Regional Variation in Electroconvulsive Therapy Use

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Abstract
Although electroconvulsive therapy (ECT) is the most powerful treatment for depression, substantial variability in use has been described in Ireland. The Mental Health Commission collects usage data from approved centres but does not include home addresses or independent sector centres. Therefore, estimates of regional variation cannot be accurate, e.g. 145 (35% of total) independent sector patients were omitted from their 2008 analysis. When public and independent sector centres are combined inter-regional variation for 2008 is more than halved (chi-squared decreased from 83 to 30), with Western region contributing most to variation (chi-squared=43). Ratio of ECT programmes to depressed admissions correlated negatively with rate for depressed admissions (r=-0.53, p=0.01), while depressed admission numbers correlated with acute beds per area (r=0.66, p<0.001). Regional variation in ECT is less than previously reported; service factors probably account for much of this with smaller centres admitting severely ill patients more likely to require ECT.

Introduction
Electroconvulsive therapy (ECT) is one of the most powerful treatments available for severe psychiatric illness, especially depression and catatonia. It is a medically safe procedure involving deliberate induction of a brief modified tonic-clonic seizure by applying a small electrical charge across the brain of an anaesthetised patient given muscle relaxant. A usual course of ECT is 6-8 such treatments given twice weekly. As in most western industrialized nations, the majority of Irish patients who have ECT are treated for depression. In Ireland, 90% of patients seek treatment with fully informed consent, often after many failed therapies.

ECT in Ireland is regulated by the Mental Health Commission (MHC) and ECT in Ireland is regulated by the Mental Health Commission (MHC) and ECT use is approved by the HSE. Further voluntary accreditation under stricter criteria is offered by the ECT accreditation service (ECTAS) of the Royal College of Psychiatrists (UK). The MHC report discusses regional variations in ECT use between centres and between Health Service Executive (HSE) administrative regions (Dublin/North-East, Dublin/Mid-Leinster, South and West). For example, they illustrate a large difference between centres in the South and West regions and independent service providers. However, these analyses were performed without reference to numbers of admissions per centre. Additionally, the MHC data collection does not include patients home addresses. Reports of regional ECT use are thus treatment centre-focused rather than patient-focused. Our aim was to collate both publicly available and independent sector data to estimate the regional rate of ECT use by the whole Irish population.

Methods
To construct a patient-centred estimate of contemporary regional use of ECT in Ireland, we extracted data from the Report of the MHC on ECT use in Approved Centres in 2008 and the report on Activities of Irish Psychiatric Units and Hospitals 2008. These data were sourced if not otherwise specified. The MHC report discusses regional variations in ECT use. Further voluntary accreditation under stricter criteria is offered by the ECT accreditation service (ECTAS) of the Royal College of Psychiatrists (UK). The MHC report discusses regional variations in ECT use between centres and between Health Service Executive (HSE) administrative regions (Dublin/North-East, Dublin/Mid-Leinster, South and West). For example, they illustrate a large difference between centres in the South and West regions and independent service providers. However, these analyses were performed without reference to numbers of admissions per centre. Additionally, the MHC data collection does not include patients home addresses. Reports of regional ECT use are thus treatment centre-focused rather than patient-focused. Our aim was to collate both publicly available and independent sector data to estimate the regional rate of ECT use by the whole Irish population.

Depression is the main indication for ECT. To compare ECT practice between treatment centres, we therefore generated an index of rates of ECT use by dividing each centre's number of ECT courses in 2008 by its number of admissions for depression in 2008. We also examined size of individual HSE ECT centres as measured by number of acute beds per 100,000 catchment area population. The independent sector treats patients from all over Ireland who have health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas. In 2007 about 49% of the adult Irish population had private health insurance and thus provides a national service not confined to specific catchment areas.

Results
In 2008, 407 people were treated with ECT in Ireland and ECT was administered in 24 of 64 approved centres. Two of these were independent centres. Based on the number of persons treated with ECT, the largest centre was St. Patrick's University Hospital (SPUH), a large independent Dublin teaching hospital providing a national service. 124 patients (30%) were treated in SPUH, accounting for 84% of independent sector ECT; 10 of these were public sector HSE patients who did not have access to a local ECT service. None of these patients were included in the MHCs report of regional differences.

Figure 1: Rates of ECT use per 100,000 of population in the four Health Service Executive (HSE) administrative areas: West, South, Dublin/North-East and Dublin/Mid-Leinster. Rates reported by the MHC are shown in black. Revised rates after re-allocation of patients treated in the independent sector are shown in grey.
The next three largest centres were St. Brigid’s Hospital Ballinasloe (n=47), Waterford Regional Hospital (n=27) and University College Hospital Galway (n=22). Figure 1 shows that there was large and significant variation in ECT use per 100,000 of population between the four administrative regions (chi square = 83, p<0.001). However, on including independent sector patients based upon home address, this variation is substantially reduced (chi squared = 30, p<0.001). The greatest difference was between the West and other regions (contribution to chi square = 41.32). The difference between the West and Dublin/North-East regions decreased from 8-fold to 2-fold on inclusion of independent sector patients.

To better determine any variability in practice between individual treating centres during 2008, the number of patients receiving ECT was expressed as a ratio of the number of depression admissions to each centre (Table 1). Most Irish university teaching centres with an established ECT department used ECT proportionate to 1 in 7 to 1 in 10 depressed inpatients. There was a notably increased rate of ECT use per depressed inpatient in two units. During 2008, the Mater Misericordiae Hospital in Dublin north central received referrals for ECT from nearby St. Vincent’s Hospital Fairview. When depressed inpatients from Fairview are accounted for, the rate of prescription falls to 1 in 14 depressed inpatients between the two hospitals. The increased rate of use (1 in 3 depressed admissions) in Ballinasloe, Co. Galway, cannot be attributed to referrals between hospitals. There were several centres where there was only very occasional ECT use.

Figure 3: Scatterplot showing depressed admissions versus acute beds per 100,000 for each catchment population. Inset plot shows the same data without the outlier St. Michaels Tipperary.
Lower ratios of in-patient beds to catchment area population may have an effect of limiting admissions to more severely ill patients, thus increasing apparent rates of prescription of ECT. We therefore compared the number of depressed admissions per 100,000 of catchment population to the percentage of depressed admissions receiving ECT and found a negative association (Figure 2; Pearson r = -0.53, p=0.01) that was stable to removal of outliers. This suggests that some HSE centres admit fewer depressed patients per capita of catchment population and that this correlates positively with rate of ECT use. Therefore, some units may have a higher threshold for admission, only admitting the severely ill and the treatment-resistant depressed patients who are more likely to require ECT. To explore this possibility, we examined the number of acute psychiatry beds per 100,000 population and the number of depressed admissions per 100,000 in 2008 and found a positive correlation (Figure 3; Pearson r=0.68, p<0.001) that was robust to removal of outliers. Assuming a constant prevalence of severe depression in regional populations, this suggests lower threshold for admission in larger units.

Discussion

Only 24 of 64 approved centres provided ECT in 2008. There is significant variation in the regional rate of prescription of ECT for a given number of depressed admissions. However, we demonstrate this is exaggerated by omitting independent-sector data from MHC reports. The remaining variation is mainly due to higher use of ECT in the West, possibly contributed to by the relatively greater ECT use in Ballinasloe. Variations between individual HSE centres are possibly due to local service factors. In catchment areas with less acute beds per capita, the threshold for admission with depression appears to be higher. This inflates the rate of ECT prescription per depressed admission in these centres.

9.6 per 100,000 Irish people were treated with ECT in 2008 (8.8 per 100,000) for admission with depression appears to be higher. This inflates the rate of ECT prescription per depressed admission. However, we demonstrate this is exaggerated by omitting independent-sector data from MHC reports. The remaining variation is mainly due to higher use of ECT in the West, possibly contributed to by the relatively greater ECT use in Ballinasloe. Variations between individual HSE centres are possibly due to local service factors. In catchment areas with less acute beds per capita, the threshold for admission with depression appears to be higher. This inflates the rate of ECT prescription per depressed admission in these centres.

Because the majority of Irish approved centres do not have an ECT service, one cannot assume that all HSE patients are treated within their local catchment area. Also, independent sector ECT clinics provide a nationwide service. To develop an accurate patient-centred picture of ECT use, it is therefore important that the MHC collected data incorporate some information on patients' home addresses. Inclusion of outpatient ECT is also required to improve accuracy of reporting. Additionally, for future reports it would be useful to meaningfully integrate data separately acquired by the MHC and the HRP as attempted in the present study and as previously suggested.

Our analyses are limited in a number of ways. The publicly available data are subject to error regarding true site-of-origin of patients treated with ECT. Data are missing from the second independent sector centre but these accounted for only 5% of all ECT courses in 2008. We also assumed a constant prevalence of depressive illness across regions and catchment areas. Although ECT is not solely used for depression, this is the major indication. As a rate comparison between centres is at issue, any small percentage excess at the regional level is not likely explained by treatment of other major psychiatric disorders. Only approved centres which actually used ECT in 2008 have been included in beds and population comparisons. ECT is a powerful and evidence-based treatment in psychiatry. To inform developments in health service delivery, legislation and meta-analysis. Lancet. 2003 Mar 8; 361:799-808.


References


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