



ECT Guide

In late 2004 the Chief Psychiatrist's Advisory Group on Electroconvulsive Therapy (ECT) commenced meeting and over an 18 month period devised and developed a Guide for the use of ECT in Western Australia. Members of the advisory group included consultant psychiatrists from the public and private mental health services, an anaesthetist, representatives from the Council of Official Visitors, the Health Consumers' Council, Carers WA, Hollywood Private Hospital, Perth Clinic, Joondalup Hospital, the Australian & New Zealand College of Mental Health Nurses, the Licensing Standards and Review Unit, the Mental Health Division and nurses with expertise in ECT.

The Guide includes indications for use, patient selection and pre-ECT evaluation, patient information and consent, technique, equipment, and evaluation, adverse effects and their management, documentation issues, continuation and maintenance ECT, nursing considerations, anaesthesia requirements, training, credentialing and clinical privileging of health care professionals and quality assessment. Included as an appendix and separately for downloading is a recommended ECT Consent Form, devised by the Office of Safety and Quality and the Office of the Chief Psychiatrist.

A copy of the Guide and the Consent Form can be accessed at <http://www.chiefpsychiatrist.health.wa.gov.au/publications/index.cfm#1> The Guide will remain as an electronic document in order for feedback to be provided from clinicians, consumers and the general public who have an interest in this treatment. Feedback should be provided to Tim Rolfe on tim.rolfe@health.wa.gov.au

Following the publication of this Guide the Chief Psychiatrist's Advisory Group will turn their attention to the important issue of Standards for the provision of ECT.

Clarification on time limitations for extensions of Forms 9 & 10

Mr Murray Allen, President of the Mental Health Review Board has noted that questions often arise regarding the length of time involuntary detaining orders or Community Treatment Orders (CTOs) are valid , particularly in relation to extensions. There appears to be some confusion about the difference between extensions of a CTO (Form 12) and the order continuing detained status (Form 9) and the Board seem to spend a good deal of time contacting clinicians to ask them to correct dates.

For clarification, an order extending a CTO can extend the period for 3 months from the date on which the order would otherwise lapse, the date specified on the Form 10. However, in relation to the continuation of detained orders, s 49(3) requires that a continuation order can only be for a period of no more than 6 months "after the order is made" that is the day the continuation order is made, not the day the previous order would have lapsed.

Mr Allen further requests that care is taken when indicating the date an order will lapse, for example where an order is made on 30 November it should be noted there is no 30 February.

INFORMATION

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One of the responsibilities of the Chief Psychiatrist is the medical care and welfare of all involuntary patients. One way that this responsibility is exercised is by ensuring that the rights of involuntary patients are recognised and respected. This is shared with other agencies such as the Council of Official Visitors who have the specific task of patient advocacy and the Mental Health Review Board who have the specific task of reviewing involuntary status.

Section 156 of the Mental Health Act (MHA) notes that an Explanation of Rights is to be given to the patient whenever a Community Treatment Order (CTO) is made in respect of a person. The Mental Health Regulations detail the information to be provided.

In June 2005 Dr Judyth Watson, Head of the Council of Official Visitors expressed concern that some patients on CTOs were not being informed of their rights under the MHA. The OCP therefore undertook a survey as to whether from the patient's view they are being informed of their rights. Earlier this year a questionnaire was distributed through the services to patients either presently on a CTO or who have been on a CTO in the last year. By mid-October 2006, 84 replies had been received and the data analysed. The research has yet to be completed so the findings presented here are preliminary. A final report on the research will be made available on the Chief Psychiatrist's website by the end of the year.

The survey requested feedback on 8 questions and also gave the opportunity for comment.

The first question asked was: *'Was being placed on a Community Treatment Order (CTO) and what that would mean discussed with you before it happened?'*

52 or 61.9% answered yes with 27 or 31.14% answering no while 5 were left blank. In 28 out of the 52 cases it was the consultant psychiatrist who discussed the issues with the patient and a member of the mental health team on the other occasions. Although less than perfect this indicates that over 60% of the time the consumer remembers that information about being on a CTO was provided and on most occasions this was done by the psychiatrist who placed the patient on the CTO. One methodological problem was that the answers to the question do not indicate how often information was provided after being placed on a CTO.

Question 2 was in relation to the treatment plan, which details what treatment the patient will receive. The specific question being: *'Was the treatment plan on your CTO discussed with you and if so by who?'* 49 patients (58.33) answered yes and 31 (36.90) answered no with 4 being left blank. As with question 1 this information was most often provided by the consultant psychiatrist (27).

Question 3 was *'Did you receive a copy of the CTO the Form 10?'* 60 out of the 84, 71.43% answered yes with 19 answering no and 6 leaving it blank. Although an improvement on previous questions this again if accurate is disappointing as section 159 of the MHA specifically states that a copy of the form is to be given to the patient or other nominated person.

Question 4 was: *'Were you told where and when your first appointment with the mental health service would be?'* and 71 (84.52%) were given that specific appointment. 7 (8.33%) answered no and 6 left it blank. Some of the comments were that the appointment was given with an appointment card or directly or by letter. This was a positive result as one of the only twopeals to reach the Supreme Court following a Mental Health Review Board hearing was regarding CTOs and knowledge of the first appointment. Justice Templeman specifically noted the importance of the consumer being aware of when that first appointment was so as not to inadvertently breach the order.

Question 5 related to whether *the patient was told they could apply for a review by the Mental Health Review Board* and 60 (71.43%) remember being told with 18 (21.43) not being told or not remembering and 6 leaving it blank. Over 70% being told is a positive as the Review Board have an important function in upholding the rights of people with mental illness and can, similarly to a psychiatrist, make a person no longer involuntary. Question 6 was similar and related to being told that they could contact the Council of Official Visitors. 47 (55.95%) remember being told and 31 (36.90%) were either not told or could not remember.

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CTOs and a Right to Information- continued

Question 7 was in relation to being '*told that they could have a second opinion from another psychiatrist*'. 36 (42.86%) can remember being told with 43 (51.19%) answering no. Some of the comments on this question were critical of the system where even if a second opinion is granted there is a great deal of distrust as to the independence of that opinion.

Finally question 8 asked; '*If the CTO was extended, were they told about the extension before the first CTO ran out?*'. This was a more difficult response to quantify as not all of the patients had their CTOs extended and we unfortunately failed to provide the option of not applicable. So although only 38 answered yes many of the 30 'Nos' could have really been put with the 16 blanks.

The results of this survey are mixed. On the positive side the numbers of patients receiving first appointments and copies of the form indicate that the administrative processes involved in relation to placing a person on a CTO are effective. The fact that this initial information is usually provided by the psychiatrist is also very positive.

Less positive is that the general information of why a person is being placed on a CTO is not being provided adequately. One clear message through the comments is that perhaps realistically the respondents note that being on a CTO means having to accept medication and that the primary purpose of a CTO is to provide medication. It is not satisfactory that information about the right to a second opinion, access to the MHRB and access to the COV are low, however this may be because when provided with a pamphlet the clinician does discuss the details of the information included in the pamphlet giving the opportunity for clarification.

What can be learned from the survey? One lesson is that some of the resentment to CTOs indicated by the respondents could be partly ameliorated by providing to the patient specific information about the MHRB and COV as well as the opportunity for a second opinion and time for discussion and ventilation. The better informed a person is about their rights and the opportunities for advocacy the less cause they may have for non-compliance. Though it must be recognised that compelling anyone to comply against their wishes inevitably raises resentment, which perhaps can only be addressed through the quality of the relationship between the clinician and consumer.

The survey indicates that mental health services are complying with the requirements of the mental health Act but could do better. Specifically they could improve in informing a patient about specific rights such as a review by the MHRB or the advocacy service provided by the COV. There could also be improvement in providing a treatment plan. Certainly this was recognised by the Review of the Act, which recommended comprehensive discharge planning.

Confidentiality, Carers and Communication Workshop

As part of Mental Health Week, Carers WA in conjunction with the Office of the Chief Psychiatrist, the Mental Health Division and the University of Western Australia conducted a workshop on communication with carers on the issue of confidentiality and sharing information. The workshop was attended by senior staff from public and private mental health services and a roleplay format was used to consider the issue of what could be disclosed to carers and what could not without the patient's consent.

Draft guidelines entitled 'Communicating with Carers and Families' devised by Carers WA and endorsed by the Chief Psychiatrist were presented and we await feedback on those guidelines before they are launched by Carers WA.

Also discussed were a new consumer consent form entitled 'Permission to Communicate Confidential Information' which indicates in a more specific way what information a consumer is prepared to share with a carer and when that consent requires review. It is the intention of staff from UWA and the OCP to conduct a research project on this form. A new Confidentiality Community Framework for tracking consumer consent was also distributed and we await feedback on that form.

If your service is interested in being involved in the research to validate the 'Permission to Communicate Confidential Information' Form please contact Tim Rolfe on 9222 4217 or e-mail him on tim.rolfe@health.wa.gov.au

CHIEF PSYCHIATRIST'S MONITORING OF STANDARDS OF CARE IN NON-GOVERNMENT AGENCIES

The Chief Psychiatrist is required under the *Mental Health Act 1996* to monitor the standard of care provided by mental health services. The Act does not distinguish between Public and Private Services. Mental health care may be provided through:

- community mental health and inpatient services;
- emergency departments;
- crisis services; advocacy services;
- hostels or other residential services;
- community assistance or rehabilitation services;
- family support services;
- recreational or therapeutic services.

Chief Psychiatrist's Clinical Governance Review of Mental Health Services

The Office of the Chief Psychiatrist (OCP) has for some time implemented a Clinical Governance Review Program of public mental health services. This same framework has also been applied to a private mental health service and negotiations have commenced for the CG review of further private service. This program is applicable to 'clinical' service provision.

Care Standards Monitoring in Non-Government Agencies

The Chief Psychiatrist's monitoring of care standards in non-Government agencies commenced in 2003 with the development of the '*Standards in Care Outcomes In Licensed Psychiatric Hostels for People with a Psychiatric Disability*' and application to Licensed Psychiatric Hostels. Monitoring of Hostels has been operational from that time.

The Mental Health Division has developed the '*Service Standards for NGO providers of Community Mental Health Services*' and along with the WA Association for Mental Health is working extensively with approximately sixty non-Government agencies to implement the standards. Those of the standards that are applicable to 'care' are compatible with the Chief Psychiatrist's care outcome standards and will be used as the basis of the Chief Psychiatrist monitoring of this sector.

The Office of the Chief Psychiatrist will convene a group in early 2007 to develop the process of monitoring that will encompass the non-Government sector agencies currently implementing the standards.

AMHP Forums

Three AMHP Forums were conducted in October and November 2006 and attended by over a hundred AMHPs. Bronwyn Williams presented on Clinical Risk Assessment and Dr Davidson on research conducted by the OCP on the rights of patients on CTOs. There was also the opportunity to interact with Mr Murray Allen, President of the Mental Health Review Board and Dr Davidson, Chief Psychiatrist. Thank you to all those that attended.

Next AMHP Program

The next Review of Skills program to become an Authorised Mental Health Practitioner will be on 19, 20 and 21 March 2007. These programs are popular and fill up fast. If your service wishes to nominate eligible mental health practitioners they should undertake to do this promptly. Further information is available from Tim Rolfe. Please note that Notification Forms for the second 6 months of 2006 will be e-mailed to all AMHP in mid-January



Dr Rowan Davidson and the staff of the Office of the Chief Psychiatrist would like to wish Seasons Greetings to all readers of the INFORM Newsletter