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Letter to the Editor

Electroconvulsive therapy training in Ireland: a self-reinforcing decline?

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As a trainee who undertook medical school and a psychiatric internship in Malaysia, where a weekly electroconvulsive therapy (ECT) list was routine practice and part of training, I moved to Ireland in January 2023. Across three subsequent years of training and non-training posts in Dublin, spanning general adult, liaison and old age psychiatry, I did not encounter routine, scheduled ECT exposure; my first opportunity to attend a session came four months into my current post in psychiatry of old age outside Dublin. I recognise this is a single trainee's experience, and that, as with the Structured Assessment of Psychotherapy Expertise (SAPE) and other key learning items, seeking ECT exposure is currently the trainee's responsibility. Nonetheless, the contrast prompted reflection on the framework within which that responsibility sits.

Across Basic Specialist Training (BST) and Higher Specialist Training (HST), the College of Psychiatrists of Ireland (CPsychI) curriculum mandates four ECT-specific learning outcomes (College of Psychiatrists of Ireland 2025). Two are descriptive, assessed in BST by the Assessment of Clinical Expertise (ACE) and mini-Assessment of Clinical Expertise (mini-ACE): the trainee must describe the ECT process and its risks and benefits. Two appear in HST: identifying a suitable patient (Case-Based Discussion, CBD) and a single administration Direct Observation of Procedural Skills (DOPS), the latter qualified such that it 'can be completed during an approved BST placement if the trainee experienced administering ECT'. No ECT-specific outcome appears in any sub-specialty section, including psychiatry of old age, the specialty in which ECT arguably has its strongest evidence base (Arnison et al. 2025; O'Connor 2001).

By contrast, within psychotherapy the curriculum requires one supervised case of at least 12 sessions in BST and one long case of at least 24 sessions in HST, alongside 40 reflective practice group sessions in BST and 26 in HST – a minimum of 102 structured experiential encounters, plus mandatory e-modules. This rigour is appropriate to the complexity of the skill; it is not equally afforded to ECT.

The Royal College of Psychiatrists' Capabilities in Electroconvulsive Therapy (April 2025) offers a useful comparator (Royal College of Psychiatrists, Committee on ECT and Related Treatments 2025). Rather than compulsory minimums, it sets out strong recommendations: attendance at three or more ECT sessions in each year of core training, at least one DOPS per year across four assessed skill domains, eight knowledge capabilities, immediate life support certification, and attendance at formal teaching such as the annual National ECT Training Day. Higher trainees in general adult and old age psychiatry are advised to complete a further block of sessions, and a Lead ECT consultant psychiatrist may sign the document once capabilities are evidenced, providing a transparent competency trail alongside the Annual Review of Competence Progression (ARCP) process. It is advisory rather than mandatory, yet offers a nationally endorsed pathway to competence; no analogous framework exists in Irish training.

The Mental Health Commission's Activity Report 2024 records that only 14 of 66 approved centres (21.2%) provided an ECT service in 2024, with 79% of national programmes concentrated in four centres and one health region neither administering nor referring residents for ECT (Mental Health Commission 2025). For trainees whose rotations fall outside this small number of higher-volume services, routine ECT exposure is unlikely to be a default feature of training. More fundamentally, this concentration means patients in some regions cannot readily or equitably access an effective treatment when indicated; the training gap is, in this sense, downstream of a service-access gap that affects patients first.

Taken together, these observations raise a question: whether a self-reinforcing pattern may be emerging, in which limited curriculum-level attention to procedural ECT exposure, geographically concentrated provision, and a progressively narrower pool of trainees with confident experience reinforce one another over time. Where exposure is this structurally scarce and unevenly distributed, a model resting largely on individual trainee initiative may be insufficient to sustain the pipeline. Where delivered, ECT remains effective: 91.4% of 2024 programmes recorded improvement as the outcome (Mental Health Commission 2025).

The wider move towards Entrustable Professional Activities (EPAs) in postgraduate training (Ranjith 2024; Ten Cate 2005) may be relevant. As a discrete, well-defined intervention, ECT lends itself to an EPA framing. At present, absent curriculum-level guidance, the minimum exposure and competence standards for completing the administration DOPS rest with individual practitioners, introducing variation in what 'competence' means across sites. An EPA-based approach, or a capabilities framework along the lines of the RCPsych document, could make these expectations explicit and consistent.

What is less clear is how trainees and consultants experience this landscape. To my knowledge, no recent Irish data describe trainee exposure across sites, self-rated confidence in recommending or delivering ECT at different stages, or consultant views

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on current provision. A national survey of BST and HST trainees and consultants could help inform whether a more structured capabilities framework would be useful here. ECT remains one of the most effective interventions in psychiatry for the conditions in which it is indicated (Semple et al. 2024; Tor et al. 2021); a clearer picture of how Irish training prepares psychiatrists to use it would, I suggest, be a valuable first step.

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