mhc
coimisiun meabhair - shláinte
mental health commission

The Administration Of Electro-Convulsive Therapy in Approved Centres:

Activity Report 2020

Promoting Quality, Safety and Human Rights in Mental Health

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GLOSSARY

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

Code of Practice refers to the *Code of Practice on the Use of Electro-Convulsive Therapy* for Voluntary Patients, prepared by the MHC in accordance with Section 33(3)(e) of the Mental Health Act 2001 (as amended).

Community Healthcare Organisations (CHOs) were established by the Health Service 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 in 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, which is designed to prevent relapse of illness. The purpose of maintenance ECT is to give the treatments as infrequently as possible, while preventing a relapse of symptoms (Source: ECT Accreditation Service, 2017).

Mental illness means a state of mind of a person which affects the person's thinking, perception, emotion or judgement 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 outpatient or day-patient basis in an approved centre.

Rules refer to the *Rules Governing the Use of ECT*, made by the MHC in accordance with Section 59(2) of the Mental Health Act 2001 (as amended).

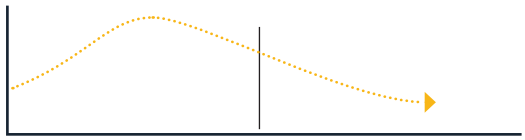
Voluntary patient is a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order

ACTIVITY SUMMARY 2020

All figures included in this summary are calculated across 2019 and 2020, unless otherwise indicated.

Programmes and treatments of ECT

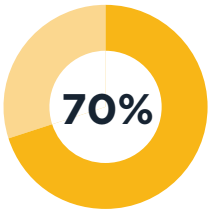
Approved centres reported that **300 programmes of ECT** were administered to **239 residents** in 2020, compared to **395** programmes of ECT administered to **286** residents in 2019.



The rate of ECT programmes per resident was **1.3 programmes** in 2020 and 1.4 programmes in 2019.

7.8 treatments

A programme of ECT may involve up to 12 individual treatments of ECT. The average number of treatments per programme was **7.8** in 2020, compared to **7.9** in 2019.



In 2020, **70%** of residents who received ECT were administered one programme of ECT, a decrease from 73% in 2019.

A total of **2,329** individual treatments of ECT were administered in 2020, a 25% decrease in comparison to 2019 (**3,124**).

Services providing ECT

Fourteen approved centres (23%) provided an ECT service in 2020, a decrease from **17** approved centres (26%) in 2019.

A further **five** approved centres (8%) reported that they referred residents to another approved centre for ECT treatment in 2020, compared to **14** approved centres reporting referral to another approved centre (19%) for treatment in 2019.

In 2020, **77%** of relevant services (those administering ECT to involuntary patients) were compliant with all aspects of the *Rules Governing the Use of ECT*, an increase from 61% compliance in 2019.

In 2020, **86%** of relevant services were compliant with all aspects of the *Code of Practice on the Use of ECT*, an increase from 81% compliance in 2019.

People receiving ECT

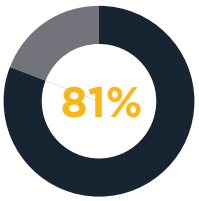
In 2020, the average age of all residents who were administered ECT was **62 years**, a slight increase from an average of 59 years in 2019. In 2020, residents receiving ECT ranged in age from **25 to 93 years**, compared to **22 to 89** years in 2019.

In both 2019 to 2020, more females than males received ECT, at a ratio of approximately **two-thirds to one-third** respectively. This was also the case in 2018. The higher ratio of female to male ECT recipients may reflect the relatively higher incidence of depressive illness in women as compared with men.

In 2020, **78%** of residents had been admitted on a voluntary basis when they commenced their programme of ECT, compared to 82% in 2019.

ECT treatment without consent

In 2020, **19%** of programmes of ECT (59), compared to 16% (62) in 2019, involved one or more treatments without consent. Section 3.4 outlines the rules for the administration of ECT in the absence of patient consent.



In 2020, **81%** of ECT treatments (1,881) were administered with consent, and **19%** (442) were administered without consent. In 2019, **84%** of treatments (2,621) were administered with consent, and **16%** of treatments (516) were administered without consent.

In 2020, **5%** of residents (16) withdrew consent during the course of their programme of ECT, compared to 3% (13) in 2019.

Reasons for and outcomes of ECT

Mood disorders[1] (including depression) were reported as a diagnosis for **80%** of residents who were administered ECT in 2020, compared to 85% of residents in 2019.

Refractory (resistant) to medication was the most common single indication for ECT, accounting for **64.3%** of programmes (193) in 2020, and 66% (259) in 2019.

Improvement was reported as the outcome in **63%** of programmes of ECT (189) in 2020, compared to 76% in 2019 (299). Outcome information was not provided for nine programmes (3%) in 2020.

[1] Mood (affective) disorders involve a change in mood either to depression (with or without anxiety) or to elation. The mood change is usually accompanied by a change in overall level of activity. Mood disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations (ICD-10, 2019).

CHAPTER

1

Introduction

INTRODUCTION

The Mental Health Commission (**MHC**) is the regulator for mental health services in Ireland. The MHC is an independent statutory body established in 2002. It'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 MHC's mission is to regulate and engage to promote, support, and uphold the rights, health and wellbeing 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.

In addition, the ECT Accreditation Scheme (ECTAS) was established in 2003 by the Royal College of Psychiatrists to support quality improvement of ECT clinics in both Ireland and the UK. The ECTAS standards have been developed for the purposes of review and accreditation of ECT centres, and there is also a guide for new or developing ECT services (Royal College of Psychiatrists, 2020). It should be noted that three ECTAS-accredited centres in Ireland delivered 64% of ECT programmes in 2020. While the MHC does not require approved centres to be ECTAS accredited in order to carry out ECT treatment, ECTAS is nevertheless recognised by the MHC as best practice, and all approved centres are encouraged to become ECTAS accredited in the future.

This is the MHC's eleventh annual activity report on the use of ECT in approved centres. *The Administration of Electro-Convulsive Therapy in Approved Centres: Activity Report 2020* reports on 2020 data and includes previously published 2018 and 2019 data (MHC, 2019). Data for previous years (2008 to 2019) are available at 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 15 February 2016. Following implementation of the Mental Health (Amendment) Act 2015, ECT may be administered to an involuntary patient without consent only where it has been determined that the patient is unable to consent to the treatment (see Section 3.4).

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

This report describes the administration of ECT in 2020 nationally, by sector (by Community Healthcare Organisations (CHOs) and independent service providers), and by individual service.

The MHC would like to thank staff in approved centres for their ongoing cooperation 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 MHC appreciates the local commitment required to report this data on an annual basis.

In early 2020, the MHC initiated roll-out of its online Comprehensive Information System (CIS) ECT function, which aimed at gathering better data about the use of ECT in approved centres. The system was piloted with two services, St Patrick's University Hospital and the 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 providing a contemporaneous data entry for each ECT treatment.

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

CHAPTER

2

About the data

ABOUT THE DATA

2.1 Data coverage

Data are presented for all approved centres that were entered on the Register of Approved Centres during 2018, 2019 and 2020. *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*

	2018	2019	2020
Approved centres	65	65	**66**
Approved Centres using ECT	15	18	**14**
Approved centres referring residents for ECT	15	14	**5**

2.2 Data collection

- *The Rules and Code of Practice on the use of electro-convulsive therapy* require that the ECT Register 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]

In 2020, data on administration of ECT were reported to the MHC from approved centres via (i) a form (Form 16: Treatment without Consent Electro-Convulsive Therapy Involuntary Patient (Adult)) (ii) an annual data-collection template, specified by the MHC (see Appendix 1) and (iii) via the MHC's online CIS ECT function (where available).

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 mhcirl.ie/what-we-do/regulation/approved-centres).
- 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, which limited what could reasonably be requested from services and reported on. Initially, data were processed by the relevant approved centres and subsequently by the MHC. Due to the additional information reported in the CIS ECT function, including the laterality (location of electrodes) of treatment, and the type of anaesthesia used, the *ECT Activity Report 2021* will likely contain more detailed analysis of ECT programmes and treatments, as all data will be submitted by approved centres in this manner. 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 subsequently in an independent service, within the same year. The exception is where residents have been referred from one approved centre to another for ECT – this is recorded and accounted for.
- As per the annual ECT data-collection template in Appendix 1, approved centres completing the

[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 2019 but the information regarding reason for ending a programme of ECT and the outcome for that programme may not have been completed until January 2020. 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.

form are requested to enter the name of each approved centre that refers a resident to them for a programme of ECT, if applicable. The MHC uses this field to determine the number of approved centres that refer residents for ECT treatment. Referral data in the report may therefore be skewed by referring approved centres not being included in the original collection data.

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 **15,391 admissions nationally** in 2020 and 16,710 in 2019. 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 **16%** of admissions in 2020, an increase on 2019 (14.3%).

Table 2: *Total admissions and involuntary admissions*

	2018	2019	2020
Total admissions[4]	17,000	16,710	**15,391**
Involuntary admissions[5]	2,435	2,390	**2,463**

The Health Research Board reported that in 2019 and 2020, **depressive disorders** were the most common diagnoses recorded, accounting for **24.5%** and **24%** respectively of all admissions to inpatient mental health services. In addition, **schizophrenia** accounted for **21%** and **22%** of all admissions in 2019 and 2020.

An equal proportion of male and female service users were admitted to services in 2020, according to Health Research Board figures. This was similar to 2019, with 49.1% of admissions being female. Females had a slightly higher rate of hospitalisation for depressive disorders than males, while males had a higher rate of hospitalisation for both schizophrenia and organic mental disorders (Daly and Craig, 2020).

[3] MHC data regarding involuntary admissions include Form 13 re-grades of voluntary patients, whereas the Health Research Board reports on the legal status 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 2018' (Daly and Craig, 2019), 'Activities of Irish Psychiatric Units and Hospitals 2019' (Daly and Craig, 2020), and 'Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2020' (Daly and Craig, 2021).

[5] 'Involuntary admissions' data are sourced from the *MHC Annual Report 2018, 2019* and *2020*.

CHAPTER

3

ECT activity data

ECT ACTIVITY DATA

3.1 Programmes and treatments

Data are presented for 2020 and 2019, with 2017 and 2018 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 provider), and in relation to each individual approved centre.

Total residents, programmes and treatments

Table 3 outlines the total number of residents who were administered ECT, the total number of ECT programmes, and the total number of administered treatments of ECT.

In 2020, **239** residents were administered **one or more programmes** of ECT. In total, **300** programmes of ECT were administered. The number of treatments within a programme ranged from 1 to 12 treatments, with **2,329** treatments of ECT being administered in total, resulting in an average of **7.8** treatments per programme. In 2019, 286 residents were administered one or more programmes of ECT, for a total of 395 programmes.

The number of treatments similarly ranged from 1 to 12 treatments, with 3,124 treatments being administered in total. The average number of treatments per programme in 2018 was 7.9.

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

	2018	2019	2020
Residents administered ECT	283	286	**239**
Programmes of ECT administered	365	395	**300**
Total treatments of ECT administered	2,936	3,124	**2,329**

Programmes per resident

Figure 1 shows that the majority of residents were **administered one programme** of ECT (**70% in 2020** and 72.7% in 2019). In 2020, **22% of residents were administered two programmes** of ECT, followed by 8% who were administered three or more programmes. In 2019, 15.7% of residents were administered two programmes of ECT, with 11.5% being administered three or more programmes.

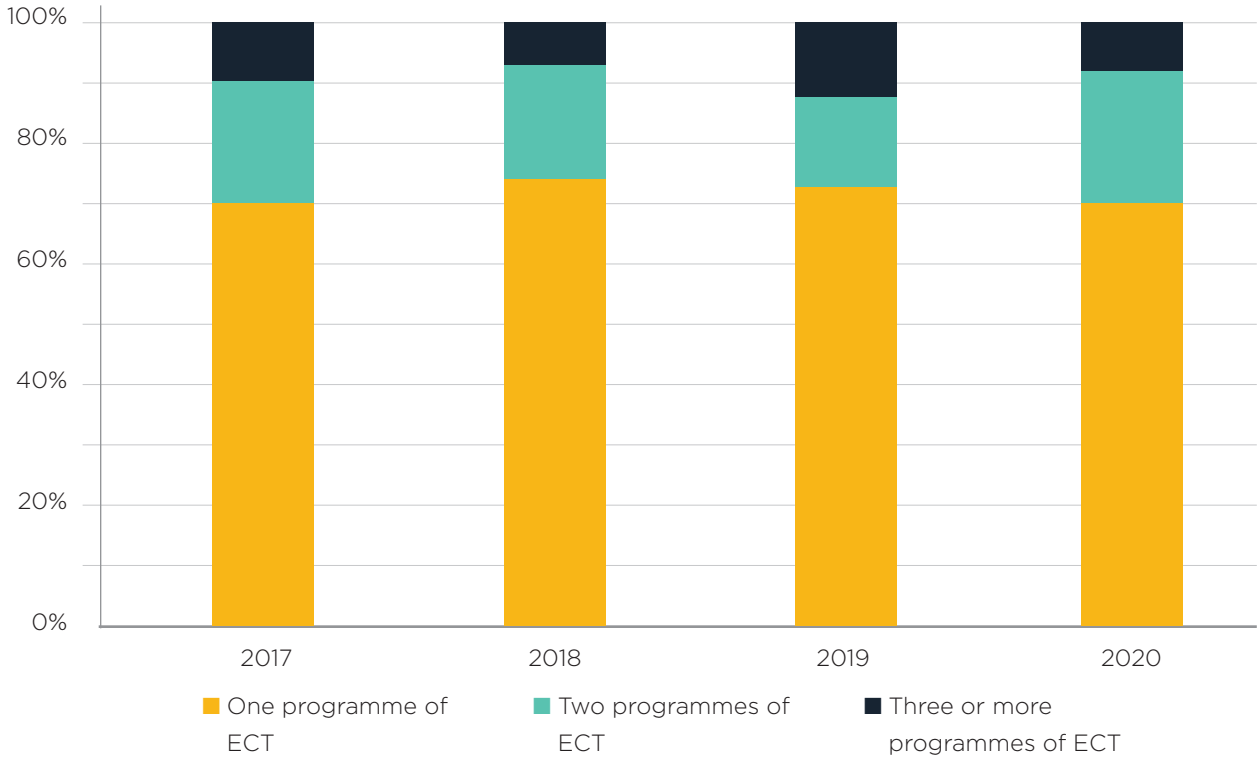


Figure 1: *Number of programmes of ECT administered to residents*

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 1 to 12 treatments. *Table 4* shows that the average number of treatments per programme was **approximately eight** in each of the years between 2018 and 2020.

Table 4: *Treatments per programme of ECT*

	2018	2019	2020
Average number of treatments per programme	8.0	7.9	**7.8**
Programmes of 12 treatments	103	102	**64**
Programmes of one treatment	13	11	**13**

Most programmes of ECT (**95.7%** in 2020 and 97.2% in 2019) **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 **21.3%** of all programmes in 2020, compared to 26.1% in 2019. 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 on 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 MHC indicate that the length 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 2018 and 2020, showing that the average duration of all ECT programmes was 42 days in 2020, and 44 days in 2019. The average duration of programmes of maintenance ECT was 115 days in 2020, and 110 days in 2019, while the average duration for ECT programmes to treat urgent or acute issues was 32 days in 2020 and 35 days in 2019. Given the distinctly different 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.

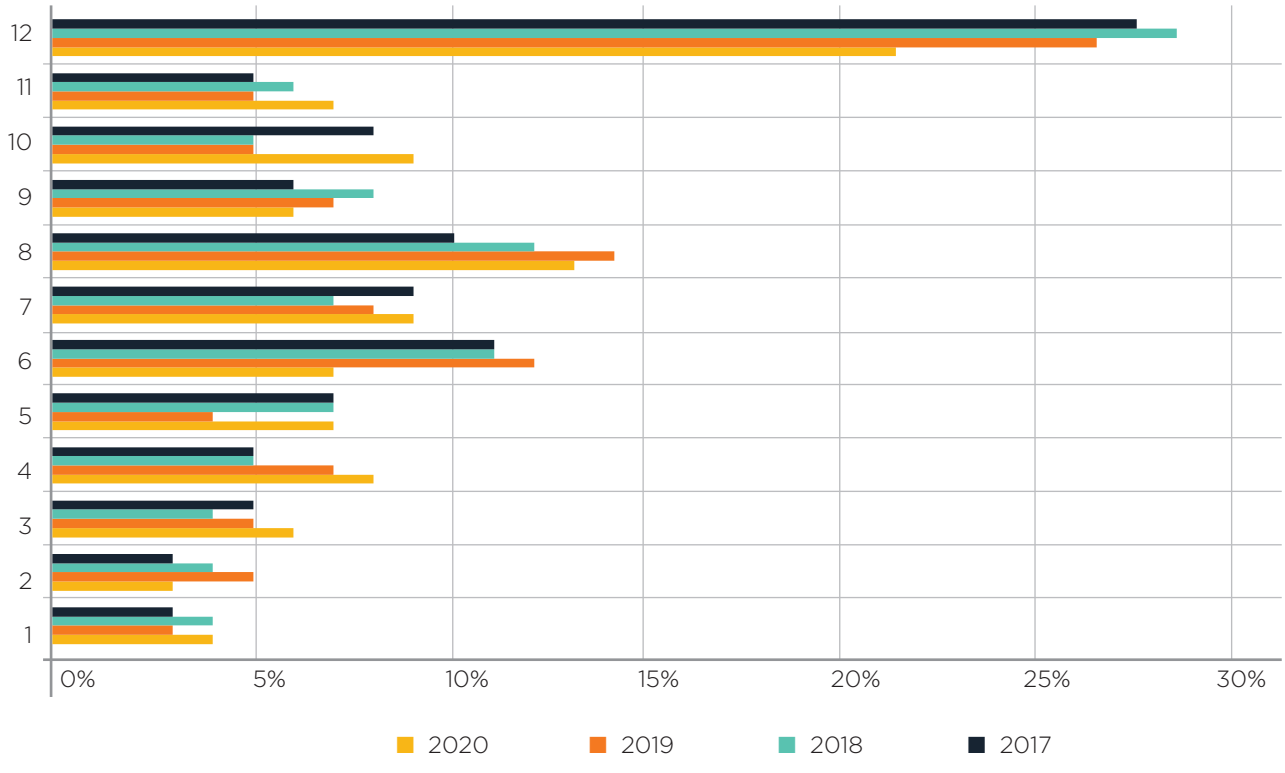


Figure 2: *Number of treatments per programme*

Table 5: *Average ECT programme duration*

ECT programme type	Number of days		
	2018	2019	2020
All programmes	46	44	42
Maintenance ECT	120	110	115
Maintenance ECT excluded	42	35	32

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 2016 to 2020. In 2020, **71.1%** of approved centres **did not provide an ECT service (either directly or by referral to another service), 21.2%** of approved centres **provided an ECT service**, and **7.6%** of services **referred residents to other approved centres for ECT treatment**. According to the data, nine approved centres that carried out ECT treatments in 2019 did not do so in 2020. These figures indicate a reduction in approved centres carrying out ECT compared to previous years. For example, in 2019, 26.2% of approved centres provided an ECT service and 18.5% of services referred residents to other approved centres for ECT treatment.

Table 6: *Overview of approved centres using ECT*

	2016	2017	2018	2019	2020
ECT service	15	16	15	17	14
	22.7%	25.0%	23.1%	26.2%	21.2%
ECT service – not used	2	0	0	0	3
	3.0%	0.0%	0.0%	0.0%	4.5%
ECT service by referral	5	8	15	14	5
	7.6%	12.5%	23.1%	18.5%	7.6%
ECT service by referral – not used	1	0	0	0	9
	1.5%	0.0%	0.0%	0.0%	13.6%
No ECT service	43	40	34	34	35
	65.2%	62.5%	52.3%	50.8%	53.0%
Total approved centres	**66**	**64**	**65**	**65**	**66**

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 2020, with 2019 and 2018 data included for context. The approved centres are ordered by sector (by CHO or national provider).

At least one approved centre in each of the **nine CHO areas** reported **one or more programmes of ECT** in the period spanning 2018 to 2020, with all nine CHO areas reporting one or more programmes of ECT in 2020. The national forensic mental health service, national intellectual disability service, and Child and Adolescent Mental Health Services (CAMHS) approved centres 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 2020 and 2019, while the Acute Adult Mental Health Unit, University Hospital Galway reported the highest number of programmes of ECT in a HSE-operated service in 2018.

In relation to the Independent Services, **St Patrick's University Hospital, a large 241-bed service, accounted for 53% of all programmes in 2020**. Similarly, the approved centre accounted for 50% and 45% of programmes in 2019 and 2018 respectively. 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.

In 2020, **7 of the approved centres (36.8%)** either using ECT or referring residents to other services for treatment reported **fewer than five programmes**, a reduction from 12 centres in 2019 (37.5%). 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*

Approved centres by area/sector	Administration	2018	2019	2020
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	11	11	<5
Sligo/Leitrim Mental Health Inpatient Unit	ECT service	<5	<5	0
CHO Area 2 – Population 453,109 – Galway, Roscommon, Mayo				
Acute Adult Mental Health Unit, University Hospital Galway	ECT service[5]	22	24	19
Adult Mental Health Unit, Mayo University Hospital	ECT service[5]	6	6	9
Department of Psychiatry, Roscommon University Hospital	By referral1,[2]	0	<5	5
CHO Area 3 – Population 384,998 – Clare, Limerick, North Tipperary/East Limerick				
Acute Psychiatric Unit, Ennis Hospital	By referral[3]	<5	0	0
Acute Psychiatric Unit 5B, University Hospital Limerick	ECT service	17	24	10
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[3]	<5	0	0
Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	By referral[3]	<5	0	0
Units 2, 3, 4, 5 and Unit 8 (Floor 2), St Stephen's Hospital, Cork	By referral[1,3]	<5	<5	0
AMHU, Cork University Hospital	By referral[1]	0	<5	0
CHO Area 5 – Population 510,333 – South Tipperary, Carlow/Kilkenny, Waterford, Wexford				
Department of Psychiatry, St Luke's Hospital	ECT service	<5	10	<5
Department of Psychiatry, University Hospital Waterford	ECT service[1]	17	<5	6
Haywood Lodge	By referral[1,2]	0	<5	<5
CHO Area 6 – Population 388,297 – Wicklow, Dun Laoghaire, Dublin South East				
Elm Mount Unit, St Vincent's University Hospital	ECT service	11	11	10
Avonmore & Glencree Units, Newcastle Hospital	By referral[1,2]	<5	<5	8
CHO Area 7 – Population 702,586 – Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West				
Acute Psychiatric Unit, Tallaght Hospital	ECT service	16	38	23
Jonathan Swift Clinic, St James's Hospital	By referral[2,3]	17	5	6
Lakeview Unit, Naas General Hospital	ECT service[3]	17	11	<5

Approved centres by area/sector	Administration	2018	2019	2020
CHO Area 8 – Population 616,229 – Laois/Offaly, Longford/Westmeath, Louth, Meath				
Department of Psychiatry, Midland Regional Hospital, Portlaoise	ECT service	9	6	5
Drogheda Department of Psychiatry	By referral[3]	<5	0	0
St Loman's Hospital, Mullingar	ECT service	5	<5	<5
Maryborough Centre, St Fintan's Hospital	By referral	<5	0	0
St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre	By referral[1,2]	0	<5	<5
CHO Area 9 – Population 621,405 – Dublin North, Dublin North Central, Dublin North West				
Ashlin Centre	By referral[3]	<5	0	0
Department of Psychiatry, Connolly Hospital	By referral[1,3]	<5	<5	0
O'Casey Rooms, Fairview Community Unit	By referral[1,3]	<5	<5	0
St Vincent's Hospital, Fairview	By referral[1,3]	<5	<5	0
Forensic Service – National Coverage				
Central Mental Hospital	By referral	0	0	0
Independent – National Coverage				
St Edmundsbury Hospital	By referral[1,3]	26	29	0
St Aloysius Ward, Mater Misericordiae University Hospital	By referral[1]	0	<5	0
St John of God Hospital & Cluain Mhuire[4]	ECT service	43	41	23
St Patrick's University Hospital[b]	ECT service[5]	166	197	159
Total all approved centres		**365**	**395**	**300**

Note: population figures taken from 2016 Census of Population, CSO.ie

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; (iv) Newcastle Hospital referred residents to Elm Mount Unit and; (v) Cluain Lir referred residents to St Loman's Hospital.

2 In 2020: (i) Jonathan Swift Clinic, St James' Hospital referred residents to APU Tallaght Hospital; (ii) DOP, Roscommon University Hospital to AAMHU; University Hospital Galway; (iii) Newcastle Hospital to Elm Mount Unit, St Vincent's University Hospital; (iv) Haywood Lodge to DOP, St Luke's Hospital and; (v) Cluain Lir to St Loman's Hospital.

3 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 referred patients to Acute Unit 5B, University Hospital Limerick.

4 The Cluain Mhuire catchment area admits to St John of God Hospital, an approved centre in the independent sector. The HSE purchases inpatient 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.

5 ECTAS-accredited approved centre that carried out ECT treatments in 2020.

b This figure includes 39 programmes of ECT in 2018 and 1 programme 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 2020, with data from 2018 and 2019 provided for context where relevant, including age, gender, and legal status.

Demographics: Age and gender

Figure 3 shows the gender of residents who were administered ECT between 2018 and 2020. Approximately two-thirds of residents in each year were female.6P.

The average age of residents who were administered ECT in 2019 and 2020 was 59 years and 62 years of age respectively. The age range was 22 to 89 years in 2019, and 25 to 93 years in 2020.

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, ward of court or outpatient.

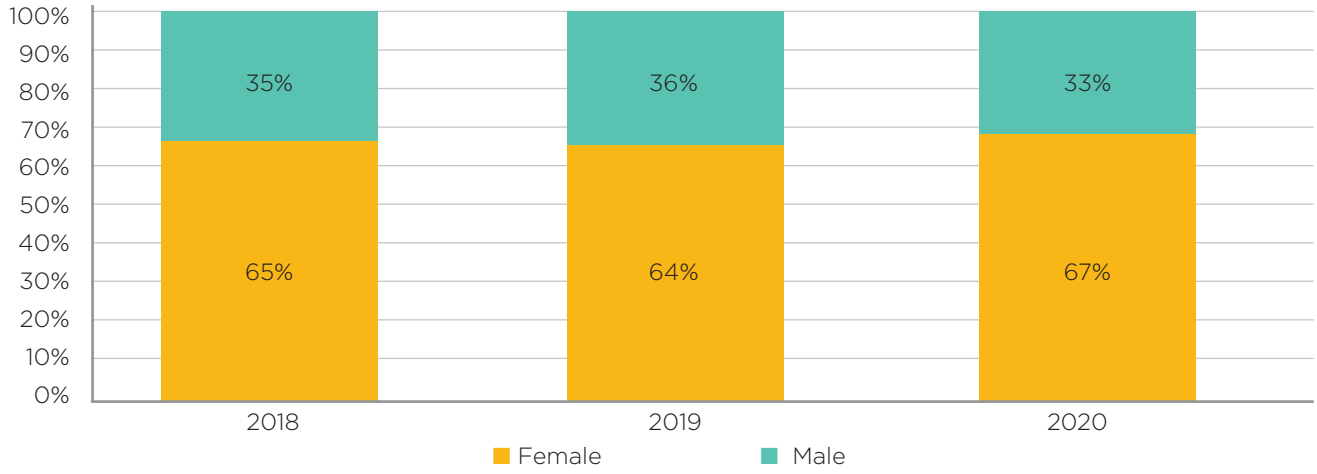


Figure 3: *Gender of residents who were administered ECT*

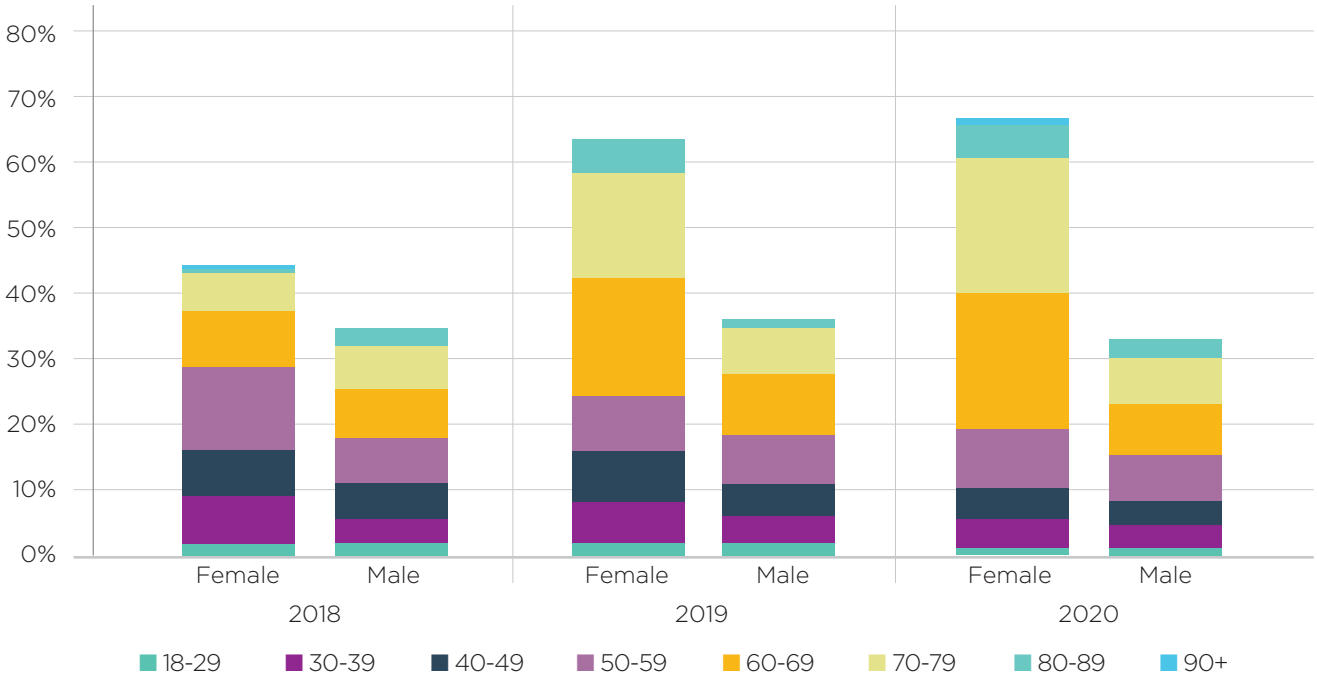


Figure 4: *Age range by gender of residents who were administered ECT (percentage of total year)*

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

Table 8 shows that in 2020, **78.3%** of ECT programmes were administered to residents with a **voluntary** legal status. 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. In 2020, **20.1%** of programmes were commenced when the legal status of the patient was **involuntary**, compared to 17.5% of residents in 2019.

Table 8: *Programmes of ECT by residents' legal status*

Legal Status	2018	2019	2020
Voluntary	78.4%	82.0%	78.3%
Involuntary	21.1%	17.5%	20.1%
Outpatient	0.5%	-	0.7%
Ward of Court	-	0.5%	1.3%

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 9* shows that a **change in legal status** was reported in relation to **14 programmes of ECT** in 2020, compared to 16 in 2019 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*

		2018	2019	2020
Change	Involuntary to voluntary	13	14	12
	Voluntary to involuntary	6	1	2
	Involuntary to Ward of Court	-	1	-
	Total changes to legal status	19	16	14
Totals	Total programmes	365	396	300

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. The Form must be placed in the patient's clinical file and a copy sent to the MHC for each programme of ECT.

Treatments without consent

Informed consent must be sought prior to the commencement of a programme of ECT, and in advance of every ECT treatment. The capacity of a patient to consent may change over the duration of the programme and must 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 **18% of programmes had one or more treatments without consent** in 2020, compared to 16% in 2019 and 19% in 2018.

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

		2018	2019	2020
Programmes without consent	Number	69	63	55
	% of total	19.0%	15.9%	18.3%
Treatments without consent	Number	516	516	442
	% of total	17.6%	16.5%	18.9%

In 2020, **442 individual treatments (18.9%)** of ECT were administered **without consent**, lower than all treatments administered without consent in both 2019 (516 treatments, 16.5%) and 2018 (516 treatments, 17.6%).

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 reasons for ending a programme of ECT.

Diagnosis

In 2020, **80%** of programmes of ECT (**240**) were administered to residents with a **mood/affective disorder diagnosis (including depressive and manic disorders)**, followed by **12%** with a diagnosis

[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.

of **schizophrenic, schizotypal and delusional disorders** (37). The figures were similar in 2019, with 85% of programmes of ECT administered to residents with a diagnosis of a mood disorder, while 11% of individuals had 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; Scottish ECT Accreditation Network, 2019; Scottish ECT Accreditation Network (SEAN), 2021).

Other primary diagnoses in 2020 and 2019 included neuroses, organic disorders and developmental disorders, as well as disorders of adult personality and behaviour.

Figure 5 shows the breakdown of diagnoses between the years 2018 and 2020.

Table 11 shows the breakdown of indications for programmes of ECT between 2018 and 2020.

Refractory (resistant) to medication was the most common single indication for ECT, accounting for 64% of indications in 2020, and 66% in 2019. Maintenance ECT and Rapid response required accounted for the second most common indications in 2020, at 13% each.

Table 11: *Indications for ECT*

Indications	2018	2019	2020
Refractory to medication	243	259	193
	67%	66%	64%
Multiple or 'other' indications[a]	3	8	16
	1%	2%	5%
Maintenance ECT	55	47	38
	15%	12%	13%
Rapid response required	45	52	38
	12%	13%	13%
Acute suicidality	12	13	8
	3%	3%	3%
Physical deterioration	7	14	7
	2%	4%	2%
Total programmes	**365**	**395**	**300**

[a] Indications labelled 'other' in 2020 did not include additional information

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 2018 and 2020.

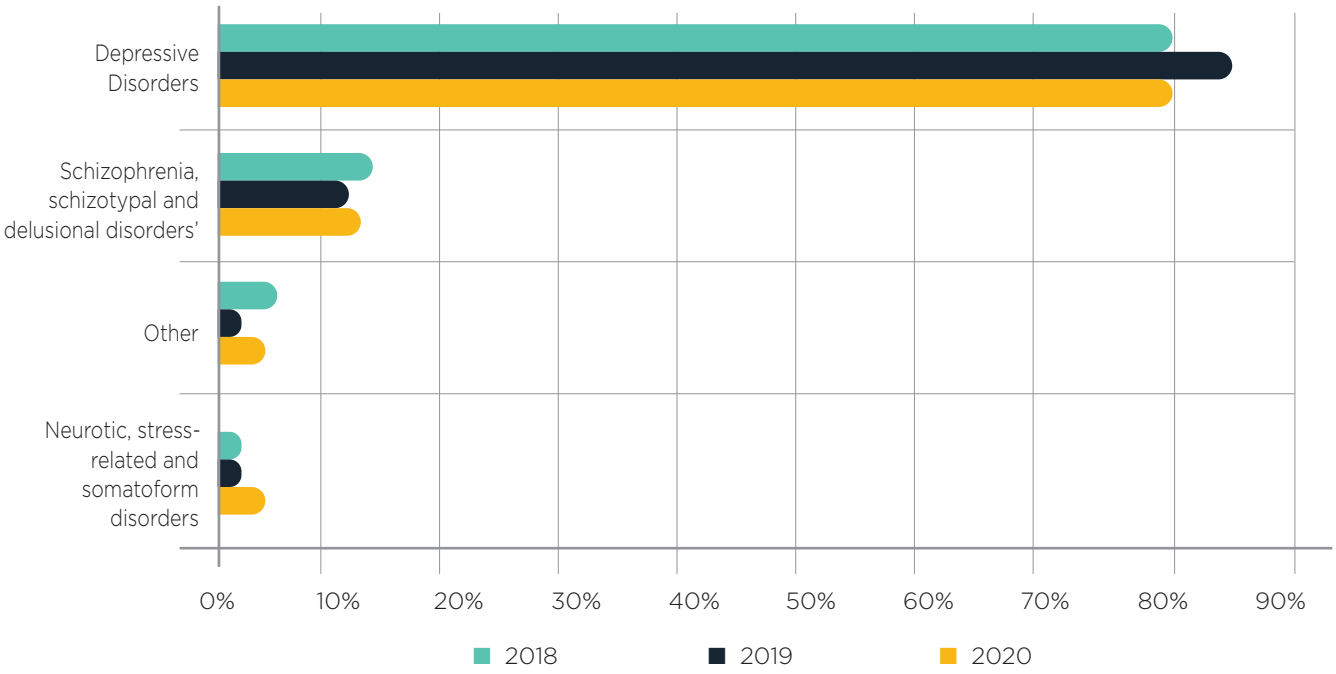


Figure 5: *Programmes of ECT by diagnosis* Indications for ECT

Improvement was reported as the reason for ending the majority of programmes of ECT, accounting for nearly two-thirds (63%) of programmes in 2020, a reduction from over three-quarters (76%) of programmes in 2019. In 2020, 10% of programmes ended after 12 treatments were administered. Programmes of ECT ended because the resident withdrew consent in 6% and 3% of programmes in 2020 and 2019 respectively. No improvement and Complications accounted for 3% and 4% of programmes ending in 2020 respectively, while Other reasons (13%) accounted for the remaining 2020 programmes.

Table 12: *Reason for ending programme of ECT*

Reason for ending ECT	2018	2019	2020
Refractory to medication	243	259	193
	67%	66%	64%
Multiple or 'other' indications[a]	3	8	16
	1%	2%	5%
Maintenance ECT	55	47	38
	15%	12%	13%
Rapid response required	45	52	38
	12%	13%	13%
Acute suicidality	12	13	8
	3%	3%	3%
Physical deterioration	7	14	7
	2%	4%	2%
Total programmes	**365**	**395**	**300**

[a] 'Other' reasons for ending programmes of ECT did not include additional information

Outcome at the end of a programme of ECT

Improvement was reported as the **outcome in 86%** of programmes of ECT in 2020, lower than in 2019 (87%) and 2018 (92%). *Table 13* presents the outcome at the end of programmes of ECT administered from 2018 to 2020. It should be noted that the ECT programme outcome scale was amended in 2020, so a direct comparison to previous years cannot be made. However, Table 13 groups the 2018 and 2019 outcomes with the 2020 outcomes using a best-fit approach.

Much Improved or **Very much Improved** was reported as the outcome for **72% of ECT programmes in 2020**. In comparison, 76% and 80% of residents reported moderate to significant improvement, up to complete recovery in 2019 and 2018 respectively. **In 2020**, **14%** of respondents reported being **Minimally Improved**, while 12% and 13% of programmes reported Some Improvement in 2018 and 2019 respectively. **In 2020**, **9%** of programmes reported **no change**, up from 5% in both 2018 and 2019. Programmes with a negative outcome of **Minimally Worse**, **Much Worse** or **Very Much Worse** accounted for only **1% of programmes in 2020**. Residents reported Deterioration in 2% and 1% of programmes in 2019 and 2018. **Other programme outcomes** accounted for 1%, 5% and **4%** of programmes in 2018, 2019 and 2020.

Table 13: *Outcome at end of ECT programme*

Pre 2020 Responses	2020 Responses	2018	2019	2020
Complete Recovery	Very Much Improved	104	95	112
		28%	24%	
Significant Improvement		163	153	
		45%	39%	37%
Moderate Improvement	Much Improved	26	50	104
		7%	13%	35%
Some Improvement	Minimally Improved	45	52	41
		12%	13%	14%
No Change	No Change	20	21	28
		5%	5%	9%
Deterioration	Minimally Worse	4	6	3
				1%
	Much Worse			1
				0%
	Very Much Worse			0
		1%	2%	0%
Multiple Outcomes Recorded	-	0	0	0
		0%	0%	0%
Register Not Completed	-	3	18	0
		1%	5%	0%
-	Not Assessed	0	0	2
		0%	0%	1%
-	No Information	0	0	9
		0%	0%	3%
Total	365	395	300	

CHAPTER

4

Compliance with ECT Rules and Code of Practice

COMPLIANCE WITH ECT RULES AND CODE OF PRACTICE

The Inspector of Mental Health Services 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.

It is important to note that Part 2 of the *Rules* deals with the issue of consent to treatment and provides safeguards for situations where the patient is unable to consent. The MHC carries out inspections of all approved centres where ECT is provided and seeks evidence that these safeguards are followed (see Section 3.4 for more information).

In 2020 and 2019, the Inspector of Mental Health Services inspected 14 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 2020, of those 14 approved centres, the *Rules* were **not applicable to one centre**, as no involuntary patient had received ECT since the last inspection. The *Code* was **applicable to all 14 centres in 2020**. In 2019, of the 16 approved centres using ECT, the *Rules* were not applicable to five approved centres, and the *Code* was not applicable to two approved centres.

Reasons for non-compliance for both the *Rules* and *Code* were similar and included:

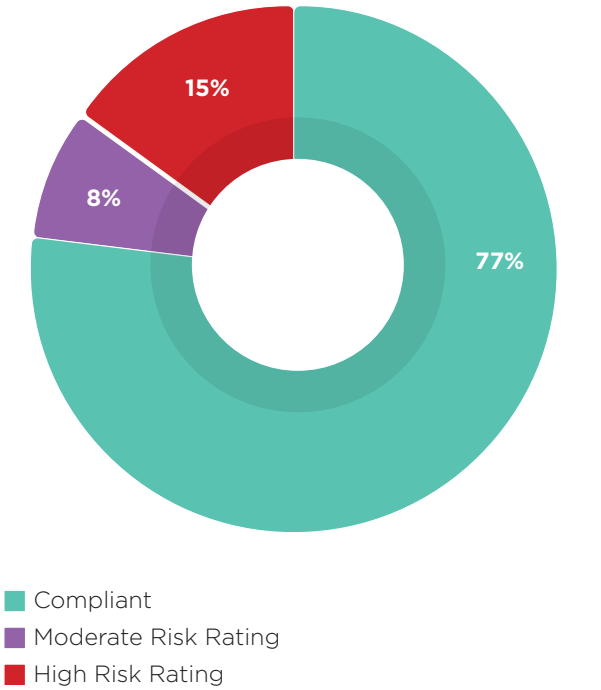
- The prescription of ECT did not include the alternative therapies that were considered or had proved ineffective.
- There was no documentary evidence that a cognitive assessment was completed before the programme of ECT.
- The approved centre did not have a named consultant anaesthetist with overall responsibility for anaesthesia.

Further details on approved centre compliance can be found at:

mhcirl.ie/what-we-do/regulation/approved-centres/

Figure 6 shows the numbers of approved centres compliant with the *Rules Governing ECT* in 2020. Of the 13 approved centres for which the Rules were applicable, **10 were compliant**, while **3 were non-compliant**. Of the three non-compliant approved centres, **1 had a moderate risk rating, while 2 were rated as high risk**.

Figure 6: *Relevant approved centre compliance with* Rules Governing the Use of Electro-Convulsive Therapy, 2020



By comparison, Figure 7 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, 5 were compliant, while 6 were non-compliant. Of the 6 non-compliant approved centres, 1 had a low-risk rating, 4 had a moderate risk rating, and 1 was risk rated as critical.

Figure 8 shows the numbers of approved centres compliant with the Code on ECT in 2020. Of the 14 approved centres for which the Code was applicable, **12 were compliant and two were non-compliant**. One non-compliant centre had a **moderate risk rating** while the other had a **high-risk rating**.

By comparison, Figure 9 shows the numbers of approved centres compliant with the *Code* on ECT in 2019. Of the 16 approved centres for which the *Code* was applicable, 13 were compliant and three were non-compliant. All three non-compliant centres had a moderate risk rating.

Figure 7: *Relevant approved centre compliance with* Rules Governing the Use of Electro-Convulsive Therapy, 2019

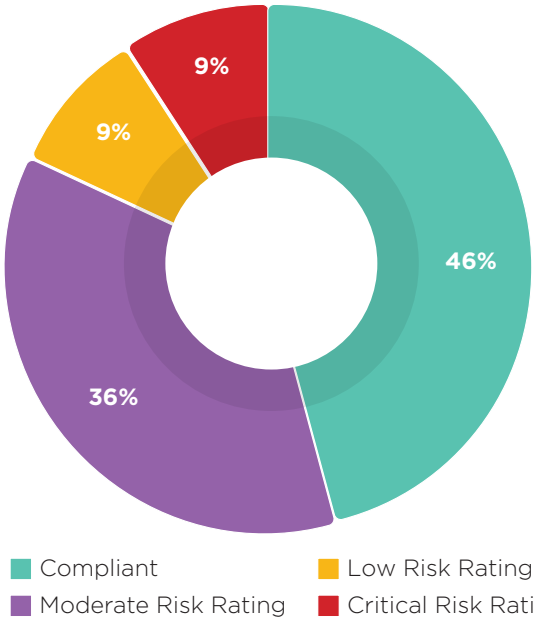


Figure 8: *Relevant approved centre compliance with Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, 2020*

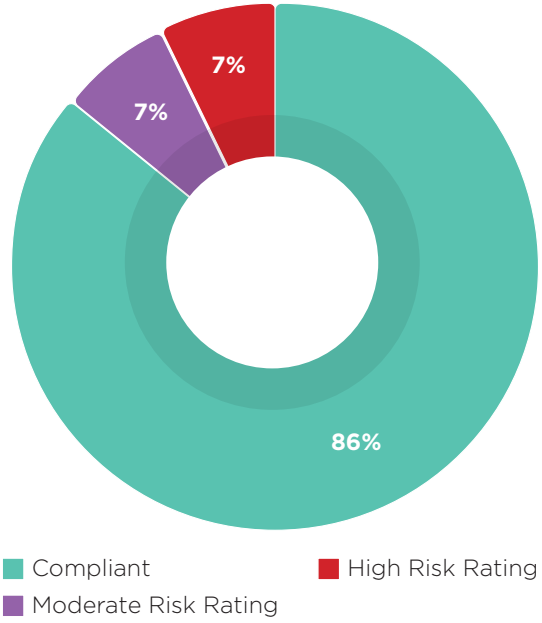
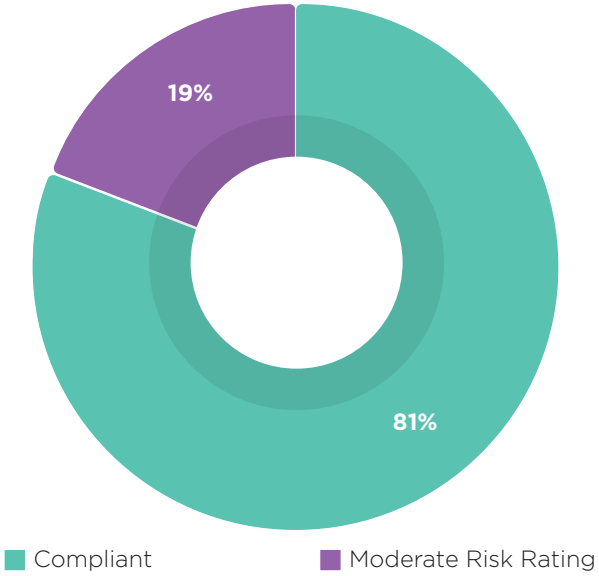


Figure 9: *Relevant approved centre compliance with* Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, 2019



Discussion

DISCUSSION

This report is being issued 12 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 2020 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 to 2020
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. A general increase in residents and programmes is visible between 2015 and 2019, which may indicate that more residents are undergoing the full complement of treatments per programme than in previous years. There is a noticeable decrease in 2020, however. The COVID-19 pandemic may have played a factor in the availability and administration of ECT programmes in 2020 but further research would be required to make any definitive findings in this regard.

Figure 10: *Comparison of number of residents and programmes in approved centres, 2008–2020*

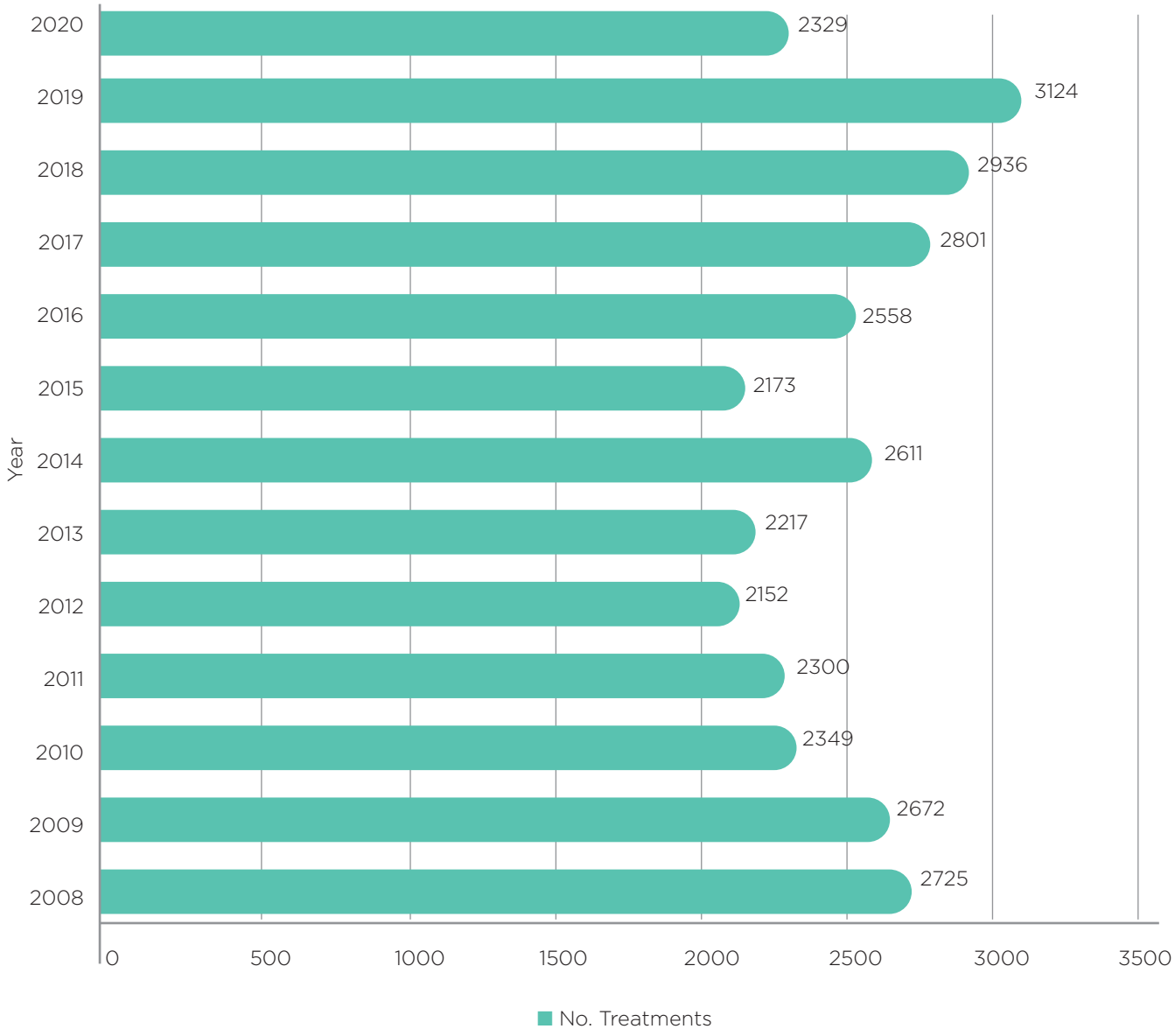


Figure 11: *Comparison of number of ECT treatments per year, 2008–2020*

Figure 12 outlines the total inpatient mental health service admissions recorded by the Health Research Board between the years 2008 and 2020, compared to the numbers of patients involuntarily admitted to inpatient mental health services over the same period. Involuntary admissions have increased year-on-year from **2,004** to **2,463** over the twelve-year period, while total admissions have fallen considerably, from **20,752 at the highest in 2008 to 15,391 at the lowest in 2020**.

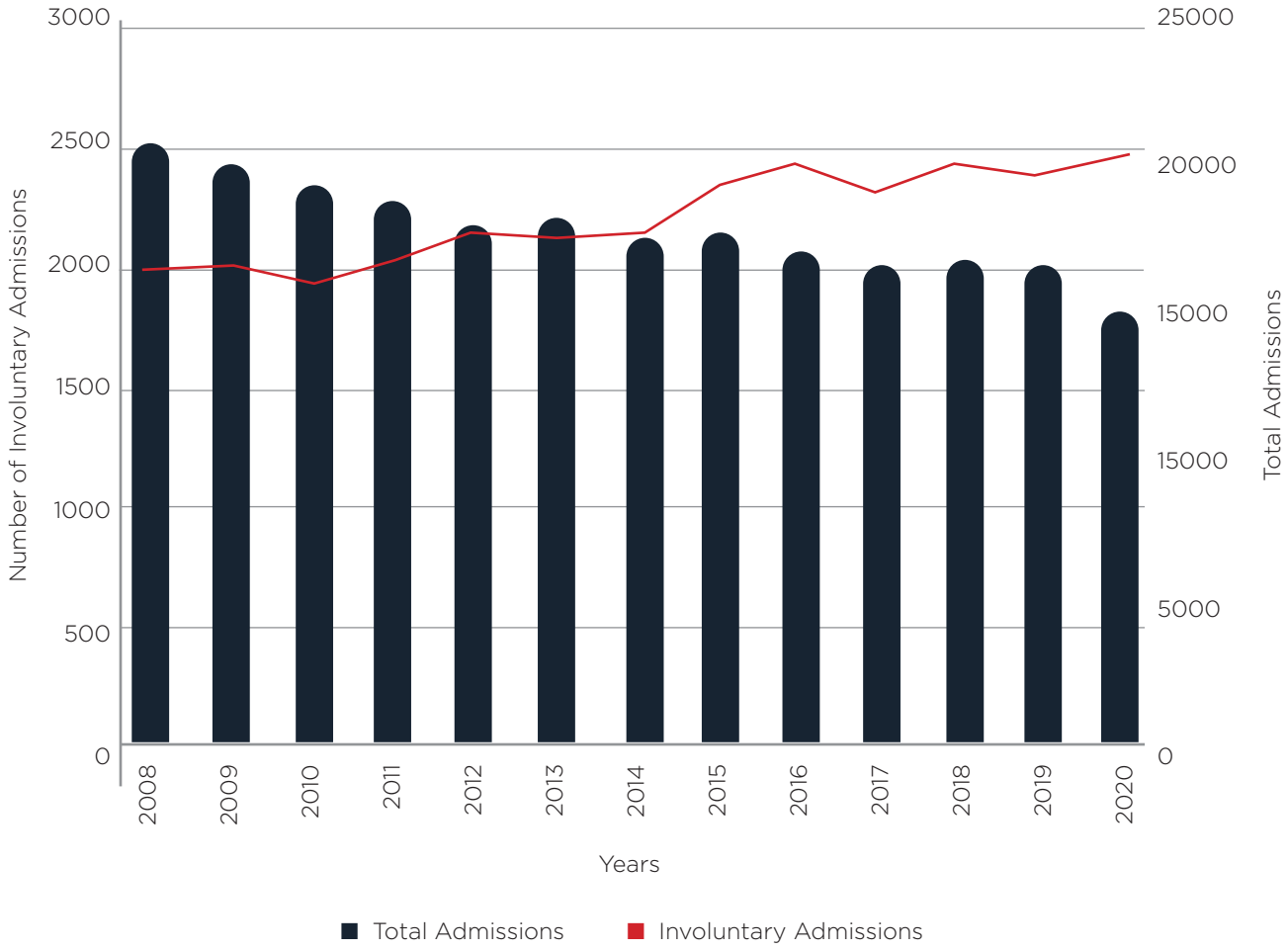


Figure 12: *Comparison of total admissions to involuntary admissions, 2008–2020*

Figure 13 shows that the ratio of female to male residents administered ECT remained fairly static (approximately 2:1) over the 12-year period. As previously discussed, this may be as a result of the relatively higher rate of diagnosed mood disorders in women than men in Ireland.

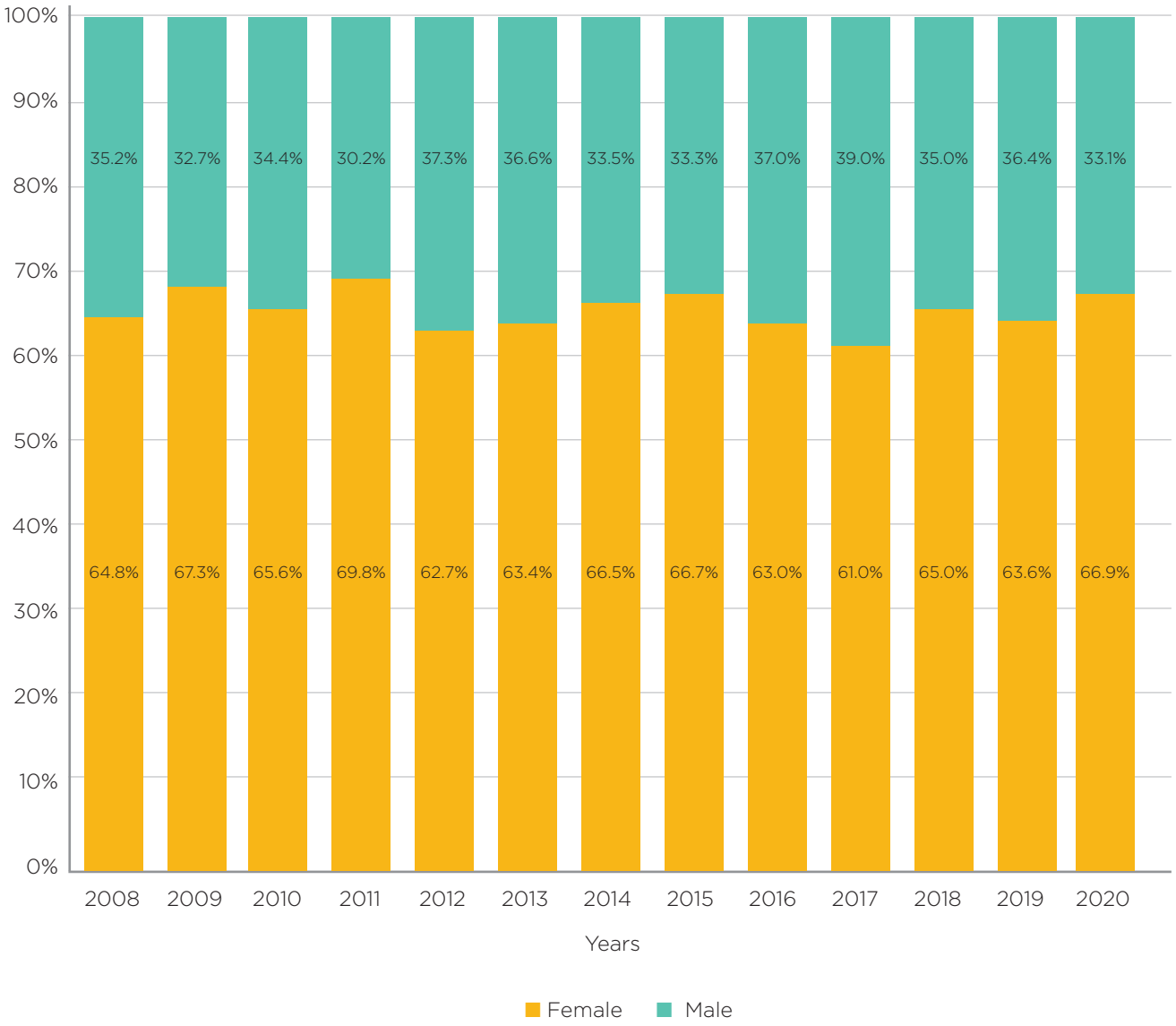


Figure 13: *Comparison of gender of residents who were administered ECT, 2008–2020*

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.

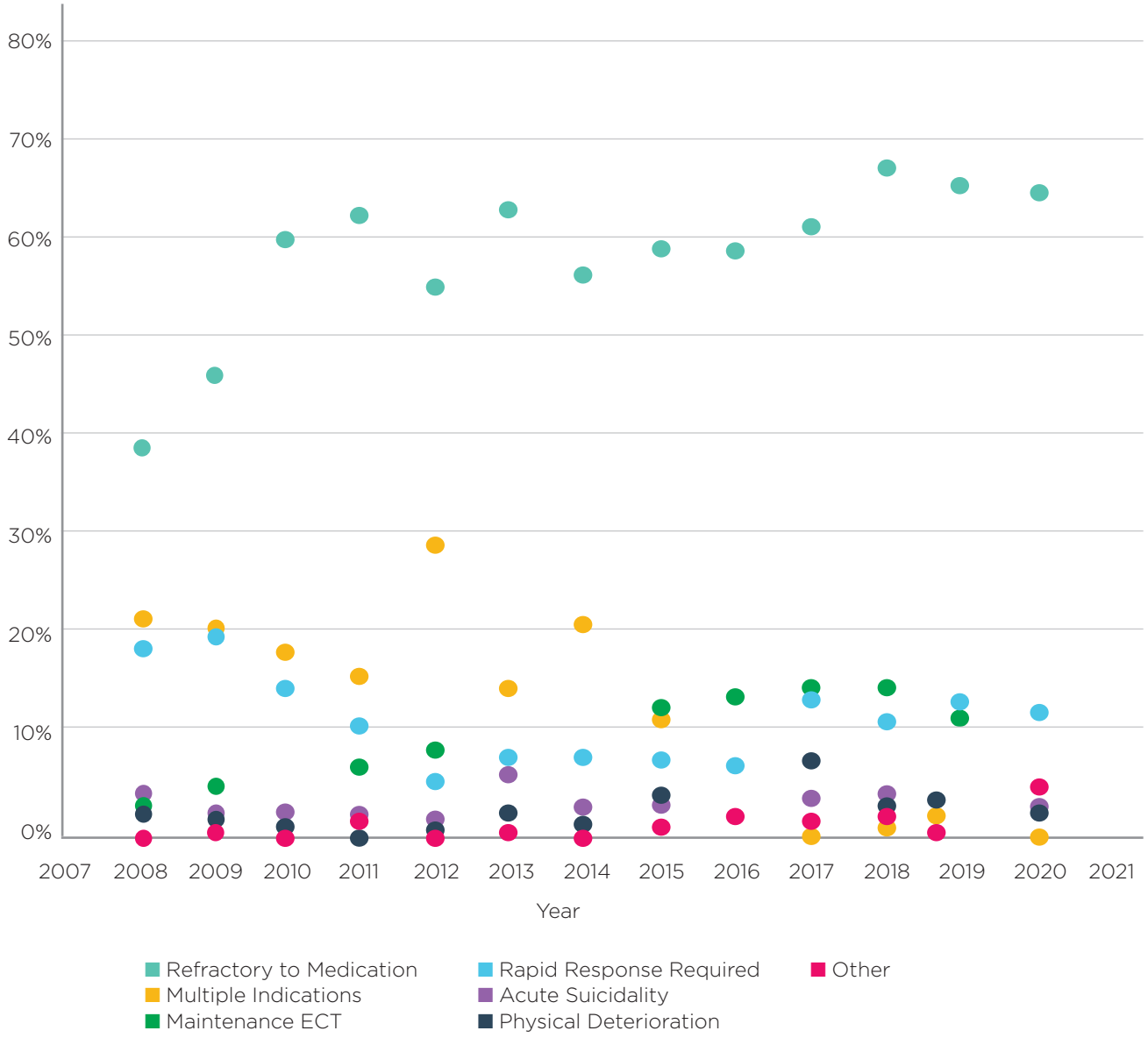


Figure 14: *Comparison of indications for use of ECT, 2008–2020*

Figure 15 indicates that, between 2008 and 2020, the most common diagnosis for residents undergoing ECT treatment has consistently been **mood disorders** (including depression; at between **78.0%** and **88.2%** per annum), followed by **schizophrenic**, **schizotypal** and **delusional disorders**. The least common diagnoses have been **personality and behavioural disorders**, and **organic disorders**.

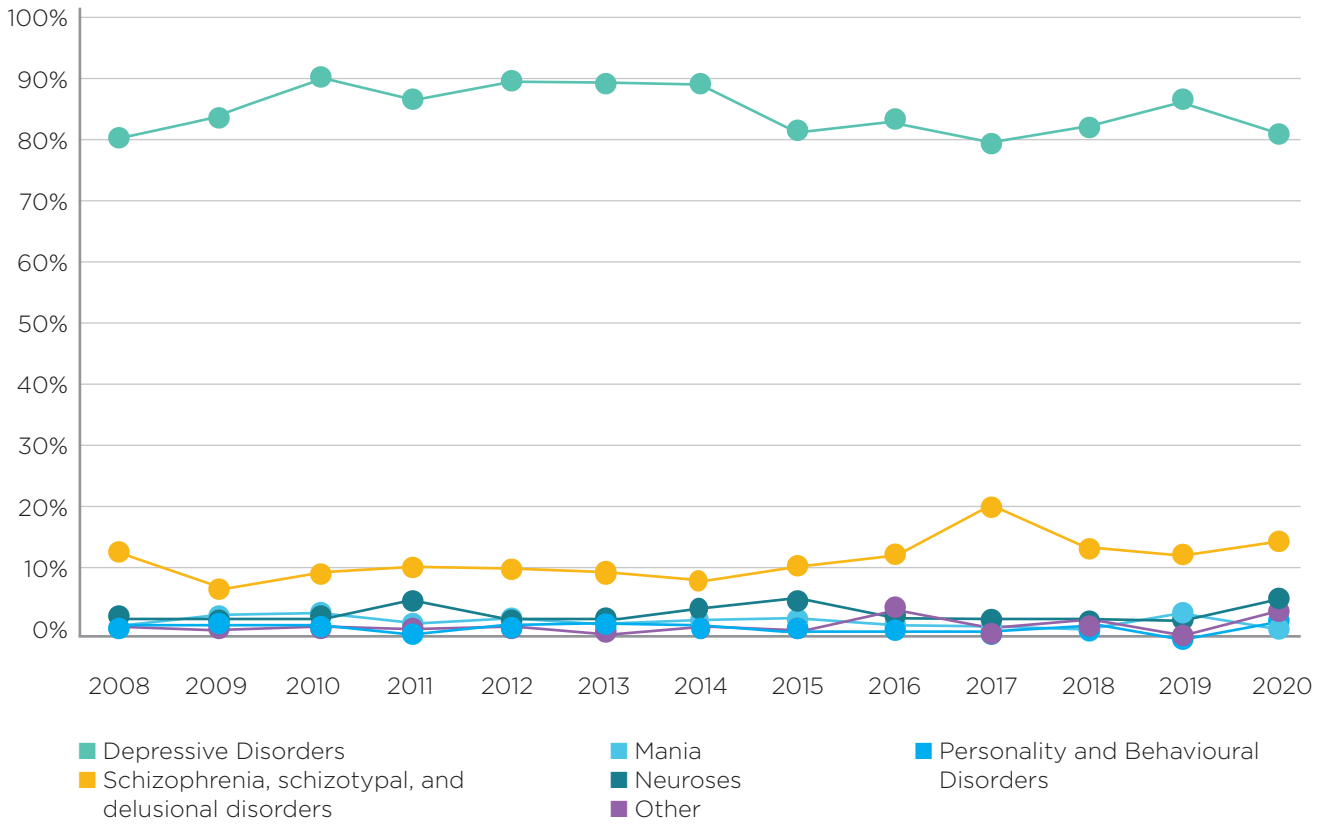


Figure 15: *Comparison of programmes of ECT by diagnosis, 2008–2020*

As discussed in Section 3.5, the ECT programme outcome scale was amended in 2020. *Figure 16* below attempts to compare the ECT programme outcomes from 2008 to 2020, using the newly defined 2020 outcomes and a best-fit approach. The graph shows that **Very Much Improved** has been the **most consistent ECT programme outcome**. It should be noted that on the graph, the Very Much Improved outcome between 2008 and 2019 is a combination of two legacy outcomes: Significant Improvement and Complete Recovery. This explains the visible dip in the curve in 2020.

The next most frequent outcomes were **Much Improved** and **Minimally Improved**. Programmes that reported **No Change** or **Minimally Worse** to **Very Much Worse** outcomes were **significantly less common**. 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.

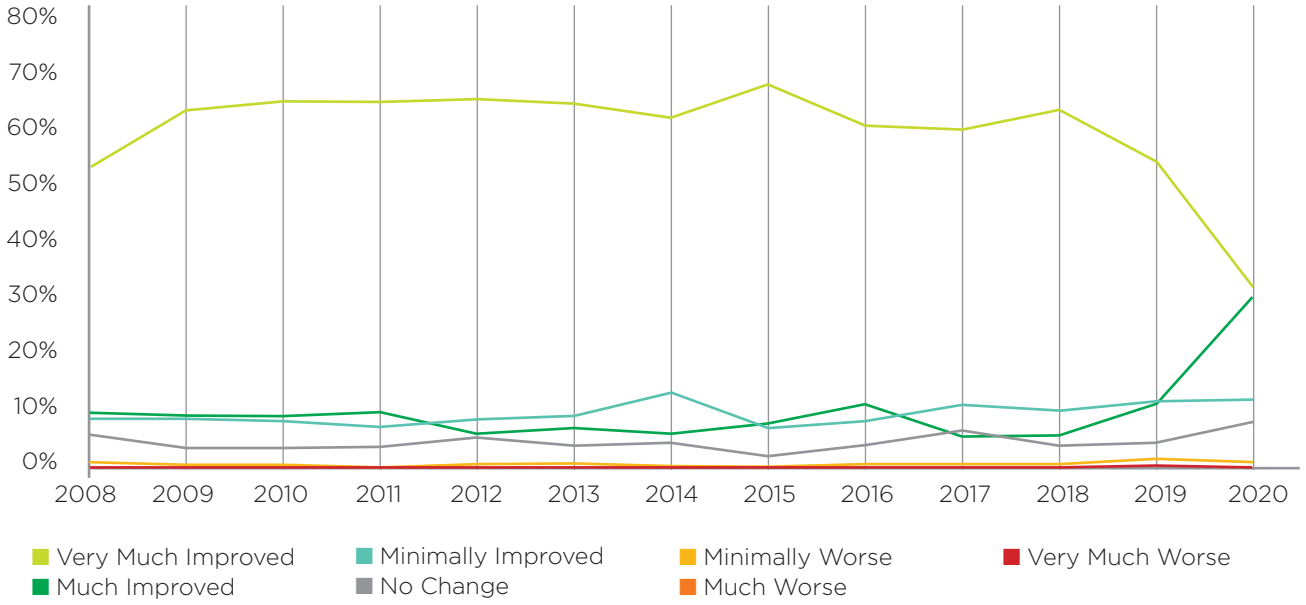


Figure 16: *Comparison of outcomes of ECT treatment, 2008–2020*

Figure 17 indicates that the average age of residents receiving ECT rose between 2010 (the first year that the age of ECT residents was collected from approved centres) and 2020, from 57 to 62 years of age. A reason suggested for the elevated average age of ECT users, as compared with the average age of residents admitted to Irish hospitals generally (including approved centres) (45 years [10 11 12]) is that ECT tends to be in most cases and as outlined in *Figure 13* above 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.

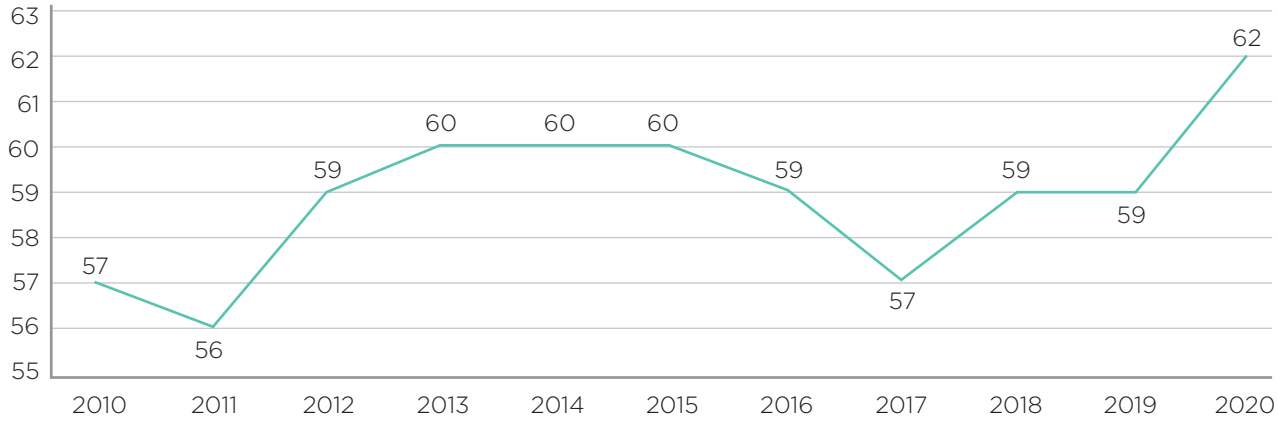


Figure 17: *Comparison of average age of ECT residents, 2008–2020*

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

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

[12] Daly A, Craig S (2021), HRB StatLink Series 5 Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2020. Health Research Board, Dublin.

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 by each approved centre and submitted to the MHC. There are limitations, on the basis of data protection, which restrict the amount of information that can legally be requested. Other information could, in theory, make a comparative analysis more useful. This might include: 1) geographic area or address, as the majority of ECT is administered in national services and data on the location of residents is not included; and 2) long-term recovery or improvement statistics collected from residents who underwent ECT treatments, at 6-month, 1-year and 5-year increments. Furthermore, and in support of the HIQA recommendation (Health Information and Quality Authority, 2009), a national system of unique health identifiers (UHIs) for patients would provide for a more detailed data analysis of ECT programmes in Ireland, while protecting patient confidentiality. Considering 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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Appendices

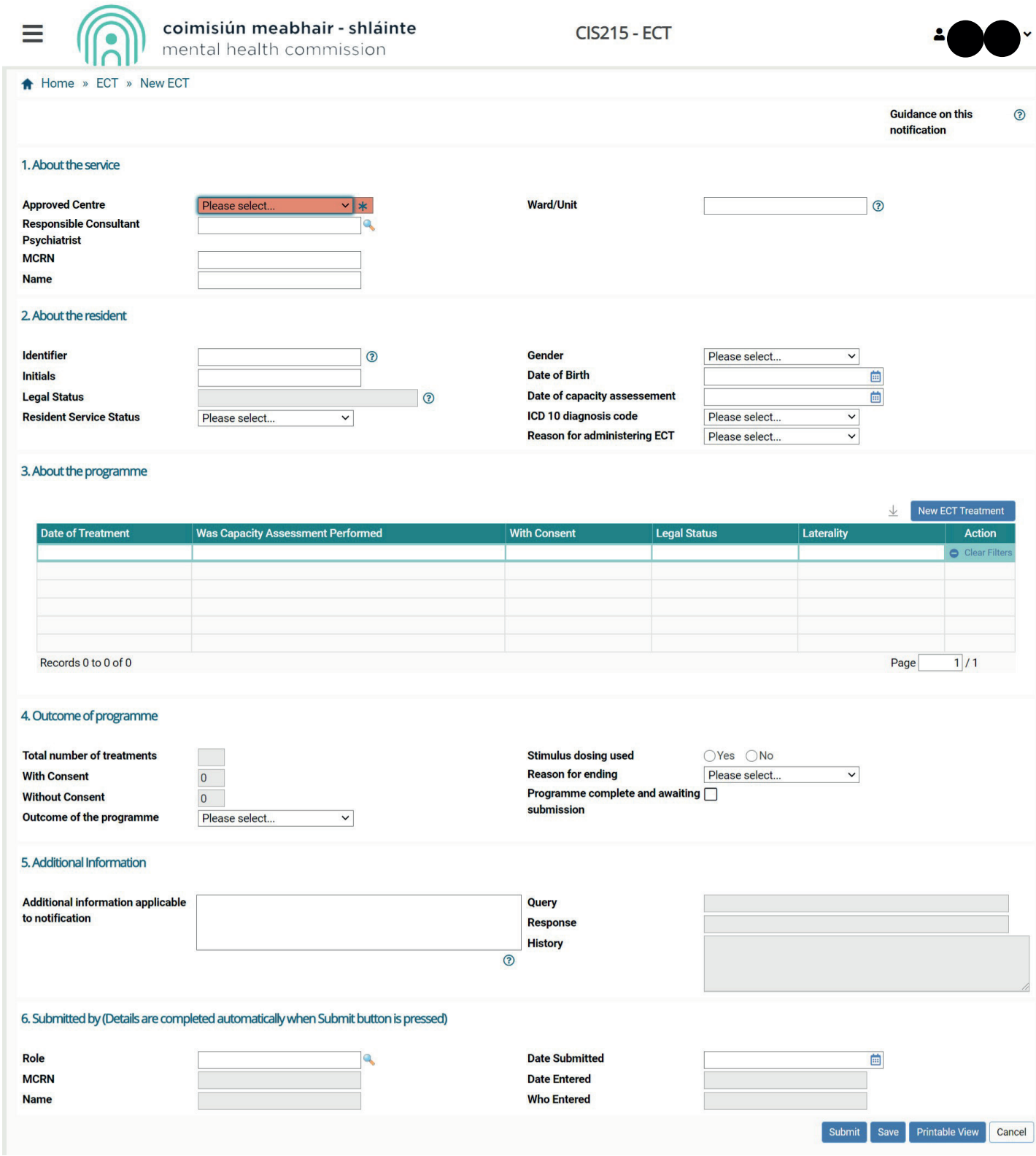
APPENDIX 1: ECT DATA-COLLECTION TEMPLATE AND CIS215: ECT FUNCTION NEW PROGRAMME NOTIFICATION SCREEN AND FORM 16S

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											


coimisiún meabhair - shláinte
mental health commission
CIS215 - ECT
Home » ECT » New ECT
Guidance on this notification
1. About the service
Approved Centre
Please select...
Responsible Consultant Psychiatrist
MCRN
Name
Ward/Unit
2. About the resident
Identifier
Initials
Legal Status
Resident Service Status
Please select...
Gender
Date of Birth
Date of capacity assessement
ICD 10 diagnosis code
Reason for administering ECT
3. About the programme
New ECT Treatment
Date of Treatment
Was Capacity Assessment Performed
With Consent
Legal Status
Laterality
Action
Clear Filters
Records 0 to 0 of 0
Page 1 / 1
4. Outcome of programme
Total number of treatments
With Consent
0
Without Consent
0
Outcome of the programme
Stimulus dosing used
Yes
No
Reason for ending
Programme complete and awaiting submission
5. Additional Information
Additional information applicable to notification
Query
Response
History
6. Submitted by (Details are completed automatically when Submit button is pressed)
Role
MCRN
Name
Date Submitted
Date Entered
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 15 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 Treatment Without Consent Electro-convulsive Therapy involuntary patient (adult)

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mental health commission

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

NOTES

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mental health commission

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