RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

ECTAS
ELECTROCONVULSIVE THERAPY ACCREDITATION SERVICE

ECTAS

Dataset report

01 January 2024 – 31 December 2024

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EXECUTIVE SUMMARY

Responses

88

clinics submitted data

65

healthcare providers

2,627

submissions received

2,234

acute courses

167

continuation courses

226

maintenance courses

Responses were received from **88** out of 90 full member clinics. This represents a clinic response rate of **98%**. Data were submitted for **2,234** acute courses of ECT, provided to **2,045** individual patients, **167** continuation courses, provided to **155** patients, and **226** maintenance courses, provided to **218** patients.

A full list of ECTAS member services can be found on the network's website.

Results

- Most acute courses (**85%**) were given to treat depressive episodes. Much smaller numbers of patients were treated for other conditions, including schizophrenia, manic episode, mixed affective episode and catatonia.
- The most common reasons for using ECT were a poor response to other treatments and a requirement for a rapidly acting treatment.
- Of the patients who lacked the mental capacity to consent to ECT at the beginning of treatment, **31%** had regained capacity by the time of prescription of their final ECT treatment.
- Following acute treatment, **88%** improved to some degree, with **66%** 'much improved' or 'very much improved' on the Clinical Global Impression scale. Highly statistically significant reductions in mean scores on all clinician-rated symptom scales were seen, with an average drop of **22** points on the most commonly used assessment, the Montgomery-Åsberg Depression Rating Scale.

- Furthermore, **64%** of patients treated for depressive episode exhibited response (i.e. a 50% reduction in score) to ECT, with **47%** reaching remission.
- Objective cognitive scores slightly improved during acute courses of ECT, with a highly statistically significant mean increase of **2.0** points on the Mini-Mental State Examination, the most commonly used assessment. Around **12%** of patients experienced a subjective worsening of their memory after receiving ECT, while **14%** experienced an improvement and **75%** stability.
- Continuation ECT followed about **7%** of acute courses. Maintenance ECT was rarely used, with just **226** patients, on average fewer than **3** patients per clinic, receiving this annually. This is, however, an increase over previous years.

Summary of recommendations

For clinics

- To assist in data analysis, ECTAS strongly recommends that the original 17-item version of the Hamilton Depression Rating Scale (HAM-D17, Appendix 3) is adopted universally by clinics for use when treating patients for depressive episode.
- Similarly, the Brief Psychiatric Rating Scale (BPRS, Appendix 4), the Bush-Francis Catatonia Rating Scale (BFCRS, Appendix 5) and the Young Mania Rating Scale (YMRS, Appendix 6), should be used when treating patients for schizophrenia, catatonia and manic episode, respectively.
- There is no single objective cognitive test that is recommended over any other but, given that most clinics use either MoCA or MMSE, it will assist in data analysis if other clinics do so too.
- Bilateral ultrabrief-pulse ECT is less effective than other forms of the treatment, confers no secondary advantages, and should not be routinely used.
- Because high-dose right unilateral ECT is as effective as bilateral ECT in depressive episode, but has cognitive advantages, it should always be considered for right-handed patients with depressive episode.
- Decisions on electrode placement, pulse width and electrical charge should be made by the ECT team, in conjunction with the patient as appropriate, rather than by referring psychiatrists.
- Twelve treatments must not be considered a 'standard course'; patients must be reviewed frequently, and treatment plans must be individualised according to response.

- Whilst balancing the needs of individual patients who have shown a steady response to acute ECT, twice-weekly treatments should generally be continued until remission from symptoms has been achieved or there is a clear plateauing of therapeutic effect.
- ECT Lead Clinicians should ensure the education of their referring colleagues on these and other ECT-related matters is continuous.

For ECTAS

- ECTAS to continue to encourage all clinics to return data. This should include regular communication with individual clinics on the number of responses as well as how to use the system.
- As part of its accreditation process, ECTAS continues to support clinics to have systems in place locally for specific information to be adequately recorded.
- Guidance on the use of the HAMD-17, including a structured interview schedule, can be found in the “Structured Interview Guide for the Hamilton Depression Rating Scale" (Williams, 1988).
- Guidance on the use of the MADRS, including a structured interview schedule, can be found in the “Structured Interview Guide for the Montgomery Åsberg Hamilton Depression Rating Scale" (Williams & Kobak, 2008).

INTRODUCTION

The Electroconvulsive Therapy Accreditation Service (ECTAS) was established in 2003 to improve standards of practice in ECT services in England, Wales, Northern Ireland and the Republic of Ireland, and to award accreditation to clinics that perform well against the standards. ECTAS is one of around 30 quality networks, accreditation and audit programmes organised by the Royal College of Psychiatrists' College Centre for Quality Improvement.

ECTAS is a voluntary network which uses a system of self and peer review to improve the quality of services, using standards agreed by the network. In this way ECTAS seeks, over time, to support members to raise standards.

ECTAS does not provide regulation of ECT. In the United Kingdom, this is the responsibility of the Care Quality Commission in England, the Healthcare Inspectorate Wales in Wales, Healthcare Improvement Scotland in Scotland and the Regulation and Quality Improvement Authority in Northern Ireland.

ECTAS has member ECT clinics in England, Wales, Northern Ireland and Republic of Ireland. ECTAS does not collect data from ECT clinics in Scotland, which are collected through the Scottish ECT Accreditation Network (SEAN). For the whole calendar year 2024, **90** clinics were full members of the network. These comprised **71** in England, **6** in Northern Ireland, **5** in Wales and **8** in the Republic of Ireland. In addition, there were 3 affiliate member clinics in Scotland.

THIS REPORT

Methodology

From February 2021, ECTAS mandated clinics to submit outcome data, making this essential for clinics to achieve accreditation (Standards for the Administration of ECT, 15th Ed., originally published in March 2020). In previous years, the submission of data to the ECTAS dataset had been optional.

The data collected includes patients completing an acute, continuation or maintenance course of ECT in the twelve months between 1 January 2024 and 31 December 2024.

The completed raw data were reviewed by the clinicians on the ECTAS Dataset Steering Board. Inconsistencies, duplicate responses and potentially inaccurate information were highlighted and queries sent to the relevant ECT clinic for clarification. Data were then revised, if necessary, before analysis was performed.

2024 data collection tool

The Dataset Steering Board updates the data collection tool every year to ensure continued relevance to ECT clinics. As a result, the 2024 data collection tool was updated from previous years, as follows:

- The possible responses to the question asking about the reason for prescribing continuation ECT were expanded and changed slightly in wording, to read: "To prevent relapse (previous early relapse after cessation of a prior acute course of ECT)" and "To prevent relapse (no previous early relapse after cessation of a prior acute course of ECT)."
- In line with RCPsych policy, an additional question was included about the patient's recorded ethnicity.

Limitations

Most ECT clinics rely on referring teams to complete rating scales and cognitive assessments. Either way, it is recognised that many of these clinicians will have had little, if any, formal training in their use. For this reason, some of the results of the dataset should be interpreted with a degree of caution.

The response rate was 88 (**98%**) of 90 ECTAS member clinics overall. This comprised 71 (**100%**) of 71 clinics in England, 6 (**100%**) of 6 clinics in Northern

Ireland, 5 (**100%**) of 5 clinics in Wales and 6 (**75%**) of 8 in the Republic of Ireland. This is the first year that every UK member clinic has submitted its data.

Definitions

For the purpose of this report, an acute course of ECT is defined as a series of individual ECT treatments, usually given twice weekly, to relieve the symptoms of illness.

Continuation ECT (cECT) is defined as ECT that begins after an acute course, typically delivered at intervals of one week or more, for a period of up to six months, that is used to prevent a relapse of the episode of illness.

Maintenance ECT (mECT) is defined as ECT that begins after a continuation course, typically delivered at longer intervals, that is used to prevent a recurrence of the illness. mECT can continue for an indefinite period, but for the purpose of data collection, ECT clinics were asked to submit data annually on patients who were still receiving mECT at the end of the calendar year, or when a course of mECT came to an end.

ACUTE COURSES OF ECT

2,234
submissions

Numbers of courses and patients

Data were submitted for **2,234** acute courses of ECT, provided to **2,045** individual patients. Of these patients, **three** had **four courses, 17** had **three courses,** and **146** had **two acute courses** of ECT that ended during the 12-month data collection period.

Age

The mean age of unique patients receiving acute courses of ECT was **62.1** years (standard deviation (SD) = 16.1), with a range of **16 – 94**. Age data were not submitted for two patients. Figure 1 plots the distribution of patients by age.

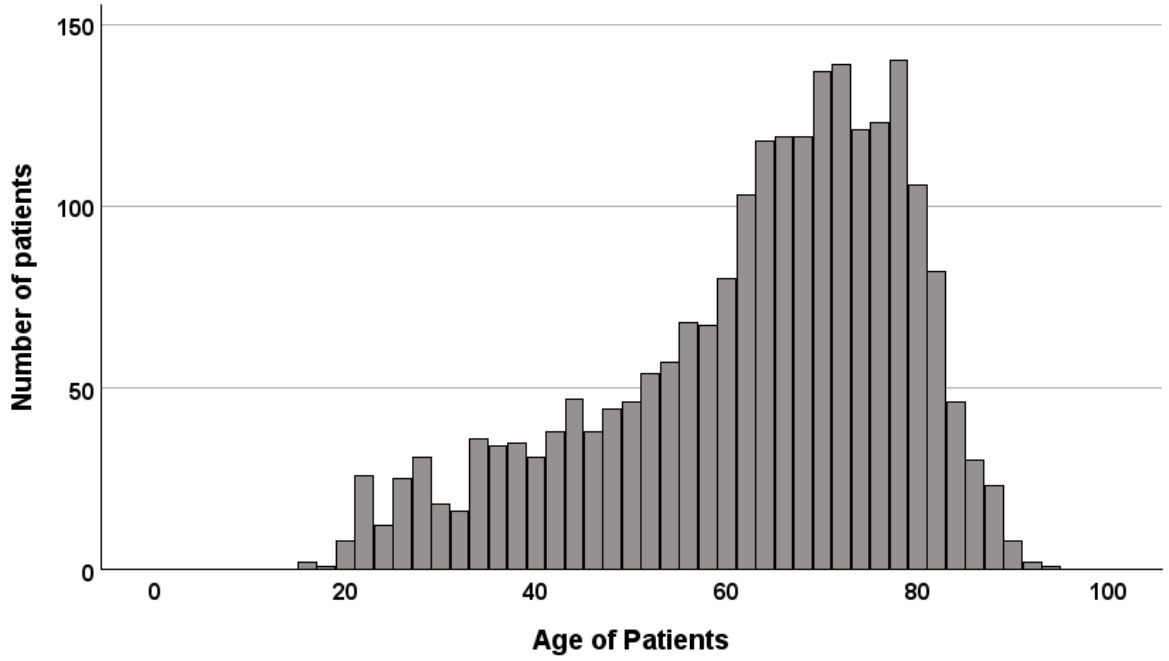

Figure 1: Age distribution for acute courses of ECT. Ages are at the first treatment in the first acute ECT course completed by each individual patient during 2024. n=2043, due to missing data for two patients.

Sex and Gender

Of 2,034 unique people who had their sex recorded, 1,323 (**65%**) were reported as female and 709 (**35%**) as male. One person was non-binary and one had preferred not to disclose their sex. Of 2,015 patients who had their gender recorded, 1,311 (**65%**) were reported as female and 703 (**35%**) as male. One person had preferred not to disclose their gender.

Ethnicity

There were 2027 unique people who had had their ethnicity recorded, as shown in Table 1.

Ethnicity	No. of patients	% of patients
White	1,799	88.8
Asian or Asian British	123	6.1
Black, Black British, Caribbean or African	66	3.3
Mixed or multiple ethnic groups	12	0.6
Other ethnic group	24	1.2
The patient had preferred not to disclose	3	0.1

Table 1: Recorded ethnicity of unique patients. n=2,027, due to missing data in 18 cases.

Diagnostic indication

For **85%** of acute courses, the patient was treated for a depressive episode. Less common indications included mixed affective episode (**3%**), manic episode (**3%**), and schizophrenia (**6%**). Whilst the syndrome of catatonia is usually caused by one of the aforementioned illnesses, **2%** of patients were treated for catatonia of another or unknown cause. There were **18** courses (**1%**) in the 'other' diagnostic category. Presenting diagnostic indications are listed in Table 2.

Diagnostic indication for ECT	No. of courses	% of courses
Depressive episode:	1,894	84.8
First episode	361	16.2
Recurrent depressive disorder	1,388	62.1
Bipolar affective disorder	106	4.7
Schizoaffective disorder	39	1.7
With catatonic symptoms	240	12.7
With psychotic symptoms	615	32.5
Mixed affective episode:	75	3.4
First episode	3	4.0
Bipolar affective disorder	46	61.3
Schizoaffective disorder	26	34.7
Catatonic symptoms	7	9.3
Psychotic symptoms	50	66.7
Manic episode:	73	3.3
First episode	5	6.8
Bipolar affective disorder	43	58.9
Schizoaffective disorder	23	31.5
Catatonic symptoms	7	9.6
Psychotic symptoms	43	58.9
Schizophrenia:	138	6.2
First episode	14	10.1
Recurrent or chronic	124	89.9
Catatonic symptoms	47	34.1
Psychotic symptoms	122	88.4
Catatonia of another or unknown cause	36	1.6
Other	18	0.8

Table 2: Diagnostic indications for all acute courses of ECT. n=2,234.

Reason for using ECT

Respondents were asked to list the reasons for using ECT. They were presented with a menu of nine options, with multiple responses possible, including an 'other' option, for which further information was requested.

The results are detailed in Table 3. There were two courses for which no reason was specified, and five for which an 'other' reason alone was documented. Two of these indicated the need for a rapid response due, respectively, to physical deterioration and poor oral intake. The remaining three documented previous good response to ECT during an earlier episode of illness as the sole reason for using ECT.

Reason for using ECT	No. of courses	% of courses
Rapid response required	1,195	53.5
Poor-response to pharmacological and/or psychological treatments i.e. treatment resistance	1,825	81.8
Poor concordance with drug treatment	410	18.4
Co-morbidities make drug treatment less desirable	44	2.0
Pregnancy makes drug treatment less desirable	1	0.04
Breastfeeding makes drug treatment less desirable	2	0.1
Patient choice	413	18.5
Carer choice	222	9.9
Other	45	2.0

Table 3: Reasons for referral for an acute course of ECT. n=2,232. No reason was specified in two cases. Percentages do not add up to 100% because multiple responses for each course were allowed.

Legal status

For each acute course of ECT, clinics were asked to specify the patient's legal status at the commencement and end of treatment. Firstly, respondents were asked to specify whether the patient was informal or detained in hospital under formal legislation (namely, the Mental Health Act 1983 in England and Wales, the Mental Health (Northern Ireland) Order 1986 in Northern Ireland and the Mental Health Act 2001 in the Republic of Ireland) and, secondly, whether the patient had the mental capacity to consent to treatment with ECT. If the patient was detained, respondents were asked whether an urgent treatment authorisation (such as Section 62 in England and Wales) was used to initiate treatment. The results are shown in Table 4 below and include all **2,234** acute courses, rather than individual patients, some of whom had differing situations during multiple courses in the calendar year.

Legal status	Informal		Detained		Total	
	n	%	n	%	n	%
Start of treatment						
With mental capacity	928	41.5	137	6.1	1065	47.7
Without mental capacity	25	1.1	1144	51.2	1169	52.3
Total	953	42.7	1281	57.3	2234	100
End of treatment						
With mental capacity	1063	47.6	354	15.8	1417	63.4
Without mental capacity	21	0.9	796	35.6	817	36.6
Total	1084	48.5	1150	51.5	2234	100

Table 4: Detention status and mental capacity of patients at the start and end of acute courses of ECT. Patients receiving two or more acute courses are represented more than once, as they might have had a different status during different courses.

Of the **1,281** patients who were detained at the start of treatment, urgent authorisations were used in **815** (**63.6%**).

It should be noted that 'end of treatment' relates to the detention status and mental capacity at the time of delivery of the last ECT treatment (decided upon at the time of its prescription), rather than following it. Of the **1.169** people who lacked capacity at the start of the course, **366** (**31%**) had regained capacity by the end of treatment. Of the **1,065** patients who had capacity at the start, **14** (**1.3%**) were judged to have lost capacity by the end.

There were **25** patients who were informal but lacking in mental capacity at the start. It is assumed that they were treated under mental capacity legislation in the relevant jurisdiction (e.g. the Mental Capacity Act 2005 in England and Wales), although this information was not specifically collected. The data in Table 3 confirm that, when a person might require ECT but lacks the mental capacity to consent to it, it is usually mental health legislation (e.g. the Mental Health Act 1983 in England and Wales) that is used to seek legal authorisation of the treatment, even if he or she is not objecting to it. This is presumably because that legislation contains provisions that relate specifically to ECT, including important safeguards for the patient and conditions that must be met before treatment can be given. There are, however, unusual situations in which such a person who is lacking capacity but not objecting to the treatment, might instead be treated in their best interests, under more generalised mental capacity legislation. In England and Wales, these might include:

- objection by the Nearest Relative to formal detention in hospital, despite their agreement with the treatment itself
- reluctance of an Approved Mental Health Professional to apply for detention in hospital when the patient has the mental capacity to make the less complex decision to be admitted to hospital and has opted to accept this
- treatment being given as an outpatient with no requirement for an overnight stay in hospital
- indication is a condition that might not be readily classified as a mental disorder, such as status epilepticus or some presentations of malignant catatonia.

Number of treatments

Respondents were asked to record the number of treatments the patient received during each acute course. The mean was **10.5** (SD = 4.9) and the mode **12,** with a range of **1 to 41**. Just **5.9%** of courses were of three treatments or fewer; **16.8%** were of 13 treatments or more. Nine courses had data missing for the number of treatments. The number of courses of each duration is shown in Figure 2.

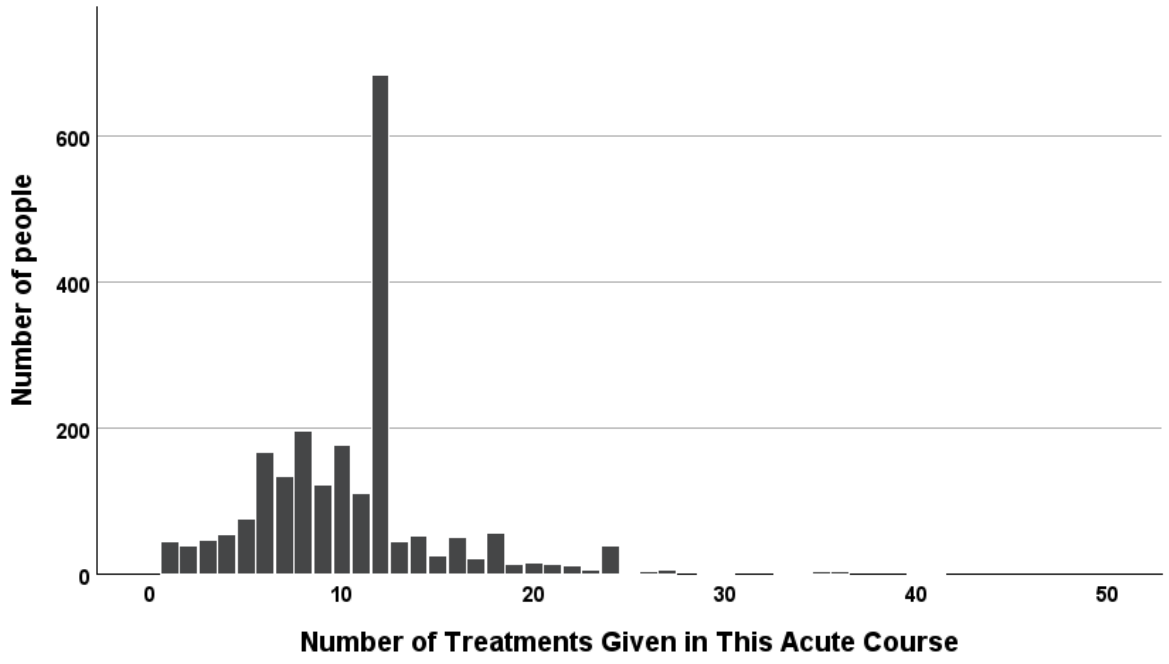

Figure 2: Number of treatments in each acute ECT. n=2,225, due to missing data for 9 courses.

Electrode placement

Courses began with bitemporal placement in 1,779 (**76.9%**) cases, bifrontal in 89 (**4.0%**), right unilateral (RUL) in 359 (**16.1%**) and left unilateral in 7 (**0.3%**). In courses given for depressive episodes, for which high-dose RUL ECT is proven to be of equal efficacy to bitemporal, whilst demonstrating a clear cognitive advantage (Kolshus et al., 2017), remarkably the rate of RUL use was still only 17.8%. Laterality was changed mid-course in just 3.2% of cases: 35 courses involved a switch from unilateral to bilateral, while 37 saw a switch from bilateral to unilateral.

Patient outcomes

Clinical Global Impression

In order to assess patients' response to treatment, clinics were asked to use the Clinical Global Impression Scale – Severity (CGI–S) to rate each patient's clinical status prior to the start of treatment, and the Clinical Global Impression Scale – Improvement (CGI–I) at the end of the course.

As shown in Table 5, **82.3%** of patients in the recorded courses were rated as 'markedly ill' or worse at the start of treatment. The proportion showing any improvement was **88.2%**, with **66.4%** 'much improved' or 'very much improved' by the end of treatment.

CGI–S score before treatment	n	%	CGI–I score after treatment	n	%
7 - Amongst the most severely ill	240	11.1	7 - Very much worse	5	0.2
6 - Severely ill	841	38.7	6 - Much worse	13	0.6
5 - Markedly ill	705	32.5	5 - Minimally worse	35	1.6
4 - Moderately ill	314	14.5	4 - No change	200	9.3
3 - Mildly ill	50	2.3	3 - Minimally improved	468	21.8
2 - Borderline mentally ill	13	0.6	2 - Much improved	890	41.5
1 - Normal, not at all ill	8	0.4	1 - Very much improved	536	25.0
Total	**2,171**	**100.0**	**Total**	**2,147**	**100.0**

Table 5: Distribution of CGI-S scores before starting ECT and CGI-I scores at the end of the acute course of ECT. n=2,171 for CGI–S score before treatment, n=2,147 for CGI–I score after treatment, due to scores not having been recorded for 63 and 87 courses respectively. Data include all diagnostic indications. CGI–S, Clinical Global Impression (Severity) scale; CGI–I, Clinical Global Impression (Improvement) scale.

Patients having treatment for conditions other than depressive episode tended to have more severe illnesses than those with depressive episode. The highest rates of improvement were recorded for patients affected with manic episodes and the lowest among those suffering from schizophrenia. These data are shown in Table 6.

Diagnostic indication	Before ECT, using CGI–S		After ECT, using CGI–I	
	n	% of patients rated 'markedly ill' or worse	n	% of patients rated 'much improved' or better
Depressive episode	1849	80.7	1826	67.5
Mixed affective episode	71	81.7	71	66.2
Manic episode	67	98.5	71	74.6
Schizophrenia	132	93.2	131	48.1
Catatonia of other or unknown cause	34	85.3	30	66.7
Other	18	94.4	18	61.1
All indications	**2171**	**82.3**	**2147**	**66.4**

Table 6: Summary of CGI–S and CGI–I findings before and after acute courses of ECT according to diagnostic indication. CGI–S, Clinical Global Impression (Severity) scale; CGI–I, Clinical Global Impression (Improvement) scale. Overall numbers indicate the number of people with a recorded CGI score.

As shown in Table 7, right unilateral and bitemporal ECT showed almost identical, higher improvement rates compared to bifrontal ECT, which was used at relatively few clinics.

Electrode placement at the first session	Before ECT, using CGI–S		After ECT, using CGI–I	
	n	% of patients rated 'markedly ill' or worse	n	% of patients rated 'much improved' or better
Bitemporal	1,721	82.3	1,703	66.5
Bifrontal	85	76.5	88	60.2
Right unilateral	358	83.2	349	67.6
Left unilateral	7	85.7	7	71.4

Table 7: Summary of CGI–S and CGI–I findings before and after acute courses of ECT according to electrode placement. CGI–S, Clinical Global Impression (Severity) scale; CGI–I, Clinical Global Impression (Improvement) scale. Overall numbers indicate the number of people with a recorded CGI score.

Table 8 shows outcomes according to pulse width, grouped by laterality. The highest improvement rates were found for brief pulse (1.0 ms) and the lowest for ultrabrief pulse (0.25 – 0.3 ms) ECT, with intermediate outcomes for near-ultrabrief pulse widths (0.5 ms).

Laterality and pulse width combination	Before ECT, using CGI–S		After ECT, using CGI–I	
	n	% of patients rated 'markedly ill' or worse	n	% of patients rated 'much improved' or better
Bilateral, BP	521	83.1	506	72.3
Bilateral, near-UBP	1,150	81.4	1,153	64.7
Bilateral, UBP	135	83.7	132	55.3
Unilateral, BP	171	84.8	170	69.4
Unilateral, near-UBP	178	83.1	170	67.6
Unilateral, UBP	16	68.8	16	50.0
All courses	**2,171**	**82.3**	**2,147**	**66.4**

Table 8: Summary of CGI–S and CGI–I findings before and after acute courses of ECT according to stimulation laterality and pulse width. CGI–S, Clinical Global Impression (Severity) scale; CGI–I, Clinical Global Impression (Improvement) scale; BP, brief pulse (1.0 ms); near-UBP, near-ultrabrief pulse (0.5 ms); UBP, ultrabrief pulse (0.25 – 0.3 ms).

There was a particularly low improvement rate (**55.3%**) for bilateral UBP treatment. This is fully in keeping with previous research, including a double-blind randomised controlled trial with a bilateral UBP remission rate of 35% (Sackeim et al., 2008) and a meta-analysis in which the remission rate was as low as 28% (Jelovac & McLoughlin, 2026).

Symptom rating scales

As well as using CGI ratings, clinics were asked to employ standardised symptom rating scales to obtain a more objective measure of clinical improvements. Clinics were able to use any appropriate scale, according to whether depressive, manic, psychotic, or catatonic symptoms were the primary target of treatment.

Outcome scores of 0 were removed from the analysis, unless they were either explicitly confirmed by correspondence with the clinic in question, or implicitly supported by a CGI–I score of 1 (very much improved) or 2 (much improved).

For the vast majority of courses, during which the patient was being treated for depressive episode, the most commonly used rating scales were the Montgomery-Åsberg Depression Rating Scale (MADRS) and the various versions of the Hamilton Depression Rating Scale (HAM-D). Additionally, several scales were used only by a very small number of clinics each and are listed in Table 9 and Figure 3, which show the mean scores and reductions on these scales before and after acute courses of ECT. On the two most frequently used tools, the MADRS and the 17-item version of the HAM-D, the mean symptom reductions were **21.9** and **14.7** points respectively.

For the treatment of conditions other than depressive episode, alternative symptom scales should be used (Table 9 and Figure 3). Only **14** cases had valid results using the **Young Mania Rating Scale** (indicated in manic episode). The scores reduced from a mean of 36.5 to 4.6 points and show the highest effect size. There were only **10** valid results using the **Brief Psychiatric Rating Scale** (indicated in schizophrenia, but also used for some cases of mixed affective disorder, mania and others), with a mean baseline score of 50.1 reducing to 32.6 at the end of treatment, a mean reduction of 34.9% ($p = 0.002$). There were **18** valid results using the **Bush-Francis Catatonia Rating Scale** (indicated in catatonia), with a mean reduction in score of 72% the end of treatment ($p = 0.001$).

Symptom rating scale	n	Mean score		Mean points reduction	% reduction	p-value
		before ECT	after ECT			
Clinician-rated scales						
MADRS	429	37.4	15.5	21.9	58.6	$1.6x10^{-113}$
HAM-D 6-item	45	15.3	7.1	8.2	53.6	$1.4x10^{-9}$
HAM-D 17-item	269	23.8	9.1	14.7	61.8	$5.6x10^{-73}$
HAM-D 21-item	67	23.1	10.7	12.4	53.7	$4.3x10^{-16}$
HAM-D 24-item	43	28.2	15.4	12.8	45.4	$2.2x^{-11}$
BPRS	10	50.1	32.6	17.5	34.9	0.002
YMRS	14	36.5	4.6	31.9	87.4	$3.8x10^{-6}$
BFCRS	18	19.3	5.4	13.9	72.0	0.001
Self-rating scales						
HADS	88	24.0	12.1	11.9	49.6	$3.4x10^{-17}$
MDI	34	35.3	19.5	15.8	44.8	$1.7x10^{-7}$
BDI	33	31.9	17.2	14.8	46.1	$5x10^{-8}$
PHQ-9	74	19.9	9.8	10.2	50.8	$5.7x10^{-12}$

Table 9: Mean symptom rating scale score before and after an acute course of ECT. n=1,124, as only courses for which there were scores before and after ECT are included and results on rating scales used for fewer than ten patients are not presented. p-values are based on paired-samples t-tests and are highly significant for all scales. Lower scores indicate fewer and/or less severe symptoms. MADRS, Montgomery-Åsberg Depression Rating Scale; HAM-D, Hamilton Depression Rating Scale; BPRS, Brief Psychiatric Rating Scale; YMRS, Young Mania Rating Scale; BFCRS, Bush-Francis Catatonia Rating Scale; HADS, Hospital Anxiety and Depression Scale; MDI, Major Depression Inventory; BDI, Beck Depression Inventory; PHQ, Patient Health Questionnaire.

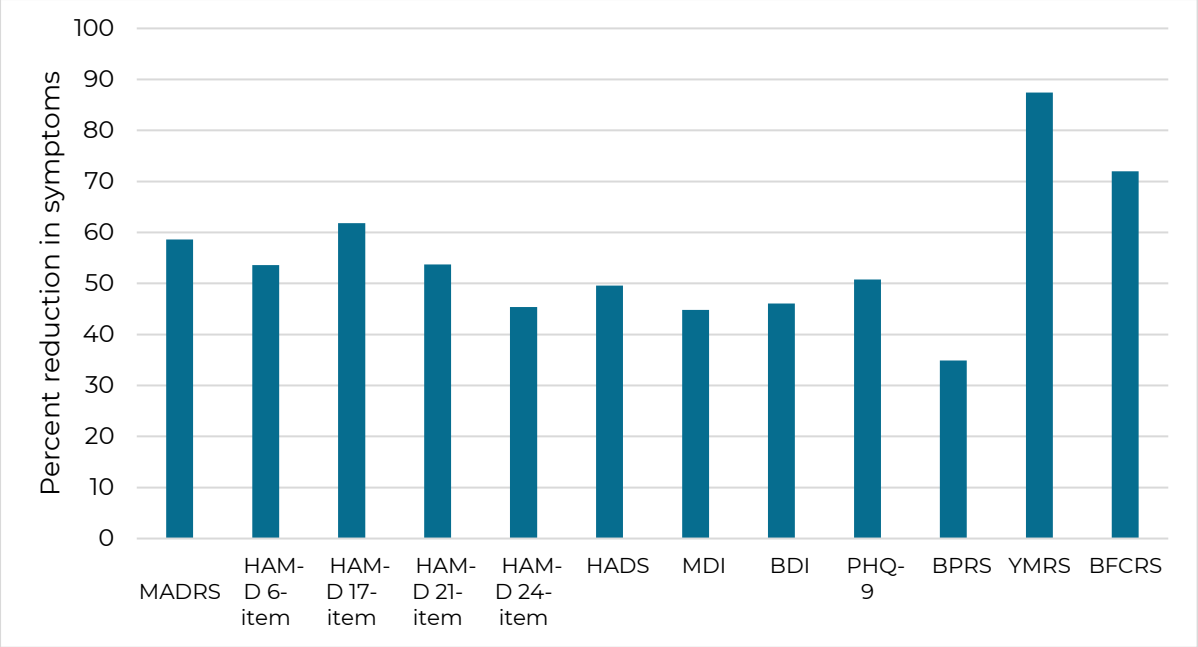

Figure 3: Reduction on symptom rating scale score following an acute course of ECT. n=1,124, as only courses for which there were scores before and after ECT are included and results on rating scales used for fewer than ten patients are not presented. MADRS, Montgomery-Åsberg Depression Rating Scale; HAM-D, Hamilton Depression Rating Scale; HADS, Hospital Anxiety and Depression Scale; MDI, Major Depression Inventory; BDI, Beck Depression Inventory; PHQ, Patient Health Questionnaire; BPRS, Brief Psychiatric Rating Scale; YMRS, Young Mania Rating Scale; BFCRS, Bush-Francis Catatonia Rating Scale.

Remission rates

The use of standardised symptom rating scales allows for the estimation of rates of response and remission achieved by patients receiving ECT. The criteria set out in Table 10 were used to define remission.

Symptom rating scale	Version	Validated cut-off for remission	Reference
MADRS		≤ 10 points	Hawley et al., 2002
HAM-D	6-item	≤ 4 points	Frank et al., 1991
	17-item	≤ 7 points	Kyle et al., 2016
	21-item	≤ 8 points	Degenhardt et al., 2012
	24-item	≤ 10 points	Fenton & McLoughlin, 2021
BDI		≤ 12 points	Reidel et al., 2010
PHQ-9		≤ 4 points	Shueller et al., 2015
YMRS		≤ 12 points	Patel et al., 2007
BFCRS		≤ 2 points	*see note below*

Table 10: Remission cut-off scores for symptom scales. No consensus definition of remission exists for BFCRS, so a conservative definition of ≤ 2 has been used. No established remission criteria exist for Major Depression Inventory (MDI) or the Hospital Anxiety and Depression Scale (HADS) full score. MADRS, Montgomery-Åsberg Depression Rating Scale; HAM-D, Hamilton Depression Rating Scale; BDI, Beck Depression Inventory; PHQ, Patient Health Questionnaire; YMRS, Young Mania Rating Scale; BFCRS, Bush-Francis Catatonia Rating Scale.

It should be noted that some researchers have suggested two consecutive ratings should be required to confirm remission (Hawley et al., 2002), but that only one rating has been used here. In order to compare the results with previous years, an analysis restricted to MADRS and HAM-D scores showed remission was achieved in 432 of 919 acute courses for which these data were available. This remission rate of **47.0%** is very similar to previous years.

Higher remission rates were noted on YMRS and BFCRS (used to score symptoms of mania and catatonia respectively), and lower rates were recorded on the self-rated depression scales

Response rates

For all scales used (except BPRS), **response** is defined as a 50% reduction from baseline (Koesters et al., 2017) (Table 11). Analysing the 885 courses with valid pre- and post-treatment scores on a clinician-rated scale (MADRS, HAM-D, YMRS, BFCRS), 570 ended in clinical response, giving a response rate of 64.4%. Restricting this analysis to MADRS and HAM-D, the response rate was **63.5%**. On the self-rated depression scales, there were 226 courses with valid scores, of which 115 (50.9%) reached response. For all scales and all indications, the response rate from ECT was 61.7% (685 courses out of 1111 with valid ratings).

Symptom rating scale	Remission			Response		
	Total courses	Courses meeting criterion	%	Total courses	Courses meeting criterion	%
Clinician-rated scales						
MADRS	485	226	46.6	429	280	65.3
HAM-D (all)	434	206	47.5	425	262	61.6
6-item	45	23	51.1	45	27	60.0
17-item	279	139	49.8	270	177	65.6
21-item	67	30	44.8	67	41	61.2
24-item	43	14	32.6	43	17	39.5
YMRS	15	13	86.7	12	12	100.0
BFCRS	24	13	54.2	19	16	84.2
Patient-rated scales						
HADS	-	-	-	88	37	42.0
MDI	-	-	-	34	17	50.0
BDI	37	13	35.1	30	15	50.0
PHQ-9	86	31	36.0	74	46	62.2
All scales	1,081	502	46.4	1,111	685	61.7

Table 11: Remission and response rates using an array of outcomes measures. Results on rating scales used for fewer than ten patients are not presented. No established criteria exist for Major Depression Inventory (MDI) or the Hospital Anxiety and Depression Scale (HADS) full score. MADRS, Montgomery-Åsberg Depression Rating Scale; HAM-D, Hamilton Depression Rating Scale; YMRS, Young Mania Rating Scale; BFCRS, Bush-Francis Catatonia Rating Scale; HADS, Hospital Anxiety and Depression Scale; MDI, Major Depression Inventory; BDI, Beck Depression Inventory; PHQ, Patient Health Questionnaire.

Objective cognitive assessments

For each acute course, clinics were asked which objective cognitive assessment tool had been used and to submit the scores at baseline and after the patient's final treatment.

Table 12 shows the results for the most frequently used tools, for patients who had both pre- and post-ECT ratings. ECT courses for which a score of 0 was entered, either before or after treatment, were excluded from the analysis. This score is typically entered when a patient is too impaired by illness to co-operate in

completing a test or, perhaps, when the test has simply not been carried out. This was confirmed by communication with clinics. Excluding these 0 scores should protect against artificial inflation of any positive effect of ECT upon cognition. This analysis is based on all acute courses for the treatment of depressive episodes.

Cognitive assessment tool	Maximum score	Acute courses, n	Mean score		p-value
			Before ECT	After ECT	
MMSE	30	426	25.2	27.2	$1.7x10^{-16}$
MoCA	30	368	21.9	24.1	$2.3x10^{-16}$
Mini-ACE	30	167	22.3	24.8	$2.7x10^{-6}$
ACE-III	100	8	79.9	76.2	0.7
Hodges	6	32	4.2	5.0	0.037
6CIT	28	118	6.9	5.0	0.001

Table 12: Mean scores on cognitive assessment tools for patients treated for depressive episodes who had both pre- and post-ECT tests. Lower scores indicate a greater degree of cognitive impairment, except on Hodges and 6CIT, for which the reverse holds. Scores of zero were not included in the analysis, except for Hodges and 6CIT, for which such a score indicates intact cognition. p-values are based on paired samples t-tests. MoCA, Montreal Cognitive Assessment; MMSE, Mini-Mental State Examination; mini-ACE, mini-Addenbrooke's Cognitive Examination; ACE-III, Addenbrooke's Cognitive Examination version 3; 6CIT, 6-item Cognitive Impairment Test; n.s., not significant.

These data show significant improvements in cognitive functioning on most assessment tools. Notably, precise data regarding the exact timing of such assessments were not collected here.

In previous ECTAS datasets we showed that the modest mean improvement in cognition across the whole sample is driven by dramatic cognitive improvements in a subset of patients who had performed very poorly on testing prior to ECT, whereas most patients exhibit stability. This was indeed the case in the current dataset as well (data not presented).

Subjective memory ratings

Clinics were directed to ask item No. 17 of the Comprehensive Psychopathological Rating Scale (CPRS) immediately before every ECT treatment and following completion of the course. This item has been used in ECT-related research (Sigström et al., 2020). The outcomes are shown in Table 13 and suggest that severe problems with memory are slightly more frequent before, rather than after ECT, a finding likely to reflect the severity of the psychiatric illnesses being

treated. The only categories showing increases after ECT were 2 ("occasional increased lapses of memory") and the yet milder category of 1, lying between the aforementioned category and normality.

Score on CPRS item-17	Cases before ECT		Cases after ECT	
	n	% of recorded entries	n	% of recorded entries
0 - Memory as usual	956	57.8	1,046	54.6
1 -	138	8.3	205	10.7
2 - Occasional increased lapses of memory	356	21.5	488	25.5
3 -	67	4.0	75	3.9
4 - Reports of socially inconvenient or disturbing loss of memory	104	6.3	79	4.1
5 -	12	0.7	12	0.6
6 - Complaints of complete Inability to remember	22	1.3	12	0.6
Total cases with valid ratings	**1,655**		**1,917**	

Table 13: Subjective memory ratings by patients before and after an acute course of ECT. Patients having more than one course of ECT are represented more than once. Patients with any diagnosis are included. Patients were too unwell to give responses for 399 courses pre-ECT and 126 courses post-ECT. No data was submitted for a further 180 courses pre-ECT and 191 courses post-ECT. CPRS = Comprehensive Psychopathological Rating Scale.

Further analysis of the data included the **1,596** courses for which both pre- and post-ECT scores were available. Defining stability as a 0 or ±1 point change on CPRS item 17, in **188** cases (**11.8%**) memory subjectively worsened after ECT, in **216** (**13.5%**) it improved and in the remaining **1,192** (**74.7%**) it remained stable.

Conclusions

Of some **2,234** acute courses of ECT completed during 2024, the vast majority (**84.8%**) were used to treat a depressive episode. Improvement in symptoms on the CGI scale was demonstrated, with the vast majority markedly ill or worse at

the outset of treatment, and **66.4%** 'much improved' or 'very much improved' following treatment.

Unsurprisingly, a lower improvement rate of **55.3%** was seen in those having bilateral, ultrabrief-pulse treatment. This is an even worse outcome than during 2023 (58%), but is in keeping with previous research showing this combination to be a particularly weak form of ECT. It should be avoided outside ethically approved research.

The rate of right unilateral ECT usage is particularly low.

Of the **1,169** people who lacked capacity at the start of the course, **366** (**31%**) had regained capacity by the end of the course.

Scores on symptom rating scales improved markedly, with **61.7%** of patients exhibiting a pre-defined response using clinician-rated or self-rated symptom scales and **46.4%** reaching remission.

Whilst objective cognitive scores significantly improved overall during acute courses of ECT, this recovery was seen mainly in patients whose cognition was significantly impaired prior to initiation of treatment.

Finally, subjective memory ratings were much improved following ECT. These changes were particularly pronounced in those who had memory problems at baseline, with **216** showing improvements. Conversely, only **188** of **1,596** patients reported a deterioration in memory.

In summary, acute ECT is an effective and well-tolerated treatment for depressive episode and other illnesses.

CONTINUATION COURSES OF ECT

167
submissions

As stated in the introduction to this report, continuation ECT (cECT) is defined as ECT, usually delivered at intervals of one week or more, used to prevent a relapse of symptoms, for a period of up to six months after an acute course of ECT has brought about a resolution of such symptoms. The odd missed treatment during an acute course does not constitute cECT: there must be an intention to lower the frequency and a change in purpose of the ECT (from active treatment of symptoms to prevention of relapse) for the course to be considered "continuation".

Returns were made by **48** clinics for a total of **167** courses of cECT completed during 2023 given to **155** individual patients, **12** of whom had two continuation courses. This constitutes a slight increase over previous years. These figures suggest that approximately **7.5%** (167 of 2,234) of acute courses are being followed by continuation treatments, although this is an approximation, as some of the corresponding acute courses would have finished in 2023.

Age, gender and ethnicity

The mean age of unique patients starting their first course of cECT of the year was **62.2 years** (standard deviation (SD) = 17.1 years). The range was **22 – 89 years**. Of these, 104 (**67.1%**) patients were of female gender and 50 (**32.3%**) were male, with one missing entry. Regarding ethnicity, 136 (**87.7%**) patients were recorded as white, 12 (**7.7%**) as Asian, and 5 (**3.2%**) as black, with two missing entries.

Diagnostic indications

Of the 167 cECT courses, **143** followed depressive episodes, **9** schizophrenia, **2** manic episodes, **10** mixed affective episodes, and **1** catatonia of another or unknown cause.

Reasons for using cECT

Clinics were asked to list the reasons for using continuation ECT. They were presented with a menu of eight options, with multiple responses possible, including an "other" option, for which further information was required. The

results are detailed in Table 14. In most cases, a previous relapse was listed as a reason for giving cECT.]

Reason for using continuation ECT	Courses	
	n	%
To prevent relapse (previous early relapse after cessation of a prior acute course of ECT)	125	74.9
"To prevent relapse (**no** previous early relapse after cessation of a prior acute course of ECT)"	36	21.6
Poor concordance with prophylactic drug treatment	19	11.4
Comorbidities make prophylactic drug treatment less desirable	8	4.8
Pregnancy makes prophylactic drug treatment less desirable	0	0.0
Breastfeeding makes prophylactic drug treatment less desirable	0	0.0
Patient choice	53	31.7
Carer choice	38	22.8
Other	1	0.6

Table 14: Reason for referral for a continuation course of ECT. n=167. Multiple responses allowed for each course.

Legal Status

Clinics were asked about the patient's mental capacity and detention status. Results are depicted in Table 15. Although only seven patients regained capacity during their courses, symptomatic improvement is not the aim of cECT. Eighteen more patients were no longer detained at the end of the cECT.

Legal status	Informal		Detained		Total	
	n	%	n	%	n	%
Start of continuation treatment						
With mental capacity	118	70.7	19	11.4	137	82.0
Without mental capacity	1	0.6	29	17.4	30	18.0
Total	119	71.3	48	28.7	167	100
End of continuation treatment						
With mental capacity	118	70.7	26	15.6	144	86.2
Without mental capacity	1	0.6	22	13.2	23	13.8
Total	119	71.3	48	28.7	167	100

Table 15: Detention status and mental capacity of patients before and after a course of continuation ECT. n=167. cECT, continuation ECT.

Hospital status

80 patients (**47.9%**) began cECT as inpatients, but only 54 (**32.3%**) were still in hospital at completion of the continuation course.

Number and frequency of treatments

The mean number of treatments per continuation course was **9.4** (standard deviation = 7.0, range 1 to 37). Treatments were spaced at least one week apart in all cases.

Patient outcomes

At the start of the continuation course, **69.0%** of patients were rated as being 'mildly ill' or better, with **12.7%** being 'markedly ill' or worse, as shown in Table 16. This latter finding is surprising, given the expectation that cECT would be given to relatively well patients, with the intention of preserving the symptomatic improvements achieved during a recent acute course (Kellner et al., 2006). At the end of the continuation courses there was a clear further improvement in outcomes, with **79.1%** of patients being assessed as “mildly ill” or better, (Table 16).

CGI–S score	Before cECT courses		After cECT courses	
	n	%	n	%
1 = normal, not at all ill	23	13.9	47	29.7
2 = borderline mentally ill	56	33.9	48	30.4
3 = mildly ill	35	21.2	30	19.0
4 = moderately ill	30	18.2	24	15.2
5 = markedly ill	12	7.3	6	3.8
6 = severely ill	6	3.6	2	1.3
7 = amongst the most severely ill	3	1.8	1	0.6

Table 16: Severity of illness before and after continuation ECT. n=165 at the start and 158 at the end, due to missing data. CGI-S, Clinical Global Impression (Severity) scale.

Symptom rating scales

Of the **143** courses of cECT following a depressive episode, **53** were rated with HAM-D both at the start and the end, and **38** courses were rated with MADRS at the start and at the end. Table 17 shows a small improvement on the HAMD and no significant change on the MADRS scores, using paired samples t-tests.

Symptom rating scale	Patients, n	Mean score before cECT treatment	Mean score after cECT treatment	p-value
HAM-D	53	11.9	9.6	0.044
MADRS	38	14.0	13.1	n.s.

Table 17: Mean scores on symptom rating scales before and after courses of continuation. Includes patients treated for depressive episode only. MADRS, Montgomery-Åsberg Depression Rating Scale; HAM-D, Hamilton Depression Rating Scale; cECT, continuation ECT; n.s., not significant.

Objective cognitive assessments

Objective cognitive rating scale scores were reported at the start and end of **117** continuation treatment courses. Table 18 shows that the start and end scores are very similar for all rating scales, suggesting that patients did not experience any clinically significant adverse cognitive changes during continuation treatment, as measured by these scales.

Cognitive assessment	Courses, n	Mean score before cECT	Mean score after cECT	p-value
MMSE	34	27.9	28.1	n.s.
MoCA	50	24.0	25.3	0.002
Mini-ACE	25	26.6	25.6	n.s.

Table 18: Objective cognitive assessment scores at before and after continuation ECT. n=109, due to incomplete or missing data in 61 cases and other scales used in 8 cases. cECT, continuation ECT; MMSE, Mini-Mental State Examination; MoCA, Montreal Cognitive Assessment.

Subjective memory ratings

As for acute courses, clinics were asked to collect data using a subjective rating of memory functioning, namely item no. 17 of the Comprehensive Psychopathological Rating Scale (CPRS), prior to starting cECT and following completion of the course. The scores are shown in Table 19. Comparison of the mean scores before and after cECT suggests a slight deterioration in subjective memory (p=0.002; paired samples t-test).

Score on CPRS item-17	Before cECT		After cECT	
	n	% of recorded entries	n	% of recorded entries
0 - Memory as usual	77	49.7	64	41.6
1 -	22	14.2	15	9.7
2 - Occasional increased lapses of memory	43	27.7	56	36.4
3 -	5	3.2	6	3.9
4 - Reports of socially inconvenient or disturbing loss of memory	6	3.9	10	6.5
5 -	1	0.6	3	1.9
6 - Complaints of complete Inability to remember	1	0.6	-	-
Total cases with valid ratings	**155**		**154**	

Table 19: Subjective memory ratings by patients before and after a continuation course of ECT. Patients having more than one continuation course of ECT are represented more than once. Patients with any diagnosis are included. Patients too

unwell to give responses for 4 courses pre-cECT and 5 courses post-cECT. No data submitted for a further 8 courses pre-cECT and 8 courses post-cECT. cECT, continuation ECT; CPRS, Comprehensive Psychopathological Rating Scale.

Conclusions

Continuation ECT was prescribed after about **5 to 10%** of acute courses, primarily in cases where there has been a rapid relapse following an earlier acute course, to lower the risk of a further relapse. Both objective measures of cognitive functioning suggest there is no evidence that continuation ECT leads to further cognitive problems although subjective assessments showed a small but significant deterioration. This is in contrast to 2023 data. In view of the well documented significant risk of relapse following successful acute treatment of depressive episode (Kirov et al., 2021) and the evidence of efficacy from randomised controlled trials (Jelovac et al., 2025), it could be postulated that continuation treatment should be used more frequently.

MAINTENANCE COURSES OF ECT

226 submissions

As stated in the introduction to this report, maintenance ECT (mECT) is defined as ECT, usually delivered at intervals of between one week and three months, used to prevent a recurrence of illness, starting from six months after an acute course of ECT has brought about a resolution of symptoms (i.e. from the end of a six-month period of continuation ECT). Subject to regular clinical review, mECT can continue for an indefinite period, but for the purpose of data collection, ECT clinics were asked to submit data annually on patients who were still receiving mECT at the end of the calendar year, or when a course of mECT came to an end.

Returns were made by **64** clinics for a total of **226** maintenance courses received by **218** patients (**8** patients received two maintenance courses, presumably after their illness recurred upon discontinuation of the first maintenance course). This is an increase compared to 168 patients the previous year.

Age, gender and ethnicity

The mean age of unique patients receiving mECT was **66.2 years** (standard deviation (SD) = 14.9 years), with no data missing. The range was **24 – 91 years**. Fifty-one patients were of male gender (**24.1%**) and 161 female (**75.9%**), with missing data in six cases. Ethnicity was recorded as white in 199 (**92.1%**) patients, Asian in 13 (**6.0%**), black in two (**0.9%**) and mixed in two (**0.9%**), with missing data for two patients.

Diagnostic indications

Most courses of mECT (**175**) were for the treatment of recurrent depressive disorder, **26** for bipolar affective disorder, **5** for schizophrenia, **16** for schizoaffective disorder, **3** for recurrent catatonia of another cause or unknown cause, and **1** for other conditions.

Reasons for using mECT

Clinics were asked to list the reasons for using mECT. They were presented with a menu with eight options, with multiple responses possible, including an "other" option, for which further information was required. The results are detailed in

Table 20. In the "other" category, the free-text responses mainly included variations on the theme of reducing the risk of a return of symptoms.

Reason for using maintenance ECT	Courses	
	n	%
Previous recurrence after cessation of a prior continuation course	183	81.0
Poor concordance with prophylactic drug treatment	44	19.5
Comorbidities make prophylactic drug treatment less desirable	5	2.2
Patient choice	100	44.2
Carer choice	48	21.2
Other	10	4.4

Table 20: Reason for referral for a maintenance course of ECT. n=226. Multiple responses were allowed for each course of treatment.

Legal Status

Clinics were asked about the patient's mental capacity and detention status at the beginning and end of the maintenance course (or, in the case of a longer course of mECT lasting more than 12 months, at the beginning and/or end of the calendar year). Results are depicted in Table 21 and show the vast majority of patients were informal and had capacity to consent.

Legal status	Informal		Detained		Total	
	n	%	n	%	n	%
Start of maintenance treatment (or calendar year)						
With mental capacity	185	81.9	13	5.8	198	87.6
Without mental capacity	4	1.8	24	10.6	28	12.4
Total	189	83.6	37	16.4	226	100
End of maintenance treatment (or calendar year)						
With mental capacity	192	85.0	6	2.7	203	89.8
Without mental capacity	9	4.0	19	8.4	23	10.2
Total	201	88.9	25	11.1	226	100

Table 21: Detention status and mental capacity of patients before and after a course of maintenance ECT. n=167. mECT, maintenance ECT.

Hospital status

37 (**16.4%**) patients began mECT as inpatients; 25 (**11.1%**) were in hospital at the end of the maintenance course (or at the end of the data collection year for ongoing courses).

Number of treatments

The mean number of treatments during maintenance courses was **13.8** (SD = 10.6, range **1 – 64**). The mean total number of consecutive maintenance treatments, including those given prior to 2024, was **35.8** (SD = 53.7, range **1 – 499**), with data missing in three cases. **14** people had received over 100 ECT treatments, presumably over a period of some years.

Treatment frequency

The frequencies of treatments in courses of mECT are shown in Table 22. The frequency was reported as constant in **147** cases, most commonly using one to four-week intervals, but longer intervals of six weeks or more are used in the care of some patients. The rate was variable in the remaining **79** cases, mostly in the direction of reducing frequency.

Frequency of treatments	Patients, n
½ week	0
1 week	17
1½ weeks	3
2 weeks	44
3 weeks	16
4 weeks	54
5 weeks	3
6 weeks	6
8 weeks	1
10 weeks	2
12 weeks	1
A varied schedule	79

Table 22: Frequency of maintenance ECT treatments. n=226.

Patient outcomes

Clinical global impression

At the start of the maintenance course (or, for longer-term courses, at the start of the calendar year), **66.7%** of patients were rated as being 'mildly ill' or better, with **15.3%** being 'markedly ill' or worse, as shown in Table 23. By the end of the maintenance courses (or, for longer-term courses, at the end of the calendar year), there had been further improvement in outcomes, with **80.5%** of patients assessed as “mildly ill” or better (Table 23).

CGI–S score	Before mECT courses		After mECT courses	
	n	%	n	%
1 = normal, not at all ill	50	22.5%	60	27.9%
2 = borderline mentally ill	49	22.1%	67	31.2%
3 = mildly ill	49	22.1%	46	21.4%
4 = moderately ill	40	18.0%	29	13.5%
5 = markedly ill	22	9.9%	9	4.2%
6 = severely ill	10	4.5%	3	1.4%
7 = amongst the most severely ill	2	0.9%	1	0.5%

Table 23: Severity of illness before and after maintenance ECT. n=222 at the start and 215 at the end, due to missing data. For long-term maintenance courses, assessments took place around the beginning and/or end of the calendar year (2024). mECT, maintenance ECT; CGI–S, Clinical Global Impression (Severity) scale.

Symptom rating scales

Only **122** of the 217 courses of mECT for an affective disorder (recurrent depressive disorder, bipolar affective disorder or schizoaffective disorder) had scores, both at the start and at the end of the course, using HAM-D (42 cases) or MADRS (43 cases) or HADS (26 cases), or MDI (11 cases). Table 24 shows stability or slight improvement of mean scores using each scale.

Symptom rating scale	Patients, n	Mean score before mECT	Mean score after mECT	p-value
HAM-D	42	10.60	9.9	n.s.
MADRS	43	20.6	14.2	0.003
HADS	26	11.9	11.8	n.s.
MDI	11	14.7	9.6	n.s.

Table 24: Mean scores on symptom rating scales at the start and end of a course of maintenance ECT in patients with an affective disorder. For long-term maintenance courses, assessments took place around the beginning and/or end of the calendar year (2024). p-values calculated using paired samples t-test. MADRS, Montgomery-Åsberg Depression Rating Scale; HAM-D, Hamilton Depression Rating Scale; HADS, Hospital Anxiety and Depression Scale; MDI, Major Depression Inventory; mECT, maintenance ECT; n.s., not significant.

Objective cognitive assessment

Table 25 shows the results for the assessment tools that were applied at the start and end of treatment on 10 or more patients. Overall, there was no significant cognitive change during maintenance treatment.

Cognitive assessment	Patients, n	Mean score before mECT	Mean score after mECT	p-value
MMSE	53	25.8	26.2	n.s.
MoCA	45	23.5	24.2	n.s.
Mini-ACE	28	25.1	25.6	n.s.

Table 25: Objective cognitive assessment scores before and after maintenance ECT. For long-term maintenance courses, assessments took place around the beginning and/or end of the calendar year (2024). p-values calculated using paired samples t-test. Includes patients treated for any diagnostic indication. mECT, maintenance ECT; MMSE, Mini-Mental State Examination; MoCA, Montreal Cognitive Assessment; mini-ACE, mini-Addenbrooke's Cognitive Examination; n.s., not significant.

Subjective memory rating

As for acute and continuation courses, clinics were asked to collect data using a subjective rating of memory functioning, namely item no. 17 of the Comprehensive Psychopathological Rating Scale (CPRS), prior to starting mECT and following completion of the course (or, for prolonged courses lasting more than 12 months, around New Year). The mean scores are shown in Table 26 and

are essentially unchanged. This indicates that mECT courses did not lead to changes in subjective memory complaints.

Score on CPRS item-17	Before mECT		After mECT	
	n	% of recorded entries	n	% of recorded entries
0 - Memory as usual	106	51.5	101	48.6
1 -	21	10.2	22	10.6
2 - Occasional increased lapses of memory	60	29.1	59	28.4
3 -	9	4.4	13	6.3
4 - Reports of socially inconvenient or disturbing loss of memory	9	4.4	11	5.3
5 -	1	0.5	2	1.0
6 - Complaints of complete Inability to remember	0	0.0	0	0.0
Total cases with valid ratings	**206**		**208**	

Table 26: Subjective memory ratings by patients before and after maintenance ECT. Patients having more than one maintenance course of ECT are represented more than once. For long-term maintenance courses, assessments took place around the beginning and/or end of the calendar year (2024). Patients with any diagnosis are included. Patients too unwell to give responses for 7 courses pre-mECT and 5 courses post-mECT. No data submitted for a further 13 courses pre-mECT and 13 courses post-mECT. mECT, maintenance ECT; CPRS, Comprehensive Psychopathological Rating Scale.

Conclusions

Maintenance ECT is used only rarely in the UK and Republic of Ireland. The majority of clinics in 2024 (64 of 87) reported an average of just under four cases each, and the remainder reported no cases. The evidence collected here suggests that symptom ratings remain stable and that there is no evidence of deteriorating cognitive functioning over the period in question, as measured by both objective assessments and subjective reports. The most frequent reasons for initiating the treatment are previous recurrence after an earlier successful course of continuation ECT, patient choice (in nearly half of the cases) and carer choice.

FURTHER DISCUSSION AND RECOMMENDATIONS

Outcome measures

It has previously been recommended by ECTAS that the original 17-item version of the Hamilton Depression Rating Scale (HAM-D17, Appendix 4) (Hamilton, 1960) is adopted universally by accredited clinics for use when treating patients for depressive episode. This practice should have been adopted across the ECTAS regions by the beginning of 2024, in the hope that this report would be able to provide a more comprehensive analysis of outcomes than ever before. However, there has in fact been no discernible change in practice in this regard. In any case, it is important that ECT clinic staff, as well as the clinicians in the teams who refer patients for ECT, have adequate training and/or guidance in the use of this scale. Such training and guidance should be provided by ECTAS as required.

Similarly, it has been previously recommended that the Young Mania Rating Scale (YMRS) (Young et al., 1978) and the Brief Psychiatric Rating Scale (Gorham et al., 1960) be used when treating patients for manic episode and schizophrenia respectively. The Bush-Francis Catatonia Rating Scale (BFCRS) (Bush et al., 1996) should be used when catatonia dominates the clinical picture. A copy of each of these scales is appended to this report. However, it is recognised that ECT clinics tend to encounter such patients relatively infrequently, which may lead to difficulties reaching a sufficient degree of expertise in administering these tests.

There is no specific objective cognitive test that is perfectly suited to use in the ECT setting. The domains that have been shown to be adversely affected by ECT, namely anterograde and retrograde memory, processing speed and executive functioning (Semkovska et al., 2010), are not well covered by standard tests such as the MoCA, MMSE or even the full version of the ACE. Additionally, all these tests feature various domains known to be affected by the symptoms of a severe depressive episode but not by ECT (other than in the immediate post-recovery period), such as attention and orientation.

In light of this, although it would be ideal to have standardised, homogeneous cognitive data for analysis, there is currently no one test that is recommended over others.

Although it has been designed specifically for use in ECT, the Electroconvulsive Cognitive Assessment (ECCA) (Hermida et al., 2020) is not recommended by ECTAS. It combines elements of both patient and collateral history, along with

objective tests of cognition, into one numerical score. The objective tests cover registration, attention and short-term recall, but also include culturally sensitive tests of general knowledge and autobiographical memory. Consequently, its value in international ECT practice remains unclear.

Electrode placement and pulse width

Our data suggest there are several clinics routinely using bilateral, ultrabrief-pulse (UBP) ECT, which was yet again associated with particularly poor outcomes.

There appears to be little reason for using bilateral UBP ECT. When treating depressive episodes in right-handed patients, clinicians who are mindful of cognitive outcomes should use high-dose right unilateral, brief-pulse ECT. This is because it is just as effective as bilateral brief-pulse ECT, but is associated with quicker post-procedure recovery of orientation and a lower incidence of autobiographical memory loss (Kolshus et al., 2017).

Right unilateral UBP ECT may be considered in a small minority of cases in which cognitive sparing is considered more important than symptom resolution. However, caution should be exercised because, while it does convey some cognitive advantages, it is less effective than right unilateral, brief-pulse treatment (Tor et al., 2015).

Bilateral UBP stimulation, on the other hand, has not been shown to hold any cognitive or efficacy advantage over other forms of ECT. On the contrary, it has been shown to be markedly less effective than all other electrode placement and pulse width combinations (Sackeim et al., 2008; Jelovac & McLoughlin, 2026). Its use is strongly discouraged by ECTAS.

This report also shows that, despite its equivalent efficacy in depressive episode and its superior side-effect profile (Kolshus et al., 2017), high-dose right unilateral ECT is still vastly underused in the UK compared to most other high-income countries. Clinicians should be familiar with all three main electrode placements and consider their advantages and disadvantages for each individual patient. Specifically, high-dose right unilateral ECT should always be considered for right-handed patients with depressive episode.

Consequently, ECTAS suggests that, just like selection of the dose, decisions with patients about electrode placement and pulse width should be made by the ECT team, in conjunction with the patient as appropriate, rather than by referring psychiatrists.

Duration of treatment

Remission and response rates in this dataset were consistent with those observed in some randomised trials (e.g., Semkovska et al., 2016), but lower than in a meta-analysis of a combination of retrospective, prospective, observational, and interventional studies in major depression (van Diermen et al., 2018). Reaching remission, defined in this context as a very low degree of symptomatology, is self-evidently a particularly important goal for patients and their families.

Consequently, there is no clinical logic to explain the ongoing, habitual use of 12 treatments in acute courses of ECT. Referring clinicians must dispense with the erroneous idea that 12 sessions somehow constitute a 'standard course' of ECT that will reliably bring about remission without exposing patients to unnecessary treatments. Many patients require significantly fewer than 12 treatments, whilst others need more. Patients must be reviewed regularly between treatments, with no more than two treatments prescribed at once.

Towards the end of an acute course of ECT, during which a steady response has been observed, clinicians will naturally consider all the needs of each individual patient, taking into account any adverse as well as therapeutic effects of treatment, along with the effects of ending treatment prematurely. In general, however, ECTAS encourages clinicians to continue twice-weekly treatments, either until remission is achieved or there is a clear plateauing of therapeutic effect. In many cases, this will require courses of a duration that necessitates fresh legal authorisation for treatment, be that a new informed consent form or a repeat formal application. But clinicians are reminded that the goal of each individual patient reaching remission should be at the forefront of clinical decision-making.

It is incumbent upon ECT Lead Clinicians to ensure the education of their referring colleagues on these and other ECT-related matters.

Engagement in submission to the dataset

Engagement in submission to the dataset has improved steadily since 2020 and for the first time ever, every UK member clinic submitted data in 2024. However, not every ECTAS member clinic in the Republic of Ireland submitted data. ECTAS should continue to encourage all clinics to do so, including regular communication with individual clinics including instruction on how to use the online data submission system. As part of its accreditation process, ECTAS continues to provide support to clinics to ensure systems are in place locally to allow the necessary information to be adequately recorded.

The widespread use of zeros to signify missing data, has largely been stopped by allowing clinics to state that a particular measurement has not been taken. However, it is important that this option is not systemically misused. All clinics should have systems in place to try to gather the relevant data in as many cases as possible. Any systemic inability by a specific clinic to provide certain types of data on their patients can be readily identified and raised during that clinic's next accreditation cycle.

ECTAS would like to thank all staff members at its member clinics for their time and effort in submitting their anonymised patients' data. Without their dedicated input, it would not be possible to produce this report.

ACKNOWLEDGEMENTS

ECTAS is very grateful to all clinicians who submitted their anonymised data and reminds staff at the very small number of clinics which did not that submission is a mandatory requirement for ongoing accreditation.

ECTAS would also like to thank the Dataset Steering Board for their ongoing commitment and dedication to creating these reports.

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APPENDIX 1: FULL DATA COLLECTION TOOL

Name of ECT Clinic *

Test Service

Demographic Details

Patient's local clinic ID *

ⓘ Either use the patient's local medical records number, or assign unique numbers to each of your ECT patients for the purpose of these data returns. Do NOT use NHS numbers.

Age of patient (at the first treatment in this course)

ex: 23

ⓘ Age in years; do not use decimal points or fractions.

What sex is recorded in the patient's clinical record?

- Male
- Female
- The patient preferred not to disclose their sex
- Not recorded
- The patient prefers to self-describe (please enter below)

What gender is recorded in the patient's clinical record?

- ○ Male
- ○ Female
- ○ Transgender male
- ○ Transgender female
- ○ Non-binary
- ○ The patient preferred not to disclose their gender
- ○ Not recorded
- ○ Don't know
- ○ The patient prefers to self-describe (please enter below)

What ethnicity is recorded on the patient's clinical record?

- ○ Asian, Asian British or Asian Welsh
- ○ Black, Black British, Black Welsh, Caribbean or African
- ○ Mixed or Multiple ethnic groups
- ○ White
- ○ Other ethnic group
- ○ The patient preferred not to disclose their ethnicity
- ○ Not recorded

Serious Incidents

Have there been any serious incidents in relation to ECT and this patient? *

- ◯ Yes
- ◯ No

ECT Parameters

Type of ECT course (see FAQs for complete definitions) *

- ◯ Acute (i.e. at least twice-weekly, to treat active symptoms)
- ◯ Continuation (i.e. for preventing early relapse (≤6 months))
- ◯ Maintenance (i.e. for preventing recurrence (>6 months))

Acute

Is this the first acute course being submitted for this calendar year?

- ◯ Yes, this is the first acute course
- ◯ No, this is the second acute course
- ◯ No, this is the third acute course
- ◯ No, this is the fourth acute course

Number of treatments given in this acute course

ex: 23

ⓘ It is not uncommon for an acute course to be longer than 12 treatments.

Frequency of treatments

- ◯ Two times weekly
- ◯ Three times weekly
- ◯ Daily
- ◯ Three times weekly then two times weekly
- ◯ Other

Was this course stopped prematurely? *

- ◯ Yes
- ◯ No

Stimulus dosing method used at first session(s) *

- ◯ Dose titration (i.e. establish seizure threshold then use e.g. 6 x ST for unilateral or 1.5 x ST for bilateral ECT)
- ◯ Age-based
- ◯ Fixed dose
- ◯ Other

Clinical Details

Medical condition treated with ECT *

- ( ) Depressive episode
- ( ) Mixed affective episode
- ( ) Manic episode
- ( ) Schizophrenia
- ( ) Catatonia of another cause or unknown cause
- ( ) Neuroleptic malignant syndrome
- ( ) Other (please only use this option if it is impossible to use any of the diagnostic categories above)

Reason for using ECT (tick all that apply) *

- [ ] Rapid response required
- [ ] Poor-response to pharmacological and/or psychological treatments (i.e. treatment resistance)
- [ ] Poor concordance with drug treatment
- [ ] Co-morbidities make drug treatment less desirable
- [ ] Pregnancy makes drug treatment less desirable
- [ ] Breastfeeding makes drug treatment less desirable
- [ ] Patient choice
- [ ] Carer choice
- [ ] Other

Location of patient at initiation of acute course of ECT *

- ( ) Inpatient
- ( ) Outpatient

Legal Status

Legal status at initiation of acute course of ECT *

- ◯ Informal
- ◯ Detained

Mental capacity at initiation of acute course of ECT *

- ◯ Had capacity to consent to ECT
- ◯ Lacked capacity to consent to ECT

Legal status at end of acute course of ECT *

- ◯ Informal
- ◯ Detained

Mental capacity at end of acute course of ECT *

- ◯ Had capacity to consent to ECT
- ◯ Lacked capacity to consent to ECT

Outcome

Clinical Global Impression Severity (CGI-S) score prior to first treatment in this acute course *

- 1. Normal, not at all ill
- 2. Borderline mentally ill
- 3. Mildly ill
- 4. Moderately ill
- 5. Markedly ill
- 6. Severely ill
- 7. Amongst the most severely ill patients
- The score was not recorded

Clinical Global Impression Improvement (CGI-I) score after completion of this acute course *

- 1. Very much improved
- 2. Much improved
- 3. Minimally improved
- 4. No change
- 5. Minimally worse
- 6. Much worse
- 7. Very much worse
- The score was not recorded

Psychiatric symptom rating scale used prior to first treatment (tick all that apply)

- [ ] Montgomery-Asberg Depression Rating Scale (MADRS)
- [ ] Hamilton Depression Rating Scale (HAM-D)
- [ ] Young Mania Rating Scale (YMRS)
- [ ] Bush-Francis Catatonia Rating Scale (BFCRS)
- [ ] The score was not recorded
- [ ] Other

Psychiatric symptom rating scale used after final treatment (tick all that apply)

- [ ] Montgomery-Asberg Depression Rating Scale (MADRS)
- [ ] Hamilton Depression Rating Scale (HAM-D)
- [ ] Young Mania Rating Scale (YMRS)
- [ ] Bush-Francis Catatonia Rating Scale (BFCRS)
- [ ] The score was not recorded
- [ ] Other

Subjective memory assessment score (using Item 17 on the Comprehensive Psychopathological Rating Scale (CPRS)) prior to first treatment in this acute course

- ( ) 0 - Memory as usual
- ( ) 1
- ( ) 2 - Occasional increased lapses of memory
- ( ) 3
- ( ) 4 - Reports of socially inconvenient or disturbing loss of memory
- ( ) 5
- ( ) 6 - Complaints of complete inability to remember
- ( ) This was not recorded
- ( ) The patient was too unwell to give a response

Subjective memory assessment score (using Item 17 on the Comprehensive Psychopathological Rating Scale (CPRS)) after last treatment in this acute course

- ( ) 0 - Memory as usual
- ( ) 1
- ( ) 2 - Occasional increased lapses of memory
- ( ) 3
- ( ) 4 - Reports of socially inconvenient or disturbing loss of memory
- ( ) 5
- ( ) 6 - Complaints of complete inability to remember
- ( ) This was not recorded
- ( ) The patient was too unwell to give a response

Objective cognitive test used prior to first treatment (tick all that apply) *

- [ ] Montreal Cognitive Assessment (MOCA)
- [ ] Mini-Mental State Examination (MMSE)
- [ ] The patient was too unwell to assess
- [ ] This score was not recorded
- [ ] Other

Objective cognitive test used after final treatment (tick all that apply) *

- [ ] Montreal Cognitive Assessment (MOCA)
- [ ] Mini-Mental State Examination (MMSE)
- [ ] The patient was too unwell to assess
- [ ] This score was not recorded
- [ ] Other

Continuation

Is this the first continuation course being submitted for this calendar year?

- ◯ Yes, this is the first continuation course
- ◯ No, this is the second continuation course
- ◯ No, this is the third continuation course

Number of treatments given in this continuation course

ex: 23

ⓘ Do not include any treatments given in the preceding acute course of ECT, which should have been counted as part of a separate ECTAS data submission.

Frequency of treatments

- ◯ Every 1 week
- ◯ Every 1½ weeks
- ◯ Every 2 weeks
- ◯ Every 3 weeks
- ◯ Every 4 weeks
- ◯ A varied schedule of decreasing frequency over time

Clinical Details

Medical condition treated with the acute course of ECT that preceeded this continuation course *

- ○ Depressive episode
- ○ Mixed affective episode
- ○ Manic episode
- ○ Schizophrenia
- ○ Catatonia of another cause or unknown cause
- ○ Neuroleptic malignant syndrome
- ○ Other (please only use this option if it is impossible to use any of the diagnostic categories above)

Reason for using continuation ECT (tick all that apply) *

- ☐ To prevent relapse (previous early relapse after cessation of a prior acute course of ECT)
- ☐ To prevent relapse (no previous early relapse after cessation of a prior acute course of ECT)
- ☐ Poor concordance with prophylactic drug treatment
- ☐ Co-morbidities make prophylactic drug treatment less desirable
- ☐ Pregnancy makes prophylactic drug treatment less desirable
- ☐ Breastfeeding makes prophylactic drug treatment less desirable
- ☐ Patient choice
- ☐ Carer choice
- ☐ Other

Location of patient at first treatment in this continuation course *

- ○ Inpatient
- ○ Outpatient

Location of patient at last treatment in this continuation course *

- ○ Inpatient
- ○ Outpatient

Legal Status

Legal status at first treatment in this continuation course *

- ◯ Informal
- ◯ Detained

Mental capacity at first treatment in this continuation course *

- ◯ Had capacity to consent to ECT
- ◯ Lacked capacity to consent to ECT

Legal status at last treatment in this continuation course *

- ◯ Informal
- ◯ Detained

Mental capacity at last treatment in this continuation course *

- ◯ Had capacity to consent to ECT
- ◯ Lacked capacity to consent to ECT

Outcome

Clinical Global Impression Severity (CGI-S) score prior to first treatment in this continuation course *

- 1. Normal, not at all ill
- 2. Borderline mentally ill
- 3. Mildly ill
- 4. Moderately ill
- 5. Markedly ill
- 6. Severely ill
- 7. Amongst the most severely ill patients
- The score was not recorded

Clinical Global Impression Severity (CGI-S) score after completion of this continuation course *

- 1. Normal, not at all ill
- 2. Borderline mentally ill
- 3. Mildly ill
- 4. Moderately ill
- 5. Markedly ill
- 6. Severely ill
- 7. Amongst the most severely ill patients
- The score was not recorded

Psychiatric symptom rating scale used prior to first treatment in this continuation course (tick all that apply)

- [ ] Montgomery-Asberg Depression Rating Scale (MADRS)
- [ ] Hamilton Depression Rating Scale (HAM-D)
- [ ] Young Mania Rating Scale (YMRS)
- [ ] Bush-Francis Catatonia Rating Scale (BFCRS)
- [ ] The score was not recorded
- [ ] Other

Psychiatric symptom rating scale used after last treatment in this continuation course (tick all that apply)

- [ ] Montgomery-Asberg Depression Rating Scale (MADRS)
- [ ] Hamilton Depression Rating Scale (HAM-D)
- [ ] Young Mania Rating Scale (YMRS)
- [ ] Bush-Francis Catatonia Rating Scale (BFCRS)
- [ ] The score was not recorded
- [ ] Other

Subjective memory assessment score (using Item 17 on the Comprehensive Psychopathological Rating Scale (CPRS)) prior to first treatment in this continuation course

- ( ) 0 - Memory as usual
- ( ) 1
- ( ) 2 - Occasional increased lapses of memory
- ( ) 3
- ( ) 4 - Reports of socially inconvenient or disturbing loss of memory
- ( ) 5
- ( ) 6 - Complaints of complete inability to remember
- ( ) This was not recorded
- ( ) The patient was too unwell to give a response

Subjective memory assessment score (using Item 17 on the Comprehensive Psychopathological Rating Scale (CPRS)) after last treatment in this continuation course

- ( ) 0 - Memory as usual
- ( ) 1
- ( ) 2 - Occasional increased lapses of memory
- ( ) 3
- ( ) 4 - Reports of socially inconvenient or disturbing loss of memory
- ( ) 5
- ( ) 6 - Complaints of complete inability to remember
- ( ) This was not recorded
- ( ) The patient was too unwell to give a response

Objective cognitive test used prior to first treatment in this continuation course (tick all that apply) *

- [ ] Montreal Cognitive Assessment (MOCA)
- [ ] Mini-Mental State Examination (MMSE)
- [ ] The patient was too unwell to assess
- [ ] The score was not recorded
- [ ] Other

Objective cognitive test used after final treatment in this continuation course (tick all that apply) *

- [ ] Montreal Cognitive Assessment (MOCA)
- [ ] Mini-Mental State Examination (MMSE)
- [ ] The patient was too unwell to assess
- [ ] The score was not recorded
- [ ] Other

Maintenance

Is this the first maintenance course being submitted for this calendar year?

- ◯ Yes
- ◯ No

Number of treatments given in this maintenance course

ex: 23

Do not include any treatments given in the preceding acute or continuation courses

Total number of consecutive maintenance treatments given

ex: 23

e.g. for an annual data return of a patient who has had fortnightly mECT for 3 years, you might enter 78 here, but just 26 in the box above.

Frequency of treatments

- ◯ Every 1 week
- ◯ Every 1½ weeks
- ◯ Every 2 weeks
- ◯ Every 3 weeks
- ◯ Every 4 weeks
- ◯ Varied schedule of decreasing frequency over time
- ◯ Other

Clinical Details

Medical condition requiring maintenance course of ECT *

- ◯ Recurrent depressive disorder
- ◯ Bipolar affective disorder
- ◯ Schizoaffective disorder
- ◯ Schizophrenia
- ◯ Recurrent catatonia of another cause or unknown cause
- ◯ Other (please only use this option if it is impossible to use any of the diagnostic categories above)

Reason for using maintenance ECT (tick all that apply) *

- ☐ Previous recurrence after cessation of a prior continuation course of ECT
- ☐ Poor concordance with prophylactic drug treatment
- ☐ Co-morbidities make prophylactic drug treatment less desirable
- ☐ Pregnancy makes prophylactic drug treatment less desirable
- ☐ Breastfeeding makes prophylactic drug treatment less desirable
- ☐ Patient choice
- ☐ Carer choice
- ☐ Other

Location of patient at first treatment in this maintenance course *

- ◯ Inpatient
- ◯ Outpatient

Location of patient at last treatment in this maintenance course *

- ◯ Inpatient
- ◯ Outpatient

Legal Status

Legal status at first treatment in this maintenance course *

- ◯ Informal
- ◯ Detained

Mental capacity at first treatment in this maintenance course *

- ◯ Had capacity to consent to ECT
- ◯ Lacked capacity to consent to ECT

Legal status at last treatment in this maintenance course *

- ◯ Informal
- ◯ Detained

Mental capacity at last treatment in this maintenance course *

- ◯ Had capacity to consent to ECT
- ◯ Lacked capacity to consent to ECT

Outcome

Clinical Global Impression Severity (CGI-S) score prior to first treatment in this maintenance course (NB it is normal for patients to have a relatively low score) *

- 1. Normal, not at all ill
- 2. Borderline mentally ill
- 3. Mildly ill
- 4. Moderately ill
- 5. Markedly ill
- 6. Severely ill
- 7. Amongst the most severely ill patients
- The score was not recorded

Clinical Global Impression Severity (CGI-S) score after last treatment in this maintenance course *

- 1. Normal, not at all ill
- 2. Borderline mentally ill
- 3. Mildly ill
- 4. Moderately ill
- 5. Markedly ill
- 6. Severely ill
- 7. Amongst the most severely ill patients
- The score was not recorded

Psychiatric symptom rating scale used prior to first treatment in this maintenance course (tick all that apply)

- [ ] Montgomery-Asberg Depression Rating Scale (MADRS)
- [ ] Hamilton Depression Rating Scale (HAM-D)
- [ ] Young Mania Rating Scale (YMRS)
- [ ] Bush-Francis Catatonia Rating Scale (BFCRS)
- [ ] The score was not recorded
- [ ] Other

Psychiatric symptom rating scale used after last treatment in this maintenance course (tick all that apply)

- [ ] Montgomery-Asberg Depression Rating Scale (MADRS)
- [ ] Hamilton Depression Rating Scale (HAM-D)
- [ ] Young Mania Rating Scale (YMRS)
- [ ] Bush-Francis Catatonia Rating Scale (BFCRS)
- [ ] The score was not recorded
- [ ] Other

Subjective memory assessment score (using Item 17 on the Comprehensive Psychopathological Rating Scale (CPRS)) prior to first treatment in this maintenance course

- ( ) 0 - Memory as usual
- ( ) 1
- ( ) 2 - Occasional increased lapses of memory
- ( ) 3
- ( ) 4 - Reports of socially inconvenient or disturbing loss of memory
- ( ) 5
- ( ) 6 - Complaints of complete inability to remember
- ( ) This was not recorded
- ( ) The patient was too unwell to give a response

Subjective memory assessment score (using Item 17 on the Comprehensive Psychopathological Rating Scale (CPRS)) after last treatment in this maintenance course

- ○ 0 - Memory as usual
- ○ 1
- ○ 2 - Occasional increased lapses of memory
- ○ 3
- ○ 4 - Reports of socially inconvenient or disturbing loss of memory
- ○ 5
- ○ 6 - Complaints of complete inability to remember
- ○ This was not recorded
- ○ The patient was too unwell to give a response

Objective cognitive test used prior to first treatment in this maintenance course (tick all that apply) *

- ☐ Montreal Cognitive Assessment (MOCA)
- ☐ Mini-Mental State Examination (MMSE)
- ☐ The patient was too unwell to assess
- ☐ The score was not recorded
- ☐ Other

Objective cognitive test used after last treatment in this maintenance course (tick all that apply) *

- ☐ Montreal Cognitive Assessment (MOCA)
- ☐ Mini-Mental State Examination (MMSE)
- ☐ The patient was too unwell to assess
- ☐ The score was not recorded
- ☐ Other

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

ECTAS
ELECTROCONVULSIVE THERAPY ACCREDITATION SERVICE

ECTAS

The Royal College of Psychiatrists
21 Prescot Street
London
E1 8BB

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

CCQI
COLLEGE CENTRE FOR QUALITY IMPROVEMENT