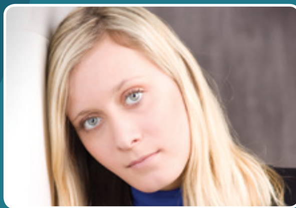
The **Regulation** and **Quality Improvement Authority**



Annual Report on the Administration of Electroconvulsive Therapy in Northern Ireland

2016/17

Who We Are and What We Do

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

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

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

RQIA use relevant standards and guidelines, the views of the public, health care experts and current research, in any review of services provided. We highlight areas of good practice and make recommendations for improvements.

Every year RQIA produces a report on the administration of ECT in Northern Ireland. RQIA undertake inspections of ECT suites using standards set out by the ECT accreditation Service (ECTAS). Our findings are published on our website at www.rqia.org.uk.

ECT Accreditation Service

The voluntary ECT Accreditation Service[1] is an initiative of the College Centre for Quality Improvement launched through the Royal College of Psychiatrists in 2003. It provides a peer review visit which will result in the Accreditation Committee awarding accreditation if the ECT service reaches the required standards. ECTAS assure the quality of the administration of ECT and engage staff in a comprehensive process of review. Good practice and high quality care are recognised and services are supported to identify and address areas for improvement.

Accreditation assures staff, service users, referrers, commissioners and regulators of the quality of services being provided. Over 78% of ECT clinics in England and Wales participate in this accreditation programme. Three trusts in Northern Ireland are ECTAS members.
RQIA continue to encourage trusts to seek ECTAS accreditation.

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

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Introduction

What is Electroconvulsive Therapy?

Electroconvulsive therapy (ECT) is a medical procedure in which an electric current is passed briefly through the brain, via electrodes applied to the frontal lobes, to induce generalised seizure activity. The person receiving the treatment is placed under general anaesthetic and muscle relaxants are given to prevent muscle spasms. Repeated treatments induce several molecular and cellular changes in the brain that are believed to stimulate antidepressant mechanisms. Normally ECT is given twice a week up to a maximum of 12 treatments per course of ECT.

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

Electroconvulsive therapy is usually provided to patients who have not responded to other treatments or for whom there are no other effective treatments. It is often considered to be a life-saving treatment for those who are actively suicidal, refusing food and fluids, or who are physically debilitated by depression. Guidelines, produced by NICE, [2]advise that ECT should be used when other treatments have failed, or in emergency situations.

There is robust scientific evidence that ECT is medically safe and effective[3]. Many patients receiving ECT do so voluntarily and provide fully informed consent, based on an understanding of the treatment, the reasons why it is being offered and the possible risks and side effects. In cases where this is not possible a second opinion is sought through an RQIA Second Opinion Appointed Doctor (SOAD).

Surveys in England have demonstrated a steady decline in the use of ECT since 1985. The trend data on the administration of ECT from 2010-2017 is set out further on page 14 of this report. Information held by RQIA shows a slight downward trend in the administration of ECT in Northern Ireland to patients between 2010 and 2017.

The availability of a greater variety of safe, alternative anti- depressants and other therapies are amongst the possible explanations for this downward trend.

[2] http://www.nice.org.uk/TA59
[3] The college of psychiatry of Ireland Electroconvulsive Therapy Position Statement EAPO1/2011

Summary and Key Findings

This report provides an overview of the administration of ECT in Northern Ireland from 1 April 2016 to 31 March 2017 and some comparative data from previous years using information made available by the trusts.

From 1 April 2016 to 31 March 2017:

123 patients received ECT.

85% of patients were rated as having **improved**

68% of patients receiving ECT were **female**

64% of patients were **under 65** years of age,

52% of courses of ECT were given on a **voluntary** basis,

13% of ECT was administered on an **outpatient** basis

6% of courses of ECT were administered as an **emergency**

- The calculated rate of administration of ECT in Northern Ireland is 6.61 per 100,000 of the population, a similar rate to that of Scotland and Ireland.

- Severe depression is the clinical condition requiring the majority of courses of ECT and the single most prevalent ICD 10 diagnosis was Depressive Episode (F32) (44%).

Purpose of Review of ECT

The purpose of gathering information on the administration of ECT is to provide a baseline position on its use. RQIA continue to seek returns from trusts on a quarterly basis to enable them to examine any trends in the use of ECT and highlight any relevant issues.

Reviews of ECT are also undertaken by the

- Irish Mental Health Commission[4];
- The ECT Accreditation Service in England[5] and Wales; and
- Scottish Electroconvulsive Therapy Accreditation Network (SEAN)[6]

This allows for some comparison of data in the administration of ECT to be made across these jurisdictions.

Seeking Consent

When ECT is proposed as being the most appropriate treatment, patients, whether voluntary or detained, are asked to give their informed consent.

When a detained patient is able to give valid consent to ECT the patient's responsible medical officer (RMO) must validate this consent. Patients who cannot give informed consent to ECT are protected under the Mental Health (Northern Ireland) Order 1986 (the Order).

Informed consent for ECT must be obtained under Article 64 of the Order or, for those patients who are not capable of giving informed consent, an independent opinion is sought from a SOAD regarding the appropriateness of a course of ECT.

All second opinions for ECT are arranged through RQIA. The procedure for seeking a second opinion for ECT is set out in Appendix C.

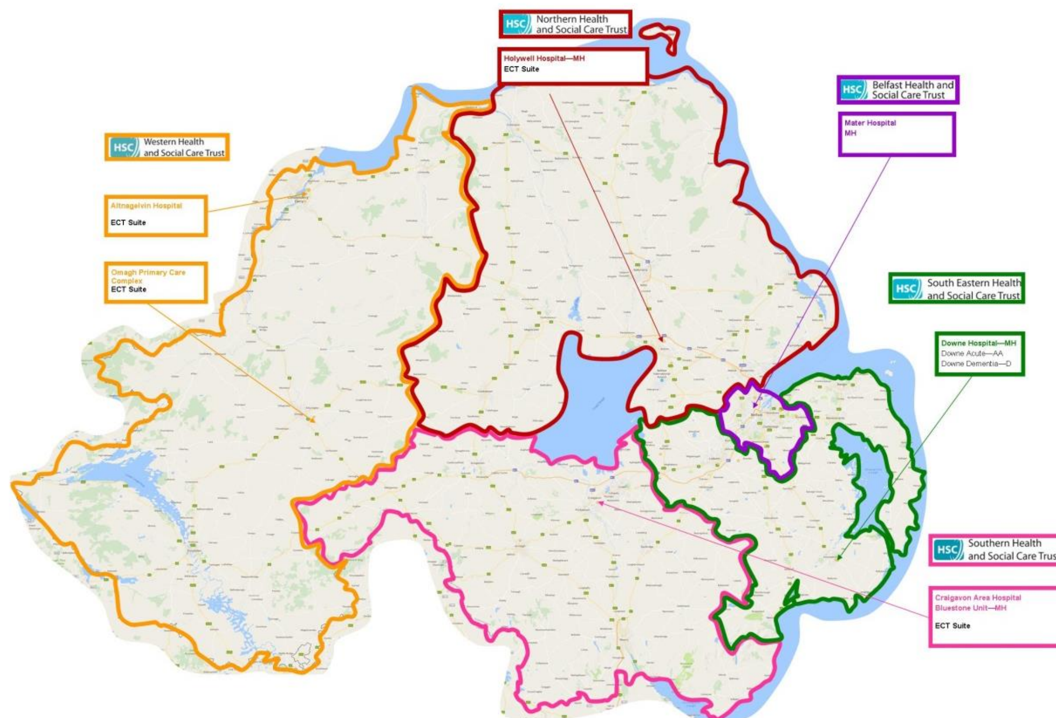
[4] http://www.mhcirl.ie/File/The-Administration-of-ECT-in-Approved-Centres-Activity-Report-2016.pdf
[5] http://www.rcpsych.ac.uk/pdf/ECTAS%20Minimum%20Dataset%20Report%202016/17.pdf
[6] http://www.sean.org.uk/AuditReport/_docs/SEAN-Report-2016.pdf?2

Location of ECT Suites in Northern Ireland

In Northern Ireland, ECT is available across all of the trusts. Three ECT suites have been accredited by the ECT Accreditation Service (ECTAS).

Table 1 - List of Hospitals in Northern Ireland and their Accreditation Status with ECTAS.

Trust	ECT Clinic	Status
Belfast Health and Social Care Trust	Mater Hospital, Belfast	Accredited to 2020
Northern Health and Social Care Trust	Holywell Hospital, Co Antrim	Accredited to Feb 2018
Southern Health and Social Care Trust	Craigavon Area Hospital, Craigavon	Not a member
South Eastern Health and Social Care Trust	Downe Hospital, Downpatrick	Accredited to Feb 2018
Western Health and Social Care Trust	Tyrone County Hospital, Omagh	Not a member
	Altnagelvin Hospital, Londonderry	Not a member



Data Returns

The data for the years 2013 to 2017 was returned to RQIA by trust ECT leads detailing courses of ECT administered to patients, per quarter, information on diagnosis, indications for ECT and the outcome of ECT using the Clinical Global Impression – Improvement Scale (CGI-I).

Findings from Comparative Data 2014-2017

The findings below present some comparative data in relation to the number of patients receiving ECT and the number of courses of ECT between 2014 and 2017.

The number of treatments administered within a course of ECT treatment varies depending on the clinical state of the patient.

The maximum number of treatments in a course is 12.

Note:

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

Note:

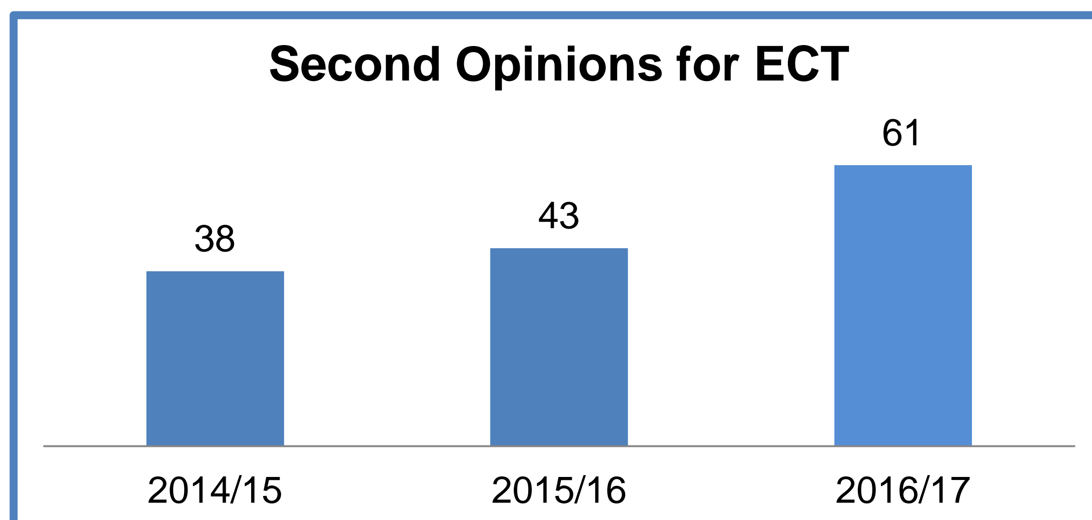
1. A patient could have both detained and voluntary status during a course of ECT. For the purpose of this report, a patient who had both detained and voluntary status during a course of ECT was counted within the detained group only, to avoid them being counted twice.

Findings

Second Opinions for ECT

Graph 1 demonstrates that the number of second opinions provided to patients has increased each year between 1 April 2014 and 31 March 2017.

Graph 1 – Second Opinions for ECT 2014 - 2017



Patients receiving ECT

Table 2 shows that the number of patients receiving ECT within trusts has fluctuated over the last three years. Overall, however, there was an increase of over 25% (25 patients) in the number of patients receiving ECT between 2014/15 and 2015/16 followed by a small increase of two patients during 2016/17.

Table 2 – Number of Patients Receiving ECT by Trust from 2014 – 2017

	2014/15	2015/16	2016/17
BHSCT	20	23	11
NHSCT	26	29	43
SHSCT	16	18	21
SEHSCT	21	28	24
WHSCT	13	23	24
Total	**96**	**121**	**123**

Details of ECT Administration

Most courses of ECT are administered on an inpatient basis. Administration of ECT on an outpatient basis varied between trusts. Some patients, however, received part of their course of ECT on an in-patient basis and continue their treatments on an out-patient basis or vice versa. During 2016/17 five courses of ECT involved a transfer between inpatient and outpatient status.

Table 3 – Number of Courses of ECT Administered on an Outpatient Basis

	2014/15	2015/16	2016/17
BHSCT	5	2	1
NHSCT	13	10	21
SHSCT	2	3	0
SEHSCT	0	1	1
WHSCT	0	0	0
Total	**20**	**16**	**23**

The Northern Trust show an increase in the number of courses of ECT administered on an outpatient basis. This decision is made by the Home Treatment Team, based on clinical judgement of the psychiatrist.

Reasons for the Administration of a Course of ECT from 1 April 2016 - 31 March 2017.

The most common primary indication for the administration of ECT was reported as the severity of the mental state of the patient, followed by non-responsiveness to medication and inadequate eating and drinking. Depressive disorder continues to be the diagnostic group which requires the majority of ECT courses. ECT is also very occasionally used in the management of treatment resistant mania and schizoaffective disorder.

Use of Emergency ECT

The consultant psychiatrist has the option to give one emergency ECT prior to the second opinion, in urgent cases or where there is an unavoidable delay in providing the second opinion. Emergency ECT was given on 10 occasions within the period of 1 April 2014 and 31 March 2016 and 9 occasions in 2016/17.

Age and Gender Data

Generally, it is found that female patients outnumber male patients receiving treatment with ECT.
During 2016/17, 68% of patients receiving ECT were female and 64% of patients receiving ECT were below 65 years of age

ECT Administration to Voluntary and Detained Patients

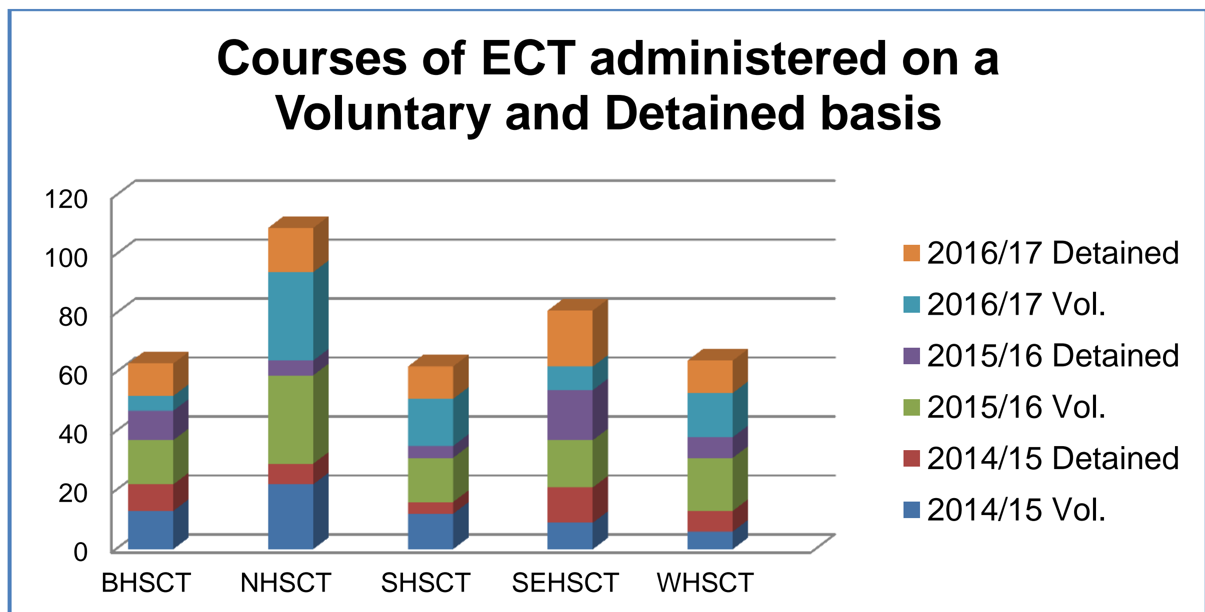
The majority of patients receiving ECT did so on a voluntary basis and were assessed as being able to give their own consent.

The number of courses of ECT administered to detained patients between 2014 and 2017 has been increasing.

This may be the result of clinicians becoming more cautious concerning the capacity of patients to consent to ECT with the subsequent greater use of the Mental Health Order and a higher number of requests for a second opinion through RQIA.

In 2014/15 year 38.6% of courses of ECT were administered to detained patients, 31.4 % in 2015/16 and 47.5% in 2016/17.

Graph 2 - Number of Courses of ECT administered on a Voluntary and Detained basis per Trust for 2013/14, 2014/15 and 2015/16



Mode of Administration of ECT

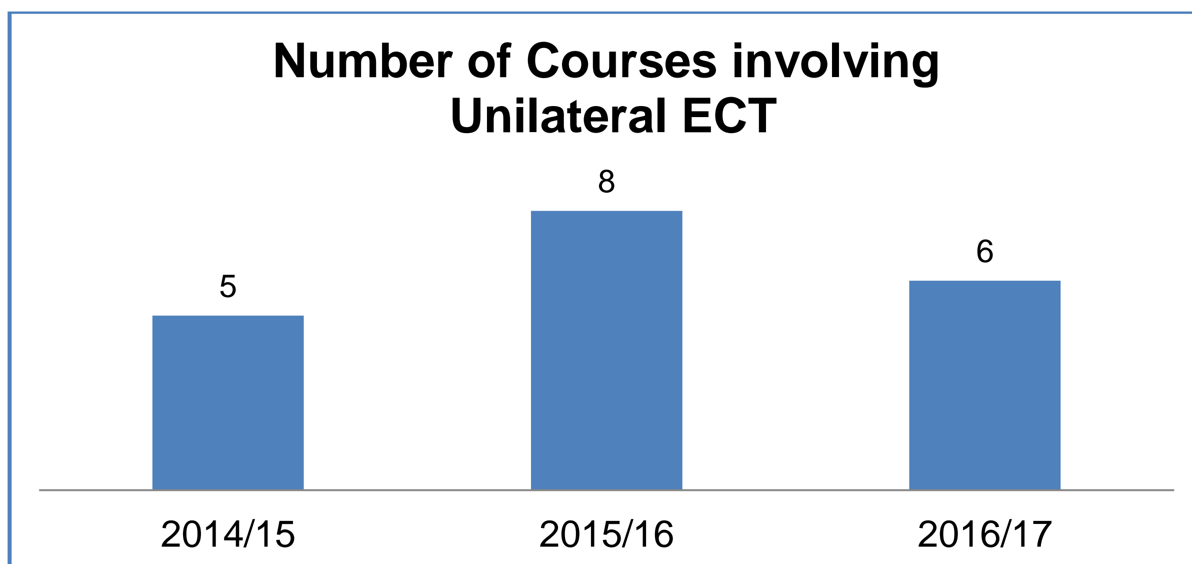
It is accepted that ECT can cause temporary anterograde and retrograde amnesia which is monitored pre and post treatment within the ECT care pathway, used across all trusts. Whether ECT causes longer term memory problems is controversial[7]. It is often hard to differentiate the memory difficulties due to ECT from the memory difficulties associated with the underlying psychiatric conditions of the patient.
Current research seeks to clarify the possibility and nature of more persistent memory loss[8].

- Bilateral ECT seems to work more quickly and effectively but may cause more side effects.

- Unilateral ECT has fewer side effects but may not be as effective and is more difficult to administer properly.

The decision about whether treatment is administered bilaterally or unilaterally will depend on a number of factors, but is mostly dependent on the desire to lessen the cognitive side effects. Graph 3 indicates that, since 2014, the majority of patients received bilateral ECT (96%). The SEAN (Scotland) report reveals a similar percentage of courses of bilateral ECT (94%).

Graph 3 - Number of courses involving Unilateral ECT from 2014-2017



Note:

1. Patients may receive both unilateral and bilateral ECT during a course of ECT for clinical reasons.

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[7] Macqueen et al. The long-term impact of treatment with electroconvulsive therapy on discrete memory systems in patients with bipolar disorder. J Psychiatry Neurosci. 2007; Jul; 32(4): 241-249
[8] How Specialist ECT Consultants inform patients about memory loss", Hanna et al, The Psychiatrist 2009, 33,412-

ICD 10 Category for Courses of ECT

Table 4 shows the distribution of the reported ICD-10 diagnostic categories related to courses of ECT from 2014 to 2017. The majority of courses during 2016/17 had either a diagnosis of Depressive Episode (44%) or Recurrent Depressive Disorder (28%).

Table 4 – Percentage of Episodes of ECT with ICD10 Diagnosis

ICD10		2014/15	2015/16	2016/17
F06	Other mental disorders due to brain damage and dysfunction and to physical disease	0%	2%	2%
F20	Schizophrenia	5%	7%	5%
F23	Acute and Transient Psychotic Disorders	0%	0%	2%
F25	Schizoaffective Disorders	8%	4%	8%
F31	Bipolar Affective Disorder	10%	9%	8%
F32	Depressive Episode	52%	52%	44%
F33	Recurrent Depressive Disorder	23%	20%	28%
F34	Persistent Mood (Affective) Disorders	0%	1%	0%
F41	Other anxiety disorders	0%	2%	2%
F53	Mental and behavioural disorders associated with the puerperium	0%	0%	1%
F60	Specific personality disorders	2%	0%	0%
Not Completed		0%	3%	0%

Clinical Global Impression - Improvement Scores

The Clinical Global Improvement Scale[9] uses a 7 point scale to assess how much the patient's clinical condition has improved or worsened since the initiation of the treatment ranging from "very much improved to very much worse". It is completed by the patient's own Consultant Psychiatrist after the course of ECT.

Results for 2016/17 reveal that 85% are rated within the "improved" categories and 12% experienced no change in their clinical condition. No patients were reported to have become worse as a result of their ECT treatment.

Graph 4 – CGI –I Scores, by Course, following ECT Treatment 2016/17

Notes:

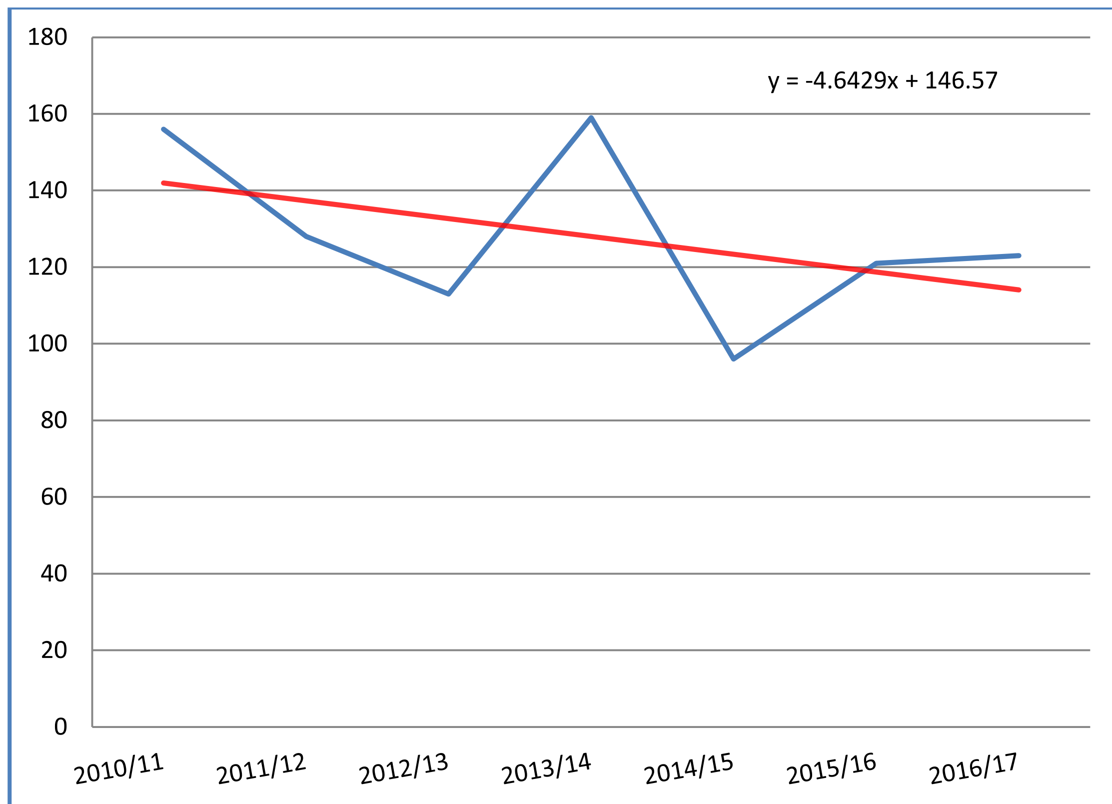
1. Percentages have been rounded to one decimal place and as a consequence some percentages may not sum to 100.
   In some instances these percentages are less than 0.1% or more than 99.9%. Users should be aware that, in such instances the percentage is rounded to zero or 100%

[9] Psychiatry (Edgmont) 2007 Jul; 4(7) 28-37

The Administration of Electroconvulsive Therapy to Patients in Northern Ireland 1 April 2010 – 31 March 2017

RQIA have a record of the number of patients who have received ECT over the last 7 years in Northern Ireland. (Appendix B). Analysis of these figures displayed graphically by year shows an overall downward trend in the number of patients receiving ECT.

Graph 5 – Number of Patients receiving ECT 2010 - 2017



ECT per 100,000 of the Catchment Population by Trust 2014 - 2017

The approximate rate of administration of ECT per 100,000 of catchment population has been calculated and presented below using Mid-Year Population Estimates for Health and Social Care Trusts from the Northern Ireland Research and Statistics Agency's (NISRA)[10] reports.

Table 5 – Summary of the Rate of Administration of ECT to Patients per 100,000 of Catchment Population by Trust for 2014-2017

	2014/15	2015/16	2016/17
BHSCT	5.68	6.50	3.10
NHSCT	5.54	6.15	9.09
SHSCT	4.33	4.82	5.57
SEHSCT	5.96	7.89	6.73
WHSCT	4.35	7.69	7.99
Total	**5.21**	**6.53**	**6.61**

Table 5 above demonstrates a variation in the rate of the administration of ECT across the five trusts. This variation was greatest in 2016/17, when there was a difference in the rates of almost 6 patients between the lowest rate of 3.10 in Belfast HSCT and the highest rate of 9.09 in the Northern HSCT. A number of reasons may account for this variation.

i. As with admissions to psychiatric facilities, there is a natural variation in the number of patients treated with ECT from year to year.
ii. The number of patients receiving ECT also depends on consultant psychiatrists' choice of treatment and some may favour combinations of medication over ECT.
iii. In respect of some patients with severe depression, treatment with ECT can bring about improvement in their mental state within a month of starting their course, whereas drug therapy may require a high dosage or a combination of drugs given over several months to effect improvement.

These factors may be extremely important in the management of an individual patient's illness when weighing up the risks and benefits of different treatments.
It should also be borne in mind when considering the disparity in these rates of administration of ECT that both under-use and over-use of treatment is undesirable.

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

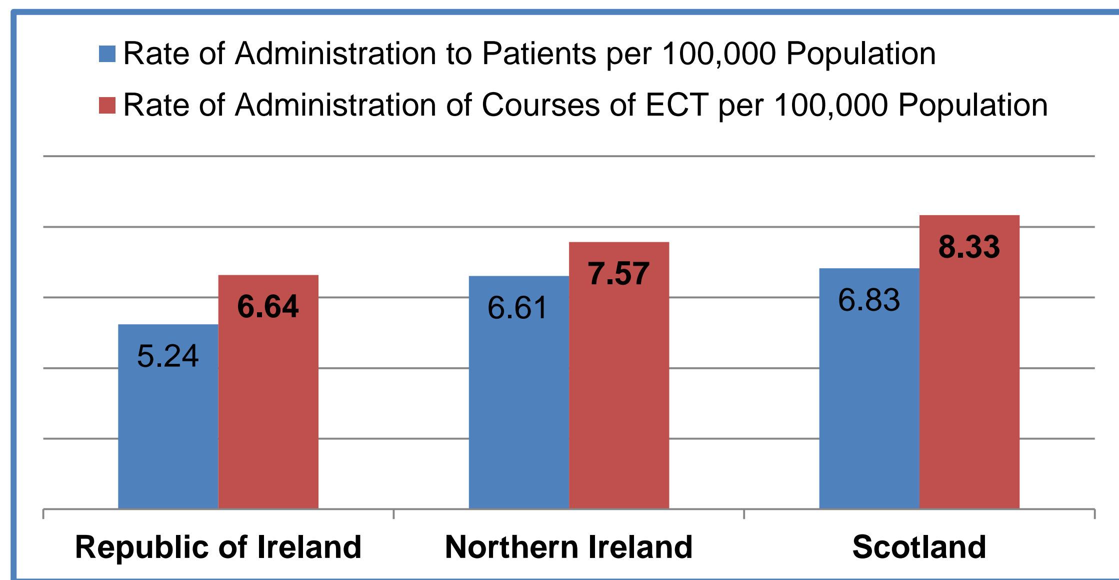
Comparisons with Other Jurisdictions

The Irish Mental Health Commission[11] reported 243 patients received 308 programmes of ECT during 2015; a rate of 5.24 people per 100,000 population and a rate of 6.64 programmes of ECT per 100,000 population.

The Scottish ECT Accreditation Network Annual Report 2016[12] reported that 367 patients received 448 episodes of ECT during 2015. This represents a rate of 6.83 people per 100,000 population and a rate of 8.33 episodes of ECT per 100,000 population.

ECTAS published a report in July 2017 "ECT Minimum Dataset Activity Report 2016/17 for England, Wales, N Ireland and Republic of Ireland[13]. It reports figures compiled from a national survey of ECT in 2016/17 comprising 71 clinics providing ECT. The 71 clinics represented a response rate of 74% of clinics nationally. 1821 acute courses of ECT were administered to 1682 people. The report did not detail a rate per 100,000 of the population or draw any direct conclusions for comparison with other regions due to the nature of the survey.

Graph 6 - A comparison of the Rate of Administration of ECT to Patients across Jurisdictions



The graph shows little variation in the rates of administration of ECT to patients across the three jurisdictions.

[11] http://www.mhcirl.ie/File/The-Administration-of-ECT-in-Approved-Centres-Activity-Report-2014/15.pdf
[12] http://www.sean.org.uk/docs/SEAN-Report-2015-web.pdf
[13] http://www.rcpsych.ac.uk/pdf/ECTAS%20Minimum%20Dataset%20Activity%20Report%20Ireland.pdf

The Patient Experience

RQIA send a questionnaire to each ECT suite to be given to patients following their treatment. The analysis of the returns continue to show that the majority of patients are very satisfied with the quality of care that they receive.

Of the respondents who provided open comments:

80.9% said ECT was **beneficial** to them

77.8% were satisfied with the **consent** process

71.4% said their care was of **the highest quality**

Due to a low response rate in 2016/17, RQIA intend to co-produce a concise, simplified and user friendly questionnaire in 2017/18 with the five trusts and the Northern Ireland Division of the Royal College of Psychiatrists. The questionnaire will be disseminated by trusts to patients following their ECT treatment.

Conclusion

A very slight increase occurred in the number of patients receiving ECT, administered to both voluntary and detained patients, across the trusts in Northern Ireland during 2016/17. As statistically the numbers are small this change is not viewed as being particularly significant.

Overall, when the data on the number of patients receiving ECT in Northern Ireland each year since 2010 is considered a small downward trend can be demonstrated. This is in keeping with the most recent data analysed by ECTAS[15] which suggests that the use of ECT is continuing to decline in England.

Over the period 2014 to 2017 more patients received ECT on a voluntary basis than on a detained basis. However, a higher proportion of patients receiving ECT were treated on a detained rather than voluntary basis during 2016/17 compared with previous years. Also, a higher number of second opinions for ECT were requested during 2016/17.

This may be the result of clinicians becoming more cautious concerning the capacity of patients to consent to ECT with the subsequent greater use of the Mental Health Order and a higher number of requests for a second opinion through RQIA.

More women than men received ECT in the period 2016/17 (68% vs.32%). This is a consistent finding amongst the UK and Irish ECT reports and is in keeping with a higher prevalence of depressive disorders in women.

The majority of ECT involved the bilateral placement of electrodes. This corresponds with practice elsewhere in the UK. This may be because unilateral ECT is more difficult to administer and is perceived to be less effective necessitating more treatments.

The CGI – I scores reveal that a high percentage of patients derive benefit from ECT (85% of courses in 2016/17 are rated within the “improved” categories).

The majority of patients in feedback to trusts have indicated they are very satisfied with the quality of the ECT treatment they have received.

Over 80% of patients indicated that ECT was beneficial for them.

Following an inspection of their new ECT Suite, RQIA noted that the Western Health and Social Care Trust have excellent tools for training staff in the correct administration of ECT. We would suggest the Trust share these tools with other trusts for regional training purposes.

RQIA would like to thank all staff involved in returning information on ECT. We will continue to monitor the administration of this treatment and will report on our findings in 2017/18.

Next Steps

RQIA will:

- Share this ECT report with the Clinical Directors and Clinical Leads of each trust.
- Encourage the Western Health and Social Care Trust to apply for ECTAS accreditation.
- Encourage the Southern Health and Social Care Trust to apply for ECTAS accreditation.
- Continue to seek additional consultant psychiatrists to undertake second opinions under Part IV of the Order.
- Co-produce with the Northern Ireland Division of the Royal College of Psychiatrists, the five HSC trusts and service users, a revised patient experience questionnaire in 2017/18.
- Request trusts to provide the revised patient experience questionnaires to all patients receiving ECT in order that RQIA can continue to monitor, review and report on the quality of the patient experience.
- Co-produce with the Northern Ireland Division of the Royal College of Psychiatrists and the five HSC trusts a regional information leaflet on the administration of ECT.
- Produce a report on the administration of ECT in 2017/18.
- Share a copy of this report with the Department of Health and colleagues from other jurisdictions.

APPENDIX A

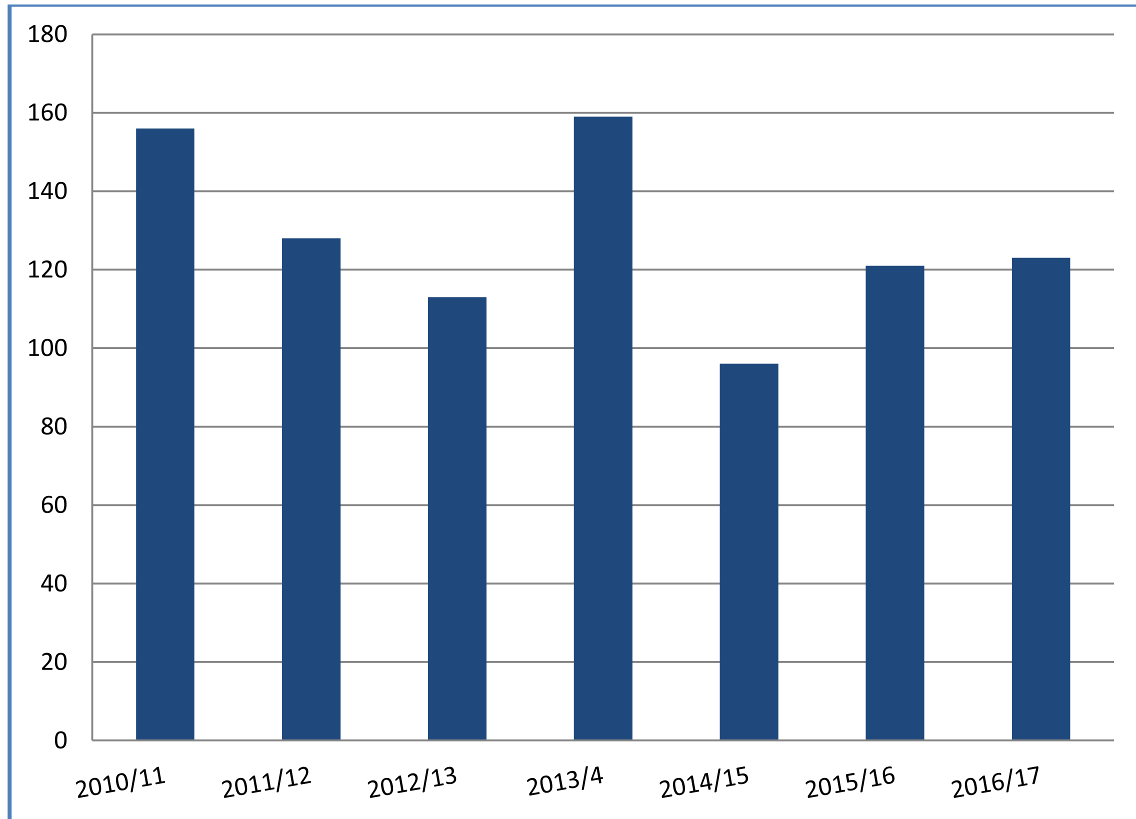
Glossary

Anterograde Amnesia	The loss or partial loss of the ability to create new memories after the event that caused the amnesia.
Bilateral ECT	The two electrodes are placed across the temporal region of the head, one on either side.
Depressive Disorders	A disorder characterised by an all-encompassing low mood accompanied by loss of interest in normally enjoyable activities, loss of weight and poor sleep and other symptoms.
Detained Patient	A detained patient is a person who has been admitted to hospital for assessment on grounds specified in the Mental Health (Northern Ireland) Order 1986, (a)suffering from mental disorder of a nature or degree which warrants his detention in a hospital; (b) failure to detain him would create a substantial likelihood of serious harm to himself or to other persons
Electroconvulsive Therapy	A form of medical treatment for certain psychiatric disorders in which seizures are induced by passing electricity through the brain of an anesthetised patient (generally used as a treatment for severe depression).
International Classification of Diseases – 10 (ICD – 10) 2010	**ICD-10** is the 10th revision of the Statistical Classification of Diseases and Related Health Problems (**ICD**), a medical classification list by the World Health Organization (WHO)
Part II Medical Practitioner	Consultant psychiatrist appointed by RQIA for the purposes of Part II of the Mental Health (Northern Ireland) Order 1986

Second Opinion Appointed Doctor (SOAD)	Consultant psychiatrist appointed by RQIA for the purposes of Part IV of the Mental Health (Northern Ireland) Order 1986
Responsible Medical Officer	The consultant psychiatrist (usually a Part II medical practitioner) in charge of the patient's assessment or treatment.
Retrograde Amnesia	The loss or partial loss of memories that existed before the event that caused the amnesia.
Unilateral ECT	The two electrodes are placed on one side of the head only.
Voluntary Patient	A voluntary patient is a person who voluntarily remains in a mental health facility for treatment, care or observation and has the same rights as people receiving treatment for physical illness

APPENDIX B

Number of Patients Receiving ECT by Year in Northern Ireland 2010-2017



APPENDIX C

Procedure for Seeking a Second Opinion for ECT and Timelines for Requesting a Second Opinion

All second opinions for ECT are arranged through RQIA. The referring consultant contacts RQIA to request a second opinion on their proposed treatment plan to administer ECT. RQIA currently hold a list of 9 approved Second Opinion Appointed Doctors (SOADs).

A SOAD who is available to provide the second opinion is required to visit and interview the patient, review the current case history, discuss the treatment options with the referring Responsible Medical Officer and provide an opinion on whether or not the treatment plan to administer ECT is appropriate. If the SOAD agrees with the treatment plan, their decision is recorded on a Form 23.

If the SOAD disagrees with the plan to administer ECT, he/she will discuss their reasons and other treatment options with the referring consultant. In this case the treatment plan to administer ECT will not proceed.

The timeline for the second opinion is determined by the referring consultant and relates to the urgency of the situation and the timing of the next ECT session. The timeline between referral and the SOAD providing a second opinion is usually within one working week, or in the case of emergency ECT, 48 hours.

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