *Depression in adults: recognition and management*. (London).

Scottish ECT Accreditation Network (2017), *Annual Report 2016: A summary of ECT in Scotland for 2016*. NHS National Services Scotland. (Edinburgh).

Shannon, J. (2016, September 15), Patients unwilling to consent to ECT. *Irish Medical Times*. Retrieved from www.imt.ie/

World Health Organisation (WHO) (1992), *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. (Geneva).

Appendix 1: ECT data collection template and Form 16s

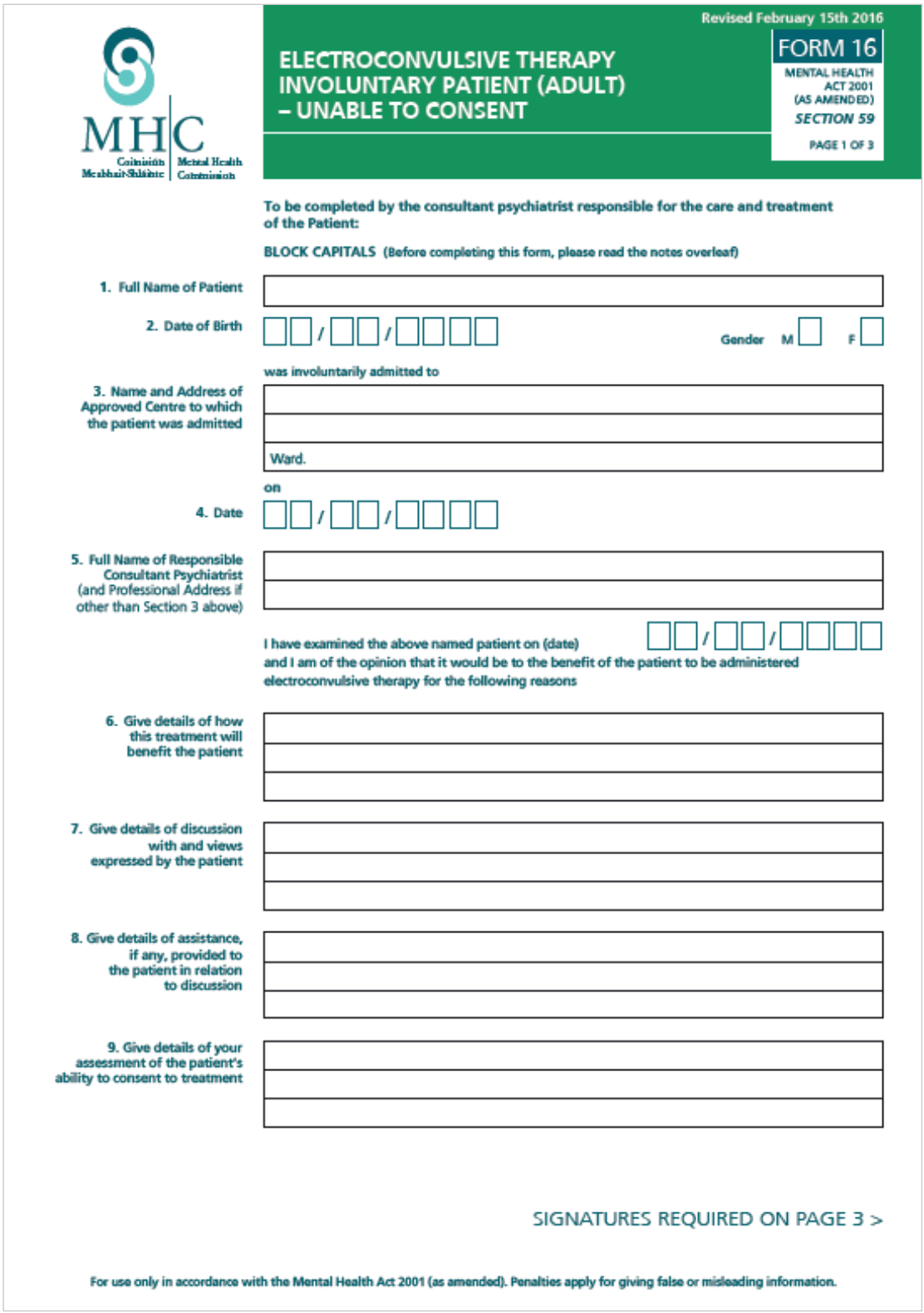
Annual ECT data collection template

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

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

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.

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. ☐

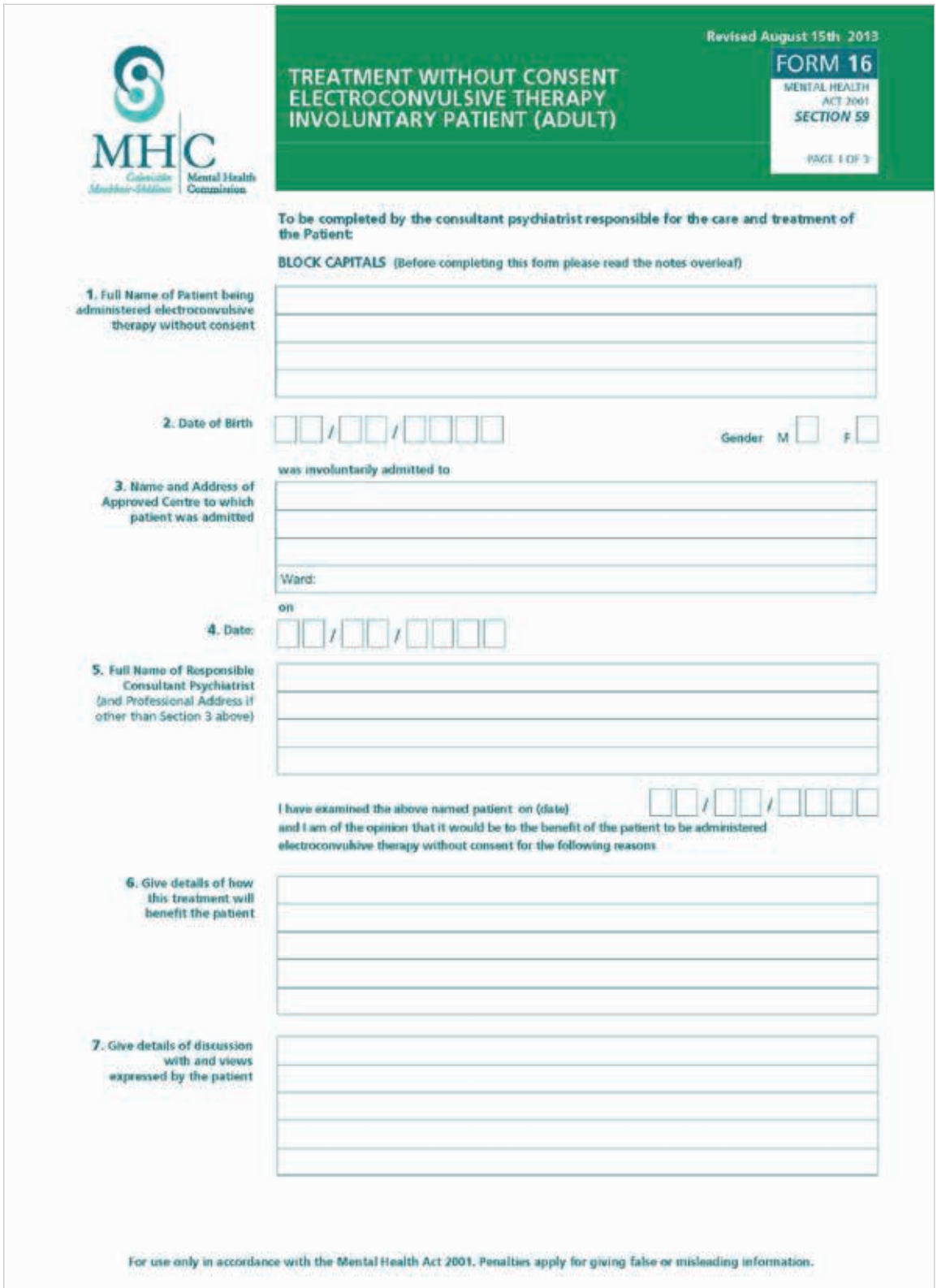
Signed: _____ MCRN: _____

(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: *TREATMENT WITHOUT CONSENT ELECTRO-CONVULSIVE THERAPY INVOLUNTARY PATIENT (ADULT)* FORMS RELATING TO PATIENTS WHO WERE UNWILLING OR UNABLE TO CONSENT TO ECT TREATMENT. EFFECTIVE TO 14TH FEBRUARY 2016



MHC Mental Health Commission

Revised August 15th 2013

TREATMENT WITHOUT CONSENT
ELECTROCONVULSIVE THERAPY
INVOLUNTARY PATIENT (ADULT)

FORM 16
MENTAL HEALTH ACT 2001
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 being administered electroconvulsive therapy without consent

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

was involuntarily admitted to

3. Name and Address of Approved Centre to which 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 without consent 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

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

MHC Mental Health Commission

Revised August 15th 2013

TREATMENT WITHOUT CONSENT ELECTROCONVULSIVE THERAPY INVOLUNTARY PATIENT (ADULT)

FORM 16
MENTAL HEALTH ACT 2001
SECTION 59

8. Give details of assistance, if any, provided to patient in relation to discussion/decision making

This patient is;

unable ☐ or unwilling ☐ to give consent to this treatment.

I approve this programme of electroconvulsive therapy. ☐

I have given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment. Yes ☐ No ☐

Signed: _____

(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.

9. 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 without consent for the following reasons

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

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

12. Give details of assistance, if any, provided to patient in relation to discussion/ decision making

This patient is;

unable ☐ or unwilling ☐ to give consent to this treatment.

I authorise this programme of electroconvulsive therapy. ☐

Signed: _____

(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. 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

Appendix 2 Table 1: 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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