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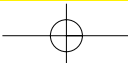
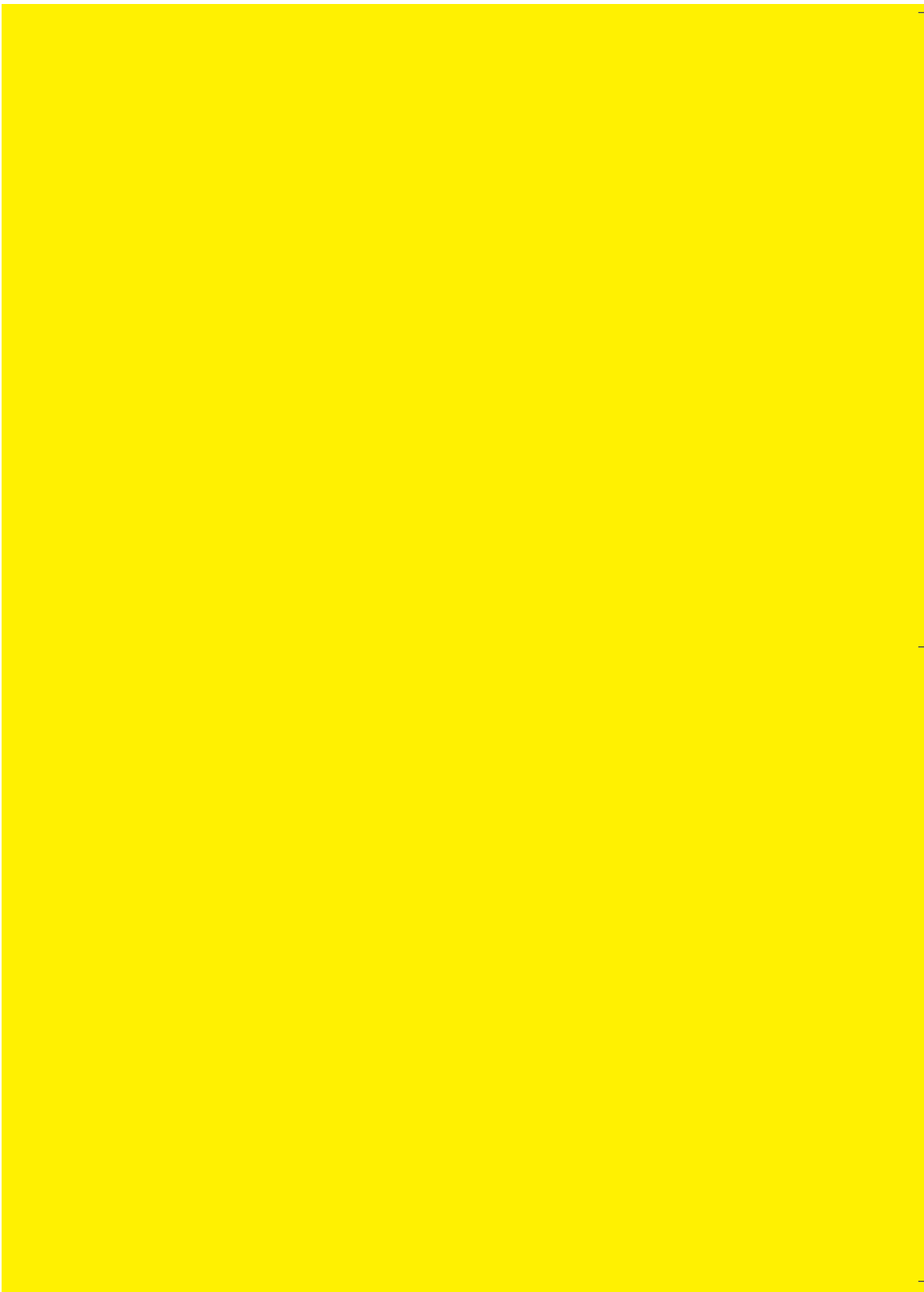
Electroconvulsive Therapy Accreditation Service
(ECTAS)

SECOND NATIONAL REPORT

October 2005 - October 2007

Editors: Joanne Cresswell, Chloë Hood, Paul Lelliott

Foreword by Dr Chris Freeman



Foreword

ECTAS is now in its 4th year of existence and we are well into the second round of accreditation visits. Over 20 clinics have been re-visited and re-accredited for their second three-year cycle of membership. We estimate that there are somewhat less than 160 ECT Clinics in England and Wales and almost two thirds have joined the ECTAS network. A number of interesting and important findings emerge in this second report.

Rates of ECT in England and Wales are still falling and the curve is a fairly steep one with no sign of levelling out. There are important clinical questions to address about what the appropriate rate of ECT might be and whether patients in some areas are being under-treated. As far as ECTAS quality assurance is concerned, the main issue is the viability of small clinics in terms of sufficient clinical activity to maintain standards. Merging smaller clinics is obviously one solution, which many Trusts have adopted, but this may result in patients travelling long distances. Evidence also indicates that when a local clinic goes, prescription rates for ECT fall even further. The cause of this decline certainly needs further investigation. In almost every other developed country rates of ECT are either steady or rising - for example, in Holland, which was giving virtually no ECT in the 1980s, they have increased from 20 clinics a few years ago to 35 currently with prescription rates continuing to rise.

The second issue to highlight is the generally high standard of ECT clinics in England and Wales. This is certainly much higher than any of us expected. We knew there were some very good clinics but expected to find more where standards were low. The high standard is certainly not because the ECTAS review process is lax - it is extremely detailed and rigorous. We think that the ECTAS process itself may be driving up standards. The public availability of the ECTAS standards, together with the self audit phase of the accreditation process, mean that the clinics are informed on current best practice and know what they need to achieve. It does appear that clinics are updating their procedures and protocols in advance of engaging with ECTAS.

The third point is the improvement in clinics between Cycle 1 and Cycle 2. This shows that standards are being, at least, maintained and probably improving further. We are constantly revising

standards and the bar always goes up rather than down. It is considerably harder to achieve accreditation with excellence in 2007 than it was in 2004 and yet several clinics have achieved this second time around. (See table 1).

We have given presentations of the ECTAS standards and process at international ECT meetings in Europe and the USA and the programme has attracted considerable interest. Many countries have expressed an interest in setting up an ECTAS type system to help them determine and drive up standards. However, the step from current circumstances to a fully functioning ECTAS type system is a major piece of work which most countries cannot immediately consider, which I think highlights the comprehensive and thorough nature of the ECTAS system.

Finally, I would like to thank all the in-house ECTAS Team for their hard work and support over the past 2 years and particularly to thank our panels of reviewers who put in a considerable amount of time and effort in carrying out accreditation visits and in attending accreditation advisory committees.

Chris Freeman
Consultant Psychiatrist/Psychotherapist
ECTAS Chairman
December 2007

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Background

The ECT Accreditation Service (ECTAS) was established in May 2003 to promote better standards of ECT practice in England, Wales, Northern Ireland and the Republic of Ireland. ECTAS is managed by the Royal College of Psychiatrists' Centre for Quality Improvement which works in partnership with the Royal College of Anaesthetists and the Royal College of Nursing.

The accreditation status of clinics is published on the website of the Royal College of Psychiatrists and shared with the Healthcare Commission. The Commission is represented on the ECTAS Reference Group and membership of ECTAS was a key indicator in the Commission's 2007 health improvement reviews of acute inpatient mental health services.

Although it results in a decision about accreditation status, the ECTAS process promotes a culture of continuous quality improvement rather than one off inspection. It involves rigorous self and peer review against a set of standards¹. Each ECTAS audit cycle is three years long beginning with a self and peer review after which a decision is made about accreditation status. Accredited clinics are provided with a full report and action plan and each undertakes a further self review at 18 months to ensure that the clinic has maintained its standards and is addressing the issues raised in its action plan. Once a clinic has completed the full three-year cycle, the process begins again and the clinic moves to Cycle 2.

The ECTAS standards are based on best available evidence and are constantly reviewed by a multi professional reference group (see appendix 1). An updated set of standards is published yearly in December and member clinics are expected to update their clinical practice in line with this.

The standards are divided into three types:

Type 1 standards are essential to safety, rights, dignity and the law.

Type 2 standards are those that an accredited clinic would be expected to meet.

Type 3 standards are aspirational and would be met by an excellent clinic.

In order for a clinic to be accredited they must meet all type 1, the majority of type 2 and some type 3 standards.

Update on recommendations made in the first report

Training was developed and provided for psychiatrists referring patients for ECT (see section 4). This will be rolled out and focused competency based training provided for all disciplines within ECT.

The Royal College of Psychiatrists' Special Committee on ECT has provided an up to date patient information leaflet which is available on the website.

AAGBI (Association of Anaesthetists of Great Britain and Ireland) *Recommendations for standards of monitoring during anaesthesia and recovery*² have now become a type 1 ECTAS standard, which all ECTAS member clinics must meet.

This report

This report summarises the work of ECTAS and focuses on what has happened since the first report was published in October 2005.

Section 1 gives an overview of the performance of ECTAS clinics, including their accreditation status and primary reasons for deferral.

Section 2 examines those clinics that have completed the self and peer-review for a second time at the beginning of Cycle 2 for evidence of improvement over time.

Section 3 discusses the provision of ECT services throughout England and changes over time by comparing the results of a recent survey undertaken by ECTAS with previous surveys by the Department of Health.

Section 4 considers the competencies and training needs of staff working in ECT clinics.

Section 5 offers the patient perspective in relation to quality of care as measured by the questionnaires completed by patients as part of the review process.

Section 6 draws recommendations from the work of ECTAS.

The appendices include ECTAS related publications, membership of committees and accounts for 2003-2007.

Section 1

Overall performance of ECTAS member clinics

As of October 2007, 95 ECT clinics in England, Wales, Northern Ireland and the Republic of Ireland are current members of ECTAS. Table 1 shows the status of these clinics at the time of writing. (Since 2003 112 clinics have enrolled with ECTAS. 17 have since closed so are not included in table 1).

Table 1: Status of member clinics at October 2007

Cycle 1

Accredited with Excellence	10
Accredited	28
Accreditation Deferred	6
Failed Accreditation	0
In self/ peer review stage	16
Total	60

Cycle 2 (all Cycle 2 clinics were accredited during Cycle 1)

Accredited with Excellence	5
Accredited	10
Accreditation Deferred	0
Failed Accreditation	0
In self/ peer review stage	20
Total	35

Accredited with Excellence

To achieve the highest category of accreditation, a clinic must meet all type 1, at least 95% of type 2 and the majority of type 3 standards. In the majority of these clinics there is also strong evidence of research, audit or teaching. The 15 clinics that at October 2007 were accredited with excellence are:

Bodmin Hospital, Cornwall
 Broadoak Unit, Liverpool
 Calderdale Hospital, West Yorkshire
 Dorothy Pattison Hospital, Walsall*
 Downshire Hospital, NI
 Elm Mount Clinic, ROI
 Fieldhead, West Yorkshire

Glenbourne Hospital, Plymouth*
 Lagan Valley Hospital, NI
 Maudsley Hospital, London
 Parkwood ECT Suite, Blackpool*
 Princess Marina, Northampton
 Priory, Roehampton
 Prospect Park, Reading
 Purbeck Suite, Poole*

*Four of these clinics progressed to excellence in Cycle 2.

Reasons for deferral

32 of the 79 clinics that have been presented to the ETSC during Cycle 1 were deferred. The primary reasons are listed in the table below. Some clinics were deferred for more than one reason.

Table 2

Reason	No. Clinics
Deficient documentation inc protocols & record keeping	20
No dedicated sessional time for a consultant psychiatrist	12
Lack of an ODP	6
Failure to record ASA grade	9
Facilities	4
Absence of a capnograph	3

Out of the 32 clinics deferred 20 had deficient documentation, protocols and record keeping, such as incomplete anaesthetic/ physical assessments and absent protocols for events such as anaphalaxis and malignant hyperthermia. As evidenced in the health record audit, in all clinics who are members of ECTAS there is some deficiency in paperwork and record keeping.

To date ECTAS has not offered examples of good practice/ protocols in this area in order to encourage clinics to develop their own which are relevant to their own practice, as clinics vary nationwide.

However, as this continues to be a problem, ECTAS has been working with the National Association of Lead Nurses in ECT to develop examples of generic protocols/ documentation which clinics will be able to download and modify to suit their own area of practice, and these will be available on both the ECTAS and NALNECT websites in the near future.

Section 2

Quality improvement and the promotion of best practice

By October 2007, 15 clinics had entered their second three-year cycle, completed their second peer-review and had the results presented to the ETSC.

All of these 15 clinics were reaccredited, with four progressing to excellence following Cycle 2. This picture of improvement is supported by table 3 which shows the percentage of all c200 ECTAS standards met by the 15 clinics at Cycle 1 and Cycle 2. At Cycle 2, three clinics met 100% of ECTAS standards.

Table 3: Overall improvement (%) of all standards met by 15 clinics in Cycle 2.

CLINIC NUMBER	2004 (Cycle 1) % Standards Met	2007 (Cycle 2) % Standards Met
29	82	86
20	85	97
3	87	96
35	88	95
17	93	93
7	81	93
11	83	100
27	84	100
24	92	100
41	84	93
38	95	97
18	97	97
6	70	93
28	78	96
13	89	98
Average	86%	96%

Section 3

The provision of ECT services³

The first ECTAS National Report suggested that the number of ECT clinics was falling with NHS providers concentrating resources and staff in fewer clinics. Although this might lead to better ECT practice, it could also lead to patients having to travel long distances for treatment and, ultimately, to patients being effectively denied access to ECT. In 2006, ECTAS appointed an honorary specialist registrar in psychiatry to research this further.

The aims of the study were to: i. measure the number of ECT treatments being delivered in England; ii. compare this with previous activity as determined by Department of Health surveys in 1999 and 2002 and iii. describe changes in provision over the previous five years and expected changes in the next five years.

The method employed was a postal survey sent to all Trusts in England asking about the number of ECT treatments delivered between 1st January and 31st March 2006 and about changes in provision of ECT clinics over the previous five years and about planned changes over the next five years.

We received responses from 56 of 76 Mental Health Trusts (74%).

Summary of results

Number of clinics

- The 56 Trusts provided a total of 109 clinics. If the respondents are typical of non-respondents, there are approximately 149 clinics in England.
- Three Trusts had no ECT clinic. Their practice was to purchase the treatment from another provider and to transport patients.
- Data from 84 clinics showed that over the past five years 27 clinics have closed.
- Fourteen Trusts planned to centralise or amalgamate the ECT service, one planned to close a clinic without re-provision and one to purchase ECT from an external provider.

Treatments

- The average number of treatments delivered per session was 3.4 with a median of two.
- Due to low patient numbers, a high number of clinic sessions were cancelled and five clinics operated on an as required basis.
- We estimate that the number of patients and applications of ECT have approximately halved since 1999 (2400 to 1300 and from about 16,500 to about 6,800 respectively).
- About the same percentage of patients are treated under the Mental Health Act as was the case in 1999 (25-30%).

The implications for ECTAS

Maintenance of skills, training and competence for ECT staff

This is mentioned in more depth in section 4 of this report. Clinics that have smaller patient numbers or run less frequently must ensure that clinicians remain skilled and updated in ECT practice and there is a dedicated ECT team to provide the service.

Availability of ECT treatment for patients and distance of travel

If Trusts over rationalise ECT provision or do not provide a service, it may no longer be an available treatment for patients who require it, or the distance required to travel to receive the treatment may make it nonviable financially or unfeasible for the patient due to the level of their illness. Trusts should take this into account during the decision making process.

On a positive note, for Trusts that have successfully rationalised their service to one or two locations, with the travel issues rectified to ensure availability for patients, this has generally had a positive impact on ECT service provision, enabling the Trusts to centralise funding, have dedicated ECT staff and optimise facilities.

Section 4

Training and Competencies within ECT

In response to a finding from Referring Psychiatrist questionnaires⁴ that one-half of 275 psychiatrists who prescribed ECT felt they required further information and support, the first ECTAS National Report recommended that training be developed and provided for this group. 47 referring psychiatrists attended a training day in November 2006 and gave very positive feedback.

ECTAS has extended this work and, as part of its remit of improving the quality of ECT practice, is developing sets of competencies and training for nurses, anaesthetists and psychiatrists who prescribe or provide ECT.

Nurses

Currently there are no national competencies for nurses working in ECT. However some clinics have devised their own local competency based training. Traditionally, the ECT nurse tends to inherit the role as part of a job package and often has to rely on their own motivation to seek to develop their knowledge and skills often relying on the goodwill of the ECT lead psychiatrist responsible or their nurse predecessors. The ECT nurse often works in isolation from his/her peers because there is rarely more than one clinic per hospital. This leads to inconsistency across services in the role specification and wide variation in knowledge, skills and therefore in practice. ECTAS is working with the National Association of Lead Nurses in ECT (NALNECT) and the Royal College of Nursing (RCN) to develop a concise set of competencies for nurses working in ECT. These will be published in January 2008. We will then offer training, accredited by the RCN, for nurses. The competencies and training will become ECTAS standards in 2008.

Psychiatrists

A consistent finding of national audits over three decades is that ECT training for the junior doctors who administer ECT is limited and ad-hoc. ECTAS and the Royal College of Psychiatrists' Special Committee on ECT are therefore devising competencies for psychiatric trainees. These competencies have three levels ranging

from awareness to expertise and have also been adapted to meet the required competency of lead psychiatrists in ECT. The competencies have been forwarded to the Dean of the Royal College of Psychiatrists to be approved and actioned for trainees and ECTAS will be working with the College Education and Training Centre to provide accredited training for lead psychiatrists. Standards drawn from these competencies will appear in the ECTAS standards in 2008.

Anaesthetists

Representatives from the Royal College of Anaesthetists on the ECTAS Reference Group are advising on standards relating to anaesthetic competencies and these will be included in the ECTAS standards in 2008.

Section 5

The Patient's Perspective⁵

Patient feedback must inform administration of ECT, provision of information and standards of care. The ECTAS team analysed 389 patient questionnaires that were collected as part of the ECTAS accreditation process between September 2004 and February 2006. The questions elicited both categorical and free-text responses.

Results

Quality of Care

Nine key standards refer to the accompaniment of the patient to the treatment room by a member of staff, the cleanliness of the clinic, the friendliness of staff, care immediately after ECT and waiting times.

- Two-thirds or more of patients (65-96%) rated these as met.
- The standard most frequently rated as unmet was being introduced to all present in the ECT suite.
- Additional comments were that human or caring qualities in staff were very important to patients.
- Concerns raised were
 - the lack of a quiet area to lie down and recover
 - long waiting times
 - lack of personal attention
 - travelling long distances to other hospitals to have ECT.

The Consent Procedure

Of those patients who had agreed to have ECT:

- 83.5% felt they had enough time to discuss the decision with others.
- Between 86-91% patients understood what the treatment was, why they were having it and what it was likely to do.
- 24.8% were unaware of alternative treatments.
- 12.9% were unaware of the possible side effects.
- 12% of patients who consented felt pressured or forced to have the treatment.

- Inadequate information on memory loss was of most concern and 23% of patients did not receive any written information prior to the treatment.

Side effects

Almost half (49%) of patients reported having suffered from some form of memory loss after ECT.

- Although a number of these patients stated that they were glad to have received ECT, several reported severe and persistent memory loss and regretted receiving the treatment.
- 21% of patients reported having headaches following ECT.
- Other common side effects were tiredness, stiffness, confusion, nausea and unstable mood.
- A number of patients (2%) remarked that there should be better follow-up care for patients with memory loss.
- The need for further research into the long-term effects of ECT was also raised. (1.58%)

Effectiveness

109 patients commented on whether or not ECT worked for them:

- 72% reported that the treatment had helped them.
- 20% reported that ECT had no effect on their condition.
- 6% experienced an initial improvement, but later relapsed.
- 5% stated that they would not want it again.

ECT was repeatedly described as a catalyst for recovery:

- 14% of those who commented believed that the procedure changed or even saved their life. Another prominent theme was the speed with which ECT produced improvement – some reported that the effect was instantaneous.

Several patients reported that they had had to persuade their psychiatrist to prescribe ECT, and that this had caused them anxiety.

Patients were clearly able to weigh up the risks and benefits of ECT. Many were glad to have had ECT despite experiencing side effects. For others however, the adverse effects outweighed the positive impact of ECT.

Section 6

Recommendations

ECTAS will work with the National Association of Lead Nurses in ECT to develop and provide examples of generic protocols/ documentation which clinics will be able to download and modify to suit their own area of practice.

ECTAS will develop standards relating to the availability of service and travelling distance for patients receiving ECT and will continue to monitor the provision of ECT.

ECTAS will continue to work with other professional bodies to ensure/ provide training for all disciplines who work within the ECT service.

ECTAS will ensure training is provided for referrers to ECT.

ECTAS will continue to support research into cognitive impairment and memory testing.

Notes

¹ Cresswell et al, Standards for the administration of ECT, Fourth Edition December 2006. www.ectas.org.uk

² AAGBI 2007. <http://www.aagbi.org/publications>

³ Bickerton, D., Worrall, A., Chaplin, R. Survey to establish trends in the administration of ECT in England. Psychiatric Bulletin. (Submitted)

⁴ Blaj, A., Worrall, A. & Chaplin R. Electroconvulsive therapy: the practice and training needs of referring psychiatrists in the United Kingdom and Republic of Ireland. Journal of ECT. 2007

⁵ Rayner, L., Kershaw, K. & Chaplin, R. Patient perspectives on consent process and side effects of ECT. Journal of Mental Health. (Submitted)

Appendix 1

The ECTAS Team between October 2005 & October 2007 (Also sit on AAC and Reference Group)

Name	Position
Ms Joanne Cresswell	Programme Manager/ ECT lead nurse
Ms Chloë Hood	Deputy Programme Manager
Ms Nicola Scanlon	Quality Improvement Worker
Mr Will Odogwu	Project Administrator (Temporary)
Ms Lynne Townley	Project Administrator (Temporary) Left July 07
Ms Lauren Rayner	Project Worker (left April 2007)
Mr John O'Sullivan	Quality Improvement Worker (p/t fixed contract Oct 06-Mar 07)
Ms Diana Chan	Programme Manager (May-December 06)

ECTAS Accreditation Advisory Committee

Membership as of 1 October 2007

Name	Profession	Area/Institution
Dr Farooq Ahmad	Consultant Psychiatrist	Reading
Dr Elaine Allsop	Consultant Anaesthetist	Merseyside
Dr John Bowley	Consultant Anaesthetist	Nottingham
Mr Anthony Deery	Representative	Healthcare Commission
Dr Andrew Easton	Consultant Psychiatrist	Leeds
Dr Jill Emerson	Consultant Psychiatrist	Wiltshire
Dr Chris Freeman (Chair)	Consultant Psychiatrist/ ECTAS Chair	Edinburgh
Mr David Hare	ECT Nurse	London
Professor Paul Lelliott	Director, Research and Training Unit	Royal College of Psychiatrists
Ms Lois Sykes	ECT Nurse	Yorkshire
Mr Adrian Worrall	Head of CCQI	Royal College of Psychiatrists
Dr Maree Wright	Consultant Anaesthetist	Devon

ECTAS Reference Group

Membership as of 1 October 2007

Name	Profession	Area/Institution
Dr Maria Atkins	Consultant Psychiatrist	Wales
Mr Peter Bestley	Service User	
Dr Andrew Blakey	Consultant Psychiatrist	Macclesfield
Dr John Bowley	Consultant Anaesthetist	Nottingham
Dr Godfrey Bwalya	Consultant Anaesthetist	Hull
Ms Vanessa Cameron	Chief Executive	Royal College of Psychiatrists
Dr Ross Clark	Consultant Anaesthetist	Manchester
Ms Alison Cobb	Representative	MIND
Ms Janie Cornish	ECT Nurse	Northamptonshire
Mr Anthony Deery	Healthcare Commission	London
Dr Chris Freeman	Consultant Psychiatrist/ ECTAS Chair	Edinburgh
Dr Adoni K Gopaldaswamy	Consultant Psychiatrist	York
Ms Nikki Hale	Senior Fellow, Competence Development	Royal College of Nursing
Ms Sonia Hashmi	Service User	
Dr Kate Hayden	Consultant Psychiatrist	Derbyshire
Mrs Annie Higgs	ECT Nurse	Bedfordshire
Dr Paul Lelliott	Director, Research Unit	Royal College of Psychiatrists
Dr Rupert McShane	Consultant Psychiatrist	Oxford
Dr Ian Pennell	Consultant Psychiatrist	Gloucestershire
Dr Roshan Perrera	Consultant Psychiatrist	Leicester
Dr Ray O'Toole	Consultant Psychiatrist	Ireland
Dr Noel Sheppard	Consultant Psychiatrist	Ireland
Dr Amanda Spencer	Consultant Anaesthetist	Leeds
Dr Simon Walker	Consultant Anaesthetist	London
Mr Adrian Worrall	Head of Centre for Quality Improvement	Royal College of Psychiatrists

Appendix 2

ECTAS Actual Budget and Projections 2003 - 2007

	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Actual + forecast
Opening Balance	22,500.23	-2,349.35	-1,020.57	-11,691.89	10,820.89
Income					
Subscription fees	11,628.36	80,773.32	123,363.32	149,030.00	188,180.00
Training income	0.00	0.00	0.00	3,610.00	855.00
Miscellaneous				732.85	0.00
Transfer to development fund			-16,090.87	-20,005.16	-24,669.13
Total Income	11,628.36	80,773.32	107,272.45	133,367.69	164,460.87
Expenditure					
Staff Costs – Payroll	27,225.37	36,313.51	32,523.49	54,832.84	54,613.00
Staff Costs – Non payroll		4,893.12	34,530.36	12,259.34	16,500.00
Temporary Personnel	68.74	17,878.35	20,055.78	8,272.48	8,000.00
Travel Subs & Accommodation – staff	1,144.12	1,400.75	2,077.66	1,928.15	1,500.00
Recruitment costs	1,858.10	1,827.50	3,901.21	3,096.28	2,000.00
Staff Training	295.00		0.00	1,102.50	1,500.00
Printing	1,085.97	30.56	1,516.00	2,814.59	3,000.00
Postage	474.55	784.40	529.11	783.11	1,000.00
Courier		9.46	8.23	106.72	100.00
Stationery	106.15	108.17	1,100.34	586.84	1,000.00
CRU internal overhead charge			18,752.98	10,140.70	6,975.87
Books and Journals		62.30	0.00	0.00	0.00
Subs to professional bodies		258.50	193.88	0.00	110.00
Bad debts		0.00	0.00	0.00	2,200.00
Telephone	50.01	213.61	302.79	127.36	400.00
Maintenance Supplies		1,357.41	0.00	0.00	0.00
Travel subs and Accommodation – Others	3,642.72	6,183.65	4,834.17	7,068.75	10,000.00
Catering	527.21	307.15	224.18	745.28	500.00
Computer equipment		3,116.10	2,093.59	2,057.34	2,500.00
Miscellaneous				4,711.28	4,883.67
Total Expenditure	36,477.94	79,444.54	117,943.77	110,854.99	117,282.54
Balance Carried Forward	-2,349.35	-1,020.57	-11,691.89	10,820.81	57,999.14

Appendix 3

ECTAS-related Publications

Blaj, A., Worrall, A. & Chaplin R. Electroconvulsive therapy: the practice and training needs of referring psychiatrists in the United Kingdom and Republic of Ireland. *Journal of ECT*. 2007

Cresswell, J., Fortune, Z., Lelliott P. ECTAS First National Report October 2003-October 2005. Royal College of Psychiatrists 2005

Cresswell, J., Hood, C., Scanlon, N., Odogwu, W. (eds). Standards for the administration of ECT. Royal College of Psychiatrists 2007

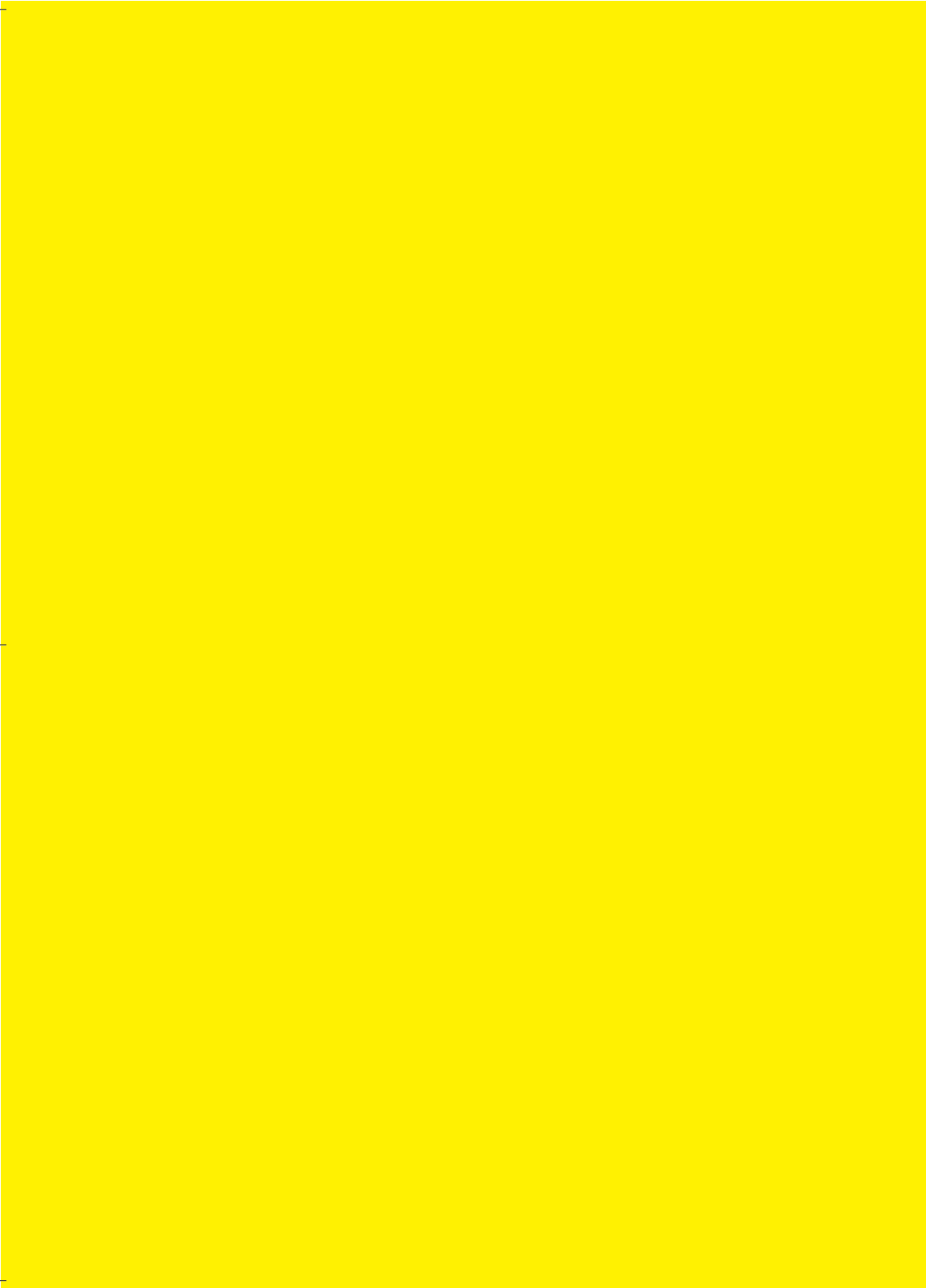
ECTAS. The Accreditation Process. Royal College of Psychiatrists 2007.

Kershaw, K., Rayner, L. & Chaplin, R.(2007) Patients' views on the quality of care when receiving electroconvulsive therapy. *Psychiatric Bulletin* 31: 414-417.

Submitted

Rayner, L., Kershaw, K. & Chaplin, R. Patient perspectives on consent process and side effects of ECT. *Journal of Mental Health*. (Submitted)

Bickerton, D., Worrall, A., Chaplin, R. Survey to establish trends in the administration of ECT in England. *Psychiatric Bulletin*. (Submitted)





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