Essex Partnership University
NHS Foundation Trust

Freedom of Information Request

Reference Number: EPUT.FOI.24.3486
Date Received: 25 April 2024

Information Requested:

Please provide Electro Convulsive Treatment (ECT) information under the FOI act to the following questions: -

1. Please supply patient's information ECT leaflet
Please find attached.

2. Please supply patient ECT consent form
Please find attached.

3. Please supply any ECT reports/investigations
The Trust can confirm that there are no report/investigations.

4. How many ECT in 2023?
608

5. What proportion of patients were men/women?
39% Men and 61% Women

6. How old were they?

ECT Financial Year	No Treatments	MALE		FEMALE	
		18 – 65	Over 65	18 – 65	Over 65
2023	608	12	13	17	22

7. What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?
Please note that the trust's policy is not to provide patient or staff numbers, where the response is less than or equal to five (≤5) as it would potentially allow identification of the individual patient/staff and would therefore be personal data.
The trust considers that release of that information would breach GDPR/DPA18 principles on the grounds that it would not be fair in all the circumstances. This information is therefore exempt under section 40 of the FOI Act 2000.

8. How many people covered by the equality act received ECT?
All - 64

9. How many people were offered talking therapy prior to ECT?
All

10. How many were receiving ECT for the first time?
31

11. How many patients consented to ECT?
33 patients
*In some circumstances, it is necessary to treat patients in the absence of consent if their condition is deemed to be life threatening or that the patient lacks capacity at the time to make an informed decision. In these circumstances the patient is assessed by two medical consultants independently to confirm if treatment is necessary and the decision is taken in the best interests of the patient.

12. How many ECT complaints were investigated outside the NHS and CCG?
There are no (zero) complaints investigated outside of the NHS and CCG.

13. How many patients died during or 1 month after ECT and what was the cause (whether or not ECT was considered the cause)?
Please note that the trust's policy is not to provide patient or staff numbers, where the response is less than or equal to five (≤5) as it would potentially allow identification of the individual patient/staff and would therefore be personal data. The trust considers that release of that information would breach GDPR/DPA18 principles on the grounds that it would not be fair in all the circumstances. This information is therefore exempt under section 40 of the FOI Act 2000

14. How many patients died within 6 months after ECT and what was the cause (whether or not ECT was considered the cause)?
None

15. How many patients died by suicide within 6 months of receiving ECT (whether or not ECT was considered the cause)?
Please note that the trust's policy is not to provide patient or staff numbers, where the response is less than or equal to five (≤5) as it would potentially allow identification of the individual patient/staff and would therefore be personal data. The trust considers that release of that information would breach GDPR/DPA18 principles on the grounds that it would not be fair in all the circumstances. This information is therefore exempt under section 40 of the FOI Act 2000

16. How many patients have suffered complications during and after ECT and what were those complications?
Please note that the trust's policy is not to provide patient or staff numbers, where the response is less than or equal to five (≤5) as it would potentially allow identification of the individual patient/staff and would therefore be personal data. The trust considers that release of that information would breach GDPR/DPA18 principles on the grounds that it would not be fair in all the circumstances. This information is therefore exempt under section 40 of the FOI Act 2000

17. Have there been any formal complaints from patients/relatives about ECT?
Yes

18. If so, what was their concerns?
ECT treatment not provided
ECT not restarted

19. How many patients report memory loss/loss of cognitive function?
19 patients

20. What tests are used to assess memory loss/loss of cognitive function?
Mini-Ace,
CPRS,
Moca

**Please note that either the Mini- Ace or Moca can used for cognitive assessment*

21. Have MRI or CT scans been used before and after ECT?
No

22. If so, what was the conclusion?
N/A

23. How does the Trust plan to prevent ECT in the future?
The Trust recognises that ECT is a recognised form of treatment for certain conditions and will continue to follow NICE and other national guidance in providing the treatments.

Please provide restraints information under the FOI act to the following questions: -

24. Please supply any Restraints/investigations
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

25. How many RESTRAINTS in 2023?
2811- It is important to note that this figure will include occasions of restraint for the same patient.

26. What proportion of patients were men/women?

	Male	Female	Other	Not Stated
Gender	23%	74%	1%	2%

*Other is an available option on the internal form that can be chosen

27. How old were they?

	0-17	18-65	65+	Not stated
Age	1181	1490	130	10

28. What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?
8%
5% of incidents do not have ethnicity recorded.

29. How many people covered by the equality act were restrained?
All Service Users are covered by the Equality Act 2010

30. How many RESTRAINTS were investigated outside the NHS and CCG?
There are no (zero) complaints investigated outside of the NHS and CCG.

8.How many patients died during or 1 month after RESTRAINTS and what was the cause (whether or not RESTRAINTS was considered the cause)?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

31. How many patients died within 6 months after RESTRAINTS and what was the cause (whether or not RESTRAINTS was considered the cause)?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

32. How many patients died by suicide within 6 months of receiving RESTRAINTS (whether or not RESTRAINTS was considered the cause)?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

33. How many patients have suffered complications during and after RESTRAINTS and what were those complications?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

34. Have there been any formal complaints from patients/relatives about RESTRAINTS?
Yes

35. If so, what was their concerns?
Inappropriate restraint

Injury from restraint

36. Are counts of forced injections available?
Counts of Rapid Tranquillisation are kept.

37. How does the Trust plan to reduce restraints in the future?
Please see attached Framework

Please provide SECLUSION information under the FOI act to the following questions: -

38. Please supply any SECLUSION reports/investigations
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual seclusion incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

39. How many SECLUSIONS in 2023?
339

40. What proportion of patients were men/women?

	Male	Female	Other	Not Stated
Gender	40%	56%	1%	4%

41. How old were they?

	0-17	18-65	65+	Not stated
Age	127	205	3	4

42. What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?
16%
6% of incidents do not have ethnicity recorded.

43. How many people covered by the Equality Act were secluded ?
All Service Users are covered by the Equality Act 2010

44. How many SECLUSIONS were investigated outside the NHS and CCG?
There are no (zero) complaints investigated outside of the NHS and CCG.

45. How many patients died during or 1 month after SECLUSION and what was the cause (whether or not SECLUSION was considered the cause)?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost

limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

46. How many patients died within 6 months after SECLUSION and what was the cause (whether or not SECLUSION was considered the cause)?

The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

47. How many patients died by suicide within 6 months of receiving SECLUSION (whether or not SECLUSION was considered the cause)?

The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

48. How many patients have suffered complications during and after SECLUSION and what were those complications?

The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

49. Have there been any formal complaints from patients/relatives about SECLUSION?

Yes

50. If so, what was their concerns?

Inappropriate use of seclusion

51. How does the Trust plan to reduce SECLUSIONS in the future?

Please see attached Framework

Please provide MEDICATION ERRORS information under the FOI act to the following questions: -

52. Please supply any MEDICATION ERRORS reports/investigations

The Trust does not hold this data centrally, to determine this would require a manual trawl of individual records for every patient who had a reported medication error of any type. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit).

53. How many MEDICATION ERRORS in 2023?

447

54. What proportion of patients were men/women?

	Male	Female	Other	Not Stated
Gender	34%	59%	2%	4%

55. How old were they?

	0-17	18-65	65+	Not stated
Age	31	259	52	105

56. What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?
13%
22% of incidents do not have ethnicity recorded.

57. How many people covered by the equality act endured medication errors?
All Service Users are covered by the Equality Act 2010

58. How many MEDICATION ERRORS were investigated outside the NHS and CCG?
There are no (zero) complaints investigated outside of the NHS and CCG.

59. How many patients died during or 1 month after MEDICATION ERRORS and what was the cause (whether or not MEDICATION ERRORS was considered the cause)?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

60. How many patients died within 6 months after MEDICATION ERRORS and what was the cause (whether or not MEDICATION ERRORS was considered the cause)?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

61. How many patients died by suicide within 6 months of receiving MEDICATION ERRORS (whether or not MEDICATION ERRORS was considered the cause)?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

62. How many patients have suffered complications during and after MEDICATION ERRORS and what were those complications?
The Trust does not hold this data centrally, to determine this would require a manual trawl of each individual restraint incident and relating patient records, therefore the Trust is unable to provide all of the information requested as this would exceed the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

63. Have there been any formal complaints from patients/relatives about MEDICATION ERRORS?
Yes

64. If so, what was their concerns?
Poor management of medication
Prescribing errors
Administration errors

65. How does the Trust plan to prevent MEDICATION ERRORS in the future?
Medication incidents reported via the Trust adverse event reporting system (DATIX) are analysed to identify lessons learned to inform clinical practice Improvements. A quarterly medication incident report is undertaken which identifies themes and recommendations for improvements. These are discussed at the Medication Management Group and Medication Safety Group. A significant review of the Trusts medicines management training is underway and this will aim to support reduction in errors.

Section 12 (Exemption where cost of compliance exceeds appropriate limit):

(1) Section 1(1) does not oblige a public authority to comply with a request for information if the authority estimates that the cost of complying with the request would exceed the appropriate limit.

(2) Subsection (1) does not exempt the public authority from its obligation to comply with paragraph (a) of section 1(1) unless the estimated cost of complying with that paragraph alone would exceed the appropriate limit.

(3) In subsections (1) and (2) "the appropriate limit" means such amount as may be prescribed, and different amounts may be prescribed in relation to different cases.

(4) The Secretary of State may by regulations provide that, in such circumstances as may be prescribed, where two or more requests for information are made to a public authority—

(a) by one person, or

(b) by different persons who appear to the public authority to be acting in concert or in pursuance of a campaign, the estimated cost of complying with any of the requests is to be taken to be the estimated total cost of complying with all of them.

(5) The Secretary of State may by regulations make provision for the purposes of this section as to the costs to be estimated and as to the manner in which they are to be estimated

Section 40 (Personal information):

(1) Any information to which a request for information relates is exempt information if it constitutes personal data of which the applicant is the data subject.

(2) Any information to which a request for information relates is also exempt information if—

(a) it constitutes personal data which do not fall within subsection (1), and

(b) either the first or the second condition below is satisfied.

(3) The first condition is—

(a) in a case where the information falls within any of paragraphs (a) to (d) of the definition of "data" in section 1(1) of the Data Protection Act 2018, that the disclosure of the information to a member of the public otherwise than under this Act would contravene—

(i) any of the data protection principles, or

(ii) section 10 of that Act (right to prevent processing likely to cause damage or distress), and

(b) in any other case, that the disclosure of the information to a member of the public otherwise than under this Act would contravene any of the data protection principles if the exemptions in section 33A(1) of the Data Protection Act 2018 (which relate to manual data held by public authorities) were disregarded.

(4) The second condition is that by virtue of any provision of Part IV of the Data Protection Act 2018 the information is exempt from section 7(1)(c) of that Act (data subject's right of access to personal data).

(5) The duty to confirm or deny—

(a) does not arise in relation to information which is (or if it were held by the public authority would be) exempt information by virtue of subsection (1), and

(b) does not arise in relation to other information if or to the extent that either—

(i) the giving to a member of the public of the confirmation or denial that would have to be given to comply with section 1(1)(a) would (apart from this Act) contravene any of the data protection principles or section 10 of the Data Protection Act 2018 or would do so if the exemptions in section 33A(1) of that Act were disregarded, or

(ii) by virtue of any provision of Part IV of the Data Protection Act 2018 the information is exempt from section 7(1)(a) of that Act (data subject's right to be informed whether personal data being processed).

(6) In determining for the purposes of this section whether anything done before 24th October 2007 would contravene any of the data protection principles, the exemptions in Part III of Schedule 8 to the Data Protection Act 2018 shall be disregarded.

(7) In this section— "the data protection principles" means the principles set out in Part I of Schedule 1 to the Data Protection Act 2018, as read subject to Part II of that Schedule and section 27(1) of that Act;

- "data subject" has the same meaning as in section 1(1) of that Act;

- "personal data" has the same meaning as in section 1(1) of that Act.

Publication Scheme:

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a guide to the information that is held by the organisation. EPUT's Publication Scheme is located on its Website at the following link https://eput.nhs.uk

ECT CONSENT FORM – PART A (*for Consultant use)*

SERVICE USER DETAILS

SURNAME			
FIRST NAME(S)			
DOB:		**GENDER:**	
CONSULTANT PSYCHIATRIST			
NHS No:		**PARIS NO:**	

SPECIAL REQUIREMENTS

(other language, other communication methods etc.)

PLEASE NOTE

- Under no circumstances must the Patient be coerced into ECT, e.g. implying the MHA will be applied if the Patient refuses consent.
- Should the Patient's capacity to consent to ECT be in doubt, the Trust Mental Capacity Assessment Form" should be completed and attached to this Consent Form.
- Clinicians must comply with the MHA 1983 Code of Practice (revised 2015) relating to ECT. The relevant documentation must be completed and attached to this consent form.
- Should the patient be detained under the Mental Health Act (MHA), the consent still needs to be completed and CQC ECT Your Right about Consent to Treatment Leaflet should be given to the Patient.
-
- Should the Patient be under 18 years old, the Prescribing Consultant must adhere to MHA Code of Practice 2015.

TO BE RETAINED IN SERVICE USER'S NOTES

STATEMENT BY PRESCRIBING PSYCHIATRIST OR NOMINATED PSYCHIATRIST

EITHER: A course of Unilateral Electro Convulsive Therapy up to a maximum of …… sessions

OR: A Course of Bilateral Electro Convulsive Therapy up to a maximum of …….. sessions

I have handed out: *RCPsych* ECT Information Leaflet ☐

Step by step guide to ECT ☐

Supervising Adult Leaflet ☐

Inpatient/Outpatient guide to ECT ☐

Any other ☐

I have explained: Nature of treatment
Description of the process
The Procedure will involve both *(please tick below)*

General Anaesthesia ☐ Muscle Relaxation ☐

I have advised the patient: *that for the first 24 hours after each ECT,* ☐

- *they must be supervised by a responsible adult (so also not to be in sole charge of a child)*
- *not sign any legal documents*
- *not drink alcohol*
- *not operate machinery, including kitchen appliances*

- *They must also not drive a motor vehicle or ride a bicycle on the road for **48 hours** after each ECT if having it weekly or less often, and should not drive at all for the entirety of an acute (twice-weekly) ECT course*

I have also explained: The intended benefits ☐
Likelihood of success

I have pointed out: The risks of adverse effects ☐
Likelihood of adverse effects *(including dental damage)*
Possibility of memory loss *(occasionally permanent)*
Transient side effects e.g. anaesthetic risk, acute transient side effects (headache, muscle ache etc.), transfer to acute hospital in case of medical emergency, *(post-treatment confusion)*

I have discussed:	The likely consequences of not having ECT Treatment alternatives Alternative treatments will be available if patient decides not have ECT	☐
I have asked the Patient:	If there are any further questions about any other particular concerns	☐

SIGNED **PRINT NAME**

DESIGNATION **CONTACT DETAILS**

DATE

STATEMENT OF INTERPRETER *(where appropriate)*

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

SIGNED

PRINT NAME **DATE**

STATEMENT OF PATIENT

Please read this form carefully. You should already have ECT Information Leaflets that describes the intended benefits, procedure and other useful information regarding ECT. If not, you will be offered a copy now. If you have any further questions, do ask, we are here to help you. Should you wish to obtain additional information or access to independent advocacy, please let us know.

You have the right to change your mind **at any time, including after you have sign this form.**

I agree to the procedure and course of treatment described on this form. ☐

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will however, have appropriate experience. ☐

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. ☐

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health. ☐

I have been informed about additional procedures which may become necessary during my treatment. I have listed below…… any procedures **which I do not wish to be carried out** without further discussion. ☐

I understand that I have at least 24 hours to think about the ECT information provided. I can use this time to discuss the ECT with my relatives, friends and/or advisors. Only after this will I make a final decision about consenting for the treatment. ☐

I have received the ECT information leaflets to read prior to giving consent ☐

I have had the opportunity to discuss the following concerns …….. about ECT with the doctor. ☐

PATIENT'S SIGNATURE

PRINT NAME **DATE**

A witness should sign below if the service user is unable to sign but has indicated his or her consent.

SIGNED **PRINT NAME**

DESIGNATION **DATE**

IMPORTANT NOTES *(Please tick if applicable)*

☐ See Advanced Directive / Advanced Decision *(e.g. Jehovah's Witness Form)*

☐ Service user's relatives have been informed about the treatment. This does not conflict with issues relating to Service User confidentiality. Please document discussions in Service User's notes.

Electroconvulsive therapy (ECT)

This information is for anyone who is considering whether to have electroconvulsive therapy (ECT) – and their families or friends.

You – and your doctors – need to be sure that you are fully informed when making a decision about whether to have ECT or not. Your doctor will talk to you about this. We hope that this information can support you in making this decision by providing information on:

- what ECT is and why it is used
- what is involved in having ECT
- the benefits of ECT
- the risks and potential side effects of ECT
- what might happen if you do not have the treatment
- deciding about having ECT treatment
- where to find further information.

Disclaimer

This resource provides information, not advice.

The content in this resource is provided for general information only. It is not intended to, and does not, amount to advice which you should rely on. It is not in any way an alternative to specific advice. You must therefore obtain the relevant professional or specialist advice before taking, or refraining from, any action based on the information in this resource.

If you have questions about any medical matter, you should consult your doctor or other professional healthcare provider without delay.

If you think you are experiencing any medical condition, you should seek immediate medical attention from a doctor or other professional healthcare provider.

Although we make reasonable efforts to compile accurate information in our resources and to update the information in our resources, we make no representations, warranties or guarantees, whether express or implied, that the content in this resource is accurate, complete or up to date.

What is ECT and why is it used?

ECT is a treatment for some types of severe mental illness that have not responded to other treatments.

An anaesthetic and muscle relaxant are given, and then an electric current is passed across your head. This causes a controlled fit, which typically lasts less than 90 seconds.

The anaesthetic means that you are asleep while this happens. The muscle relaxant reduces the movement of the fit.

It is given as a course of treatments twice a week, typically for 3-8 weeks.

What conditions can ECT be used for?

ECT is most commonly used for depression. It is also used to treat catatonia – an uncommon condition in which a patient may stop talking, eating or moving. Occasionally, it is used to treat people in the manic phase of bipolar disorder.

ECT is not advised for the treatment of anxiety or most other psychiatric conditions. ECT can help symptoms of schizophrenia which has not improved with medication, but the long-term benefits are not known so it is not often used.

When might your doctor suggest ECT?

It will usually be suggested if your condition:

- is life-threatening and you need a rapid improvement to save your life
- is either causing you immense suffering or is likely to get worse, so that a rapid improvement is needed
- has not responded to other treatments, such as medication and psychological therapy
- has responded well to ECT in the past.

How effective is ECT?

Most people who have ECT see an improvement in their symptoms.

In 2018-2019, around 68% of patients were “much-improved” or “very much improved” (1,361 courses out of a total of 2,004). Some patients saw no change in their condition and a small number (1%) felt worse.

How does ECT work?

The effects of ECT gradually build with each treatment. It causes the release of certain brain chemicals. These seem to stimulate the growth of some areas in the brain that

tend to shrink with depression. ECT also appears to change how parts of the brain which are involved in emotions interact with each other. As with many medical treatments, we need more research to help us better understand how ECT works.

Are there different types of ECT?

ECT has changed and developed over the years. For example, the amount and form of electricity used has changed. This has reduced the chance of side-effects.

There are two ways in which ECT is given: 'bilateral' and 'unilateral'.

In bilateral ECT, the current passes across your head, between your temples.

In unilateral ECT, it passes between your right temple and the top of your head.

Bilateral ECT may work faster. Depending on the dose, unilateral ECT has less effect on memory.

You may wish to ask your doctor about which type of ECT would suit you better.

'Maintenance' ECT is occasionally used to help stop you becoming unwell again after a successful course of treatment. It is given less often but over a longer period of time than the first course.

Can ECT be used for children or young people?

ECT is not used for children under the age of 11. It should only be used in a young person aged 11 to 18 as a treatment of last resort – if their illness is life-threatening or is severe and has not responded to other treatments. A formal, independent second opinion is always required before this can happen.

What happens when you have ECT?

ECT is given in hospital. You will probably already be an inpatient in hospital, although some people do have ECT as day patients.

As a day patient, a named, responsible, adult will have to accompany you to and from the ECT clinic.

The treatment will usually be done in a set of rooms called the "ECT suite", although some ECT services are based in an operating theatre. There should be a room where you can wait, a room where you have your treatment, and a room where you can recover properly before leaving. Qualified staff will look after you all the time you are there. They can help you with the process of waking up from the anaesthetic and during the time straight after the treatment.

If you have significant medical problems you may need to be treated in another hospital with more medical support.

Preparing for ECT

In the days before your course of ECT is started, your doctor will arrange for some tests to make sure it is safe for you to have a general anaesthetic. These may include:

a record of your heartbeat (ECG)

blood tests

a chest X-ray.

You must not eat or drink anything for 6 hours before the ECT, although you may be allowed to drink sips of water up to 2 hours beforehand. This is so you can have the anaesthetic safely.

What happens on the day of your ECT treatment?

If you are an in-patient, a member of staff will come with you to the ECT suite. They will know about your illness and can explain what is happening. Many ECT suites are happy for family members to stay in the waiting room while you have your treatment.

You will be met by a member of the ECT staff, who will do routine physical checks (if they have not already been done). They will check that you are still willing to have ECT and will ask if you have any further questions.

When ready, the ECT staff will take you into the treatment area.

The anaesthetic staff will connect monitoring equipment to check your heart rate, blood pressure and oxygen levels. Staff will also connect you to an electro encephalogram (EEG) machine. This will monitor your brain waves as the treament happens, so staff can measure the length of the ECT fit.

You may be given oxygen to breathe through a mask. The anaesthetist will give your anaesthetic through an injection into the back of your hand. Once you are asleep, they will add a muscle relaxant. When you are asleep, a mouth guard is put in your month to protect your teeth.

While you are asleep, two electrical pads about the size of a 50 pence piece are placed on your head. One goes on each side in bilateral ECT and both go on the same side in unilateral ECT. These are connected by wires to the ECT machine.

The ECT machine delivers a series of brief electrical pulses, for three to eight seconds. This will make you have a controlled fit. Your body will stiffen and then there will be twitching, usually seen in your hands, feet, and face. The muscle relaxant reduces the amount of movement involved. This controlled fit usually lasts from less than 90 seconds

The muscle relaxant wears off within a couple of minutes. The mouth guard will then be removed. As soon as the anaesthetist is happy that you are waking up, staff will take you through to the recovery area. Here, an experienced nurse will look after you until you are fully awake.

When you wake up, you will be in the recovery room with a nurse. They will take your blood pressure and ask you simple questions to check how awake you are. There will be a small monitor on your finger to measure the oxygen in your blood. You may wake up with an oxygen mask. It can take a while to wake up fully and,

at first, you may not know quite where you are. After half an hour or so, these effects should have worn off.

Most ECT units have a second area where you can sit and have a cup of tea or some other light refreshment. You will leave the ECT suite when your physical state is stable, and you feel ready to do so.

The whole process usually takes around an hour.

Before you leave the ECT suite, staff will advise you:

not to drink alcohol for 24 hours after each treatment

to have a responsible adult with you all the time for the 24 hours following each ECT treatment

to not sign any legal documents for at least 24 hours following each ECT treatment.

How often and how many times is ECT given?

Usually, twice per week, with a few days in between each treatment. It can take several sessions before you notice an improvement. It is not possible to predict, in advance, how many treatments you will need.

On average, the total number of treatments you might have in a course is between 9 and 10, although it is common to have 12 treatments and more may sometimes be needed.

If you have had no improvement at all after 6 treatments, your treatment plan should be reviewed with your doctor to discuss whether to continue or change the form of ECT.

Your medical team will regularly review how you are responding to the ECT. They will discuss your progress – and any side effects or concerns – usually every week.

ECT should be stopped soon after you have made a full recovery – or if you say you don't want to have it anymore and are well enough to understand this decision.

What happens after a course of ECT?

ECT is one part of getting better. It should also help you to use (or start again with) other treatments or types of support.

You will usually continue or start medication after ECT – this will help to maintain the improvements you have had from your ECT treatment.

Talking therapies – such as Psychotherapy, CBT and Counselling – can help you to work on any reasons for your depression and to develop ways of staying well. Changes in your day to day lifestyle can also be helpful: taking regular exercise, eating better, a regular sleep pattern and using techniques like mindfulness and meditation.

The clinic will usually contact you to ask about your memory 2 months after your last treatment.

How is the quality of ECT in my local hospital assessed?

The Royal College of Psychiatrists has set up the ECT Accreditation Service (ECTAS). This provides an independent assessment of the quality of ECT services. ECTAS sets standards for ECT and visits all the ECT units who are members. The visiting team involves a psychiatrist, anaesthetist, nurse, ECTAS patient representative, and a member of the ECTAS project team. Membership of ECTAS is not compulsory but almost all active ECT units are accredited. Your unit can tell you if they are accredited by ECTAS.

What are the side effects of ECT?

As with any treatment, ECT can have side effects. These are affected by factors such as the level of the current being passed through the brain and your age.

Side effects are usually mild and short term but can sometimes be more severe and potentially long-lasting.

If you experience side effects during the course, the treatment can be adjusted.

Short-term side effects

Immediately after an ECT treatment, you may feel:

- Headache.
- Aching in the muscles and/or jaw.
- Tiredness while the effects of the anaesthetic wear off.
- Confusion, particularly if you are elderly. This usually wears off after 30 minutes.
- Sickness or nausea.

A nurse will be with you while you wake up after ECT. They can also give you simple pain relief, like paracetamol.

Up to 40% of patients can have temporary memory problems while they are having ECT. For example, they may forget conversations with visitors during this time.

About a fifth (17%) of people say that their memory was already causing them problems before they have ECT. This is often because of their depression. Directly after treatment, this figure increases to 23%; however, in most people, memory difficulties clear within two months of the last treatment and it do not cause problems or distress.

Nevertheless, about 2% of people complain of severe memory problems directly after ECT.

A small number of patients report gaps in their memory about events in their life that happened before they had ECT. This tends to affect memories of events that occurred during, or shortly before, the depression started. Sometimes these memories return fully or partially, but sometimes these gaps can be permanent.

All medical procedures carry risk; however, death caused by ECT is extremely rare. If the anaesthetist considers it unsafe to give you an anaesthetic, you will not be able

to have ECT. The death rate following ECT is less than that for other minor surgical procedures.

Very rarely, ECT can trigger a prolonged seizure. This would be immediately treated by the medical staff present.

Long-term side effects

The extent of long-term side effects is controversial. Reports of these problems vary widely between studies, depending on how they are done.

Rigorous scientific research has not found any evidence of physical brain damage to patients who have had ECT. There is no increased risk of epilepsy, stroke or dementia after ECT.

Some patients do say that they have suffered brain damage and that they do have long-term side effects that have changed their lives. Testimony from user groups and observational studies have suggested that, after ECT, some people also experience a change in their personality, a loss of creativity, energy and/or drive, or lack of emotions.

However, ECT is only used when people are severely ill or other treatments have not worked, so it is difficult to separate out the effects of ECT from the effects of the illnesses it is treating.

What is clear is that most people benefit from ECT treatment and a small number report some long-lasting side effects. We need more research to understand what is happening for those patients who are reporting distressing symptoms – and to find ways to help them.

What can happen if you don't have ECT?

You and your doctor will need to look at the risks of side effects from the treatment with the risks, for you, of not having ECT. Not having the treatment may mean that you are more likely to have:

Prolonged and disabling mental illness.

Serious physical illness (and possibly death) from not eating or drinking.

An increased risk of death from suicide.

ECT can work when other treatments have failed. Some patients who have previously been successfully treated with ECT have found it so helpful that they have asked to have ECT if they become ill again.

Driving and ECT

If you are severely ill enough to need ECT you should probably not be driving. The DVLA advise that you should not drive during a course of ECT and you (or your carer) may be asked to sign a form saying that you will not drive during a course of acute ECT. After you have finished the course, it may be a little while before you can start driving again. The DVLA, with advice from your doctor, will make this decision.

The situation is different if you have maintenance ECT. You can normally continue to drive but should not do so (or ride a bike or operate heavy machinery) for at least 48 hours after an ECT treatment.

Deciding about ECT

Giving consent to having ECT

Like any significant treatment in medicine or surgery, you will be asked for your consent, or permission, to have ECT.

The ECT treatment, the reasons for doing it and the possible benefits and side-effects should be explained in a way that you can understand. If you decide to go ahead, you then sign the consent form. It is a record that ECT has been explained to you, that you understand what is going to happen, and that you give your consent to it. However, you can withdraw your consent at any point, even before the first treatment. You should be given a leaflet explaining your rights about consenting to treatment.

Can I make my wishes about having ECT known in advance?

If you have feelings about ECT (for or against), you should tell the doctors and nurses caring for you, as well as friends, family or anyone else you would like to support you or speak for you. Doctors must consider these views when they think about whether or not ECT is in your best interests.

If, when you are well, you are sure you would not want ECT if you become ill then you may want to write a statement of your wishes. This can be known as an 'advance decision' in England, Northern Ireland and Wales, or an 'advance statement' in Scotland. These wishes should be followed except under very specific circumstances – this is a complicated area and beyond the scope of this leaflet.

Can ECT be given to me without my permission?

Some people become so unwell they are said to 'lack capacity' to decide about ECT. This means they cannot properly understand the nature, purpose, or effects of the treatment. There are laws in the UK that allow doctors to decide about giving ECT treatment for people in this situation. These come with legal safeguards to ensure treatment is only given if it is really necessary.

This is the case for around half of people who receive ECT treatment. Reassuringly, people who have ECT in this way do just as well as those who have been able to give consent.

Where can I get more information?

You can find out more information via the links below:

healthtalk.org resource on ECT

MIND information on ECT

Rethink Mental Illness factsheet on ECT

Further reading

National Institute for Health and Care Excellence (NICE)

Guidance on the use of electroconvulsive therapy. Technology appraisal guidance [TA59].

Depression in adults: recognition and management. Clinical guideline [CG90].

The use of electroconvulsive therapy: Understanding NICE guidance – information for service users, their advocates and carers, and the public (PDF).

Scottish ECT Accreditation Network (SEAN)

A site designed to complement the work of SEAN, by enabling communication of the latest information on ECT in Scotland.

Visit SEAN

Electroconvulsive Therapy Accreditation Services (ECTAS)

Launched in May 2003, ECTAS aims to assure and improve the quality of the administration of ECT. It accredits clinics that meet the defined threshold of compliance with ECTAS standards.

Visit ECTAS

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Committee on ECT and related treatments

Electroconvulsive Therapy Accreditation Services (ECTAS)

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This information was revised in July 2020.

Contact for help and support

We are open 9am to 5pm

0300 790 0559

If we are not there you can leave us a message.

essexadvocacy@rethink.org

rethinkessexadvocacy.org

Rethink Mental Illness.

Leading the way to a better quality of life for everyone severely affected by mental illness.

facebook.com/rethinkcharity

twitter.com/rethink_

rethink.org

The service is free to access and is independent of all services.

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Rethink Mental Illness is the operating name of National Schizophrenia Fellowship, a company limited by guarantee.

Rethink Advocacy

Independent Mental Health Advocacy (IMHA)

Essex All Age Advocacy Service

You are entitled to support from a qualified Independent Mental Health Advocate (IMHA) if you are:

- Currently being detained under certain sections of The Mental Health Act
- Subject to a Guardianship or Community Treatment Order (CTO)
- Considering certain treatments which have been suggested to you.

Empowering

The advocacy process is something that you are in control of, your advocate will not act on your behalf without your permission.

To request advocacy please contact us on 0300 790 0559 to make a self-referral.

Or you can ask a member of staff to make a referral.

An IMHA can help you with the following:

- Rights under The Mental Health Act 1983
- Access information on medication and treatment
- Appealing your section
- Preparing for and attending meetings such as CPA meetings and ward rounds
- Raising concerns you have about your care
- Support you to ask for fewer restrictions.

Confidentiality

We believe in respecting and maintaining confidentiality, we will not share personal information unless we have your permission.

Independence

We are independent of the NHS and services.

NHS
Essex Partnership University
NHS Foundation Trust

Reducing Restrictive Practice

People together creating safety, effectiveness and experience through our Quality of Care Strategy 2024 /25

Vijay Chuttoo Deputy Director for Quality and Safety, Specialist Services

Lianne Joyce Deputy Director for Quality and Safety, Acute Services

Jason Gunn Expert by Experience and Safety Partner

Quality Planning

Why Focus on Restrictive Practices:

Regulatory compliance

Recent UK National and Local Drivers

- Winterbourne Review (2011)
- MIND Report (2011)
- RCN guidance (2013)
- Positive and Proactive Care (2014)
- MHA Code of Practice (2015)
- NICE Guideline (2015)
- NICE Quality Standard 154 (2017)
- Use of Force Act, Seni's Law (2018)
- Royal College of Psychiatrists Collaborative (2019)
- CQC Out of sight – who cares (2020)
- Towards Safer Services (2022)

Reducing Restrictive Practice 2024/25

Background and Contextual factors

- To provide person centred care with dignity and respect, understanding people are experts in their own experiences.
- Ensure any restrictive intervention are undertaken in the best interests of the person and/or others around them and only as a last resort to maintain safety
- Use of recommendations and learning from quality improvement to date, Evaluate 23/24 RRP data and ensure clear, accurate and transparent data around use of restrictive practices underpins and drive improvements through both quantitative and qualitative data
- Establish a culture of co-planning, co-production, co-delivery and co-evaluation, with develops partnership working and local level engagement with the National Collaborative
- Develop a culture of improving safety, experience and reducing the use of restrictive practices which is sustained
- Aligns with the Trust strategic objectives to be Inclusive, least restrictive, and trauma informed in promoting recovery
- Underpinned by national reports (2011), Royal colleges guidance (2013,2019) Mental Health Act (2015), NICE Quality standard(2017), Use of Force Act (2018), CQC out of sight(2020), Towards safer services(2022), CQC quality statements (2023)

Quarter 1	• Ensure any use of Seclusion and Long Term Segregation is in line with the Mental Health Act Code of Practice • Self Harm **SAFETY IMPROVEMENT PLAN** • Staff training in prevention, de-escalation and use of restraint techniques are up to date including the use of Safety Pods • Evaluate the impact of TASI training focusing on the values and attitudes towards restrictive practices • Facilitation of Reducing Restrictive Practice Learning Matters events
Quarter 2	• Use of digital technology to support learning and reduce the use of restrictive • Implementation of Safe Wards and Safety in Motion interventions • Ensure there are processes in place to review global restrictions • Establish drop-in sessions for the use of restrictive practices
Quarter 3	• Roll out of sensory strategies for de escalation across inpatient area • Ensure all patients identified as needing a PBS and Safety plan have one • Develop and embed the use of simulation in training • Evaluation of the introduction of Peer Support Workers in relation to incidents of self harm, violence and aggression and the need for restrictive interventions
Quarter 4	• Creation of a portal on EPUT intranet as a central source of information • Use quantitative data and qualitative feedback from patients, carers and staff to drive improvements • Ensure that we are monitoring physical health with any use of restrictive interventions and following any administration of rapid tranquilisation medication • Establish a model for debriefing after incidents • Develop a bespoke CAMHS training element to our training

Reducing restrictive practice 2024/25

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
To reduce restrictive practices by 7.5% by end of 2025	Enhancing Environments	1. Patient choice and empowerment 2. Communication between staff and SUs 3. Predictive tools 4. MHA CoP	Intentional rounding Safety cross SBAR DASA
	Staff and Culture	1. Leadership 2. Communication 3. Attitude (flexibility, openness, respect) 4. Training 5. Integrated working	MDT handovers Safety huddles
	Continuous Learning	1. Evidenced based interventions 2. Reduce global restrictions 3. Data	Safety Pods PBS Plans
	Co production	1. NatPatSIP Collaborative 2. Patient Safety Partners 3. Wellbeing	Debriefs DBT skills Ward Activities

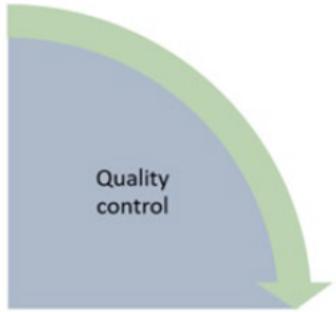
Quality Control

MONITORING AND REVIEWING

Quality Control

- We will use self-reported audits which can be used to schedule and perform audits agreed through the annual Quality planning cycle
- We will use Tendable team audits to help identify learning and where improvments are required
- Peer visits will help us develop auditing peer teams that can share best practices with other teams and share observations from audits with their own team
- ***Delivery against this framework will be monitored by the restrictive practice sub-committee. There will be quarterly reports to the Quality Committee which will hold the sub-committee to account for delivery***
- Our driver diagram sets out our areas of focus and the measures and benefits we wish to achieve throughout the framework. An action plan has been produced which is being tracked through a project plan and dashboard. The plan sets out actions, responsible officers, and timeframe for delivery for each annual milestone and will be tracked using the dashboard.
- Our Patient Safety dashboard provides up to date data on our use of restraints and is being further developed to monitor against all areas of restrictive practices as defined by the CQC.
- ***Our aim is to achieve a 7.5% reduction in our use of restraints, seclusion and our number of violent incidents by the end of Q4 2024***

Reducing restrictive practice 2024/25



Q1 and Q2– No reduction expected as we introduce our interventions

Q3 – 2.5% reduction expected

Q4 – 7.5% reduction expected

Quality Outcome Measure/ Indicator	Measure	Monitor	Challenges
Quantitative			
Restraint (key measure)	Reduction in numbers with protected characteristics thematics	RRP Group and Care Unit	Acuity, staff skills, resources to support change
Violence (Key measures)	Reduction in numbers with protected characteristics thematics	RRP Group and Care Unit	Acuity, staff skills, resources to support change
Seclusion (Key measure)	Reduction in numbers with protected characteristics thematics Standards compliance.	RRP Group and Care Unit	Acuity, staff skills, resources to support change
Long Term Segregation	Standards compliance. Reduction in duration	RRP Group and Care Unit	Acuity, staff skills, resources to support change
RIDDORS due to violence	Reduction in numbers	RRP Group and Care Unit	Acuity, staff skills, resources to support change
Blanket Rules	Clear processes to review rules	RRP Group and Care Unit	Acuity, staff skills, resources to support change
Qualitative			
Thematic review of complaints from carers/ patients in relation to use of restrictive practices	Reduction in most common themes. Protected characteristics thematics	RRP Group and Care Unit	Acuity, staff skills, resources to support change
Review of staff values and attitudes towards restrictive practices	Understanding of principles to RRP	RRP Group	Resources to support change
Thematic review of MDT communication	Understanding of principles to RRP	RRP Group	Resources to support change

Reducing restrictive practice 2024/25

Accreditation

As an organisation we are currently certified by the Restraint Reduction Network under the British Institute of Learning Disability Association of Certified Training scheme for our training that we deliver to staff called TASI, which is Therapeutic and Safe Interventions. TASI training compromises of both theoretical knowledge around reduction of violence and de escalation and physical interventions in the event that a crisis needs to be managed.

Collaborative partner quality visits

EPUT is in a Reducing Restricting Collaborative Partnership agreement with Summerset PFT, Surrey and Borders PFT , Oxford PFT and Avon and Wiltshire PFT. As a collaborative we are responsible in assuring the quality of each others reducing restrictive practice work and have a schedule of Peer review visits across the year for the training we deliver.

Quality and Safety Review and Patient Safety Walkarounds

Our Quality and Safety Review process and Patient Safety Walkarounds together with our Safety Partners will enable us to engage with clinical services around Safety, Experience and Effectiveness. The reviews and Walkarounds will help us learn how we are safely managing incidents and how teams are progressing the reducing restrictive practices work.

Proactive management of audit results and trend identification

We will continue to use data to focus our improvement work to reduce restrictive practices.

We will continue to capture feedback from our staff, patients and carers

Through engagement forums, compliments, complaints and purposeful questionnaires such as an Appreciative Inquiry we will continue to capture feedback from our staff, patients and carers.