



Canadian Federation of Mental Health Nurses

Summer 2002
Edition Number 35

President's Message

Ann Greene



I've barely returned from 10 days in Toronto.

Imagine.....Toronto.....summer.....Toronto.....hot.....Toronto.....humid.....

Toronto.....thunder.....Toronto.....lightening. Add the Regional Conference for the Canadian Federation of Mental Health Nurses, CFMHN Annual Meeting, the Canadian Nurses Association (CAN) Annual Meeting and Conference, and you have one overwhelming trip. Despite an aftermath of fatigue I have to admit that the trip was worth it. The networking alone was worth it. Throw in CNA's Conference on Diversity and our own Best Practices Conference for Mental Health Nurses, and there was no place better to be than Toronto in June.

For those of you who attended the CFMHN's Best Practices Conference, you will know what I'm talking about. For those who didn't, here is a snapshot of the day. The energy was high and the speakers dynamic. One hundred and forty-five nurses attended this one-day affair and they were not disappointed. Doug Rosser, the conference planner, pulled out all the stops to ensure, once your car was parked, the day flowed without another decision to be made. It was basically, sit back and enjoy. The information was refreshing, the atmosphere relaxed, the presenters professional and the food divine. I am hopeful that our newsletter will be able to publish some of the presentations over the next year, so our readers can reflect on some of the key Best Practice work being done across this country by psychiatric and mental health nurses. Bravo to the Planning Committee chaired by Nancy Johnston for a job well done.

Dr. Ruth Gallop (a plenary speaker and long-time advocate for the goals and objectives of CFMHN) assured the audience that she is only retiring from the University of Toronto, and not from nursing; the audience sighed with great relief. The CFMHN awarded \$2000.00 to the "Ruth Amiel Gallop Graduate Scholarship" fund at the University of Toronto. See the photo on page 2 for a view of the awarding.

The annual meeting followed an end of the day reception and an invitation to all to attend next year's annual meeting and International Conference on May 29, 30 and 31 in Toronto. The Conference is "Psychiatric Mental Health Nursing, The Art, The Science and The Ethic".

At the Annual Meeting the revised By-Laws were approved and several new Board members were elected. I want to take this opportunity to thank Sharon McLeod from Nova Scotia for her incredible commitment to the CFMHN both as Provincial Representative for NS and as our Executive Treasurer and Membership Chair. Also, a big thanks to Alice Chan from BC. Alice has kindly agreed to stay on as the chair of our Standards Committee that will see us through to a 3rd edition of the "Canadian Standards of Psychiatric and Mental Health Nursing". The Board positions of President (that's me), PEI representative (Gloria McInnis-Perry) and Manitoba representative (Cathy Lucas) were officially filled; to this point all 3 incumbents were in an acting capacity. Newly elected board members are Geertje Boschma for AB, Nancy Panagabko for BC, Sharyn Chapman for NS, and Judy Buchanan for NB. Sharyn also was appointed by the Board to the Treasurer/Membership portfolio. Sean Hopkins, YU and Val Hartley, SK were re-elected.

Wishing a fond farewell to the Federation days, I turned my sites to the CNA annual meeting and conference. The Challenge of Diversity was the official headliner, but the working title was "Primary Health Care". I used the opportunity as CFMHN President to put forth the business and goals of the CFMHN in various CNA arenas, for example, health policy and the review of recruitment and retention of nurses. I'll keep you posted on the headway we make with this national body and their 'seeking out' of expert psychiatric and mental health nurses through the CFMHN network.

Continued on page 2

Fédération Canadienne des Infirmières et Infirmiers en Santé Mentale



Continued from page 1

In conclusion, I'm sure you are all desperate to know if there was any time for 'fun' on this whirlwind of nursing conferencing and annual meetings; well yes, of course there was. The summer jazz festival just happened to have a major venue across the street from the hotel, and I wandered over occasionally to catch some great performances under the tent. Evenings were best for this west (wet) coaster. The heat and the humidity are very difficult for those who are used to temperance of temperature.



Photo: Dr. Ruth Gallop (right in photo) is recognized for her great contributions to the field of psychiatric and mental health nursing.

Nancy Johnson (left in photo) pays tribute on behalf of the CFMHN.

**Membership Notice
Canadian Federation of Mental
Health Nurses**

Please check your mailing label. The month specified after your name denotes when your renewal month is.

If there is no month listed, you are overdue. Thank you for your assistance. If you have any further questions about membership do not hesitate to contact me.

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CFMHN Executive 2002-03

From left to right: Nancy Johnston, Sean Hopkins, Alice Chan, Judy Buchanan, Gloria McInnis-Perry, Ann Greene, Sharyn Chapman, Susan Ray & Carol Ewashen Williams
Missing: Cathy Lucas (MB), Geertje Boschma (AB), Nancy Panagabko (BC) & Val Hartley (SK)

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Editorial

Judy Buchanan

As I write this I am still reeling with exuberance from CFMHN's Best Practices Conference held in Toronto on June 22nd. The event was 5 stars all the way - from the venue, to the excellent selection of speakers, to the networking opportunities, and so many other et ceteras.

This issue will focus on Serious Mental Illness from a variety of perspectives. While putting the issue together a persona of serious mental illness swept across the screen of my mind - oddly enough emerging from my long ago experiences as an institutional nurse. I'll call my composite 'Ned'. I shamefully pondered the ways that I helped to usurp his personal control. Did I attempt to keep Ned tied to his community? To his family? Did I always ensure that Ned, "my patient" was aware of his options? I answered "no" to these three questions. Did I give Ned the chance to speak for himself, or was I all too often the voice for his decisions? You can guess the answer. Thankfully that power-over and paternalistic model of nursing practice was THEN (a time long since passed), and would not be tolerated NOW. Hopefully all psychiatric and mental health nurses who work with persons with a serious mental illness now operate from a Best Practice Model of recovery, a concept which in the context of serious mental illness may perhaps be

difficult to define. In traditional medicine, recovery is equated with a cure. For persons with a serious mental illness, very often there is no cure. The seriously mentally ill or those with chronic and persistent mental disorders become such depending on the diagnosis, duration and disability.

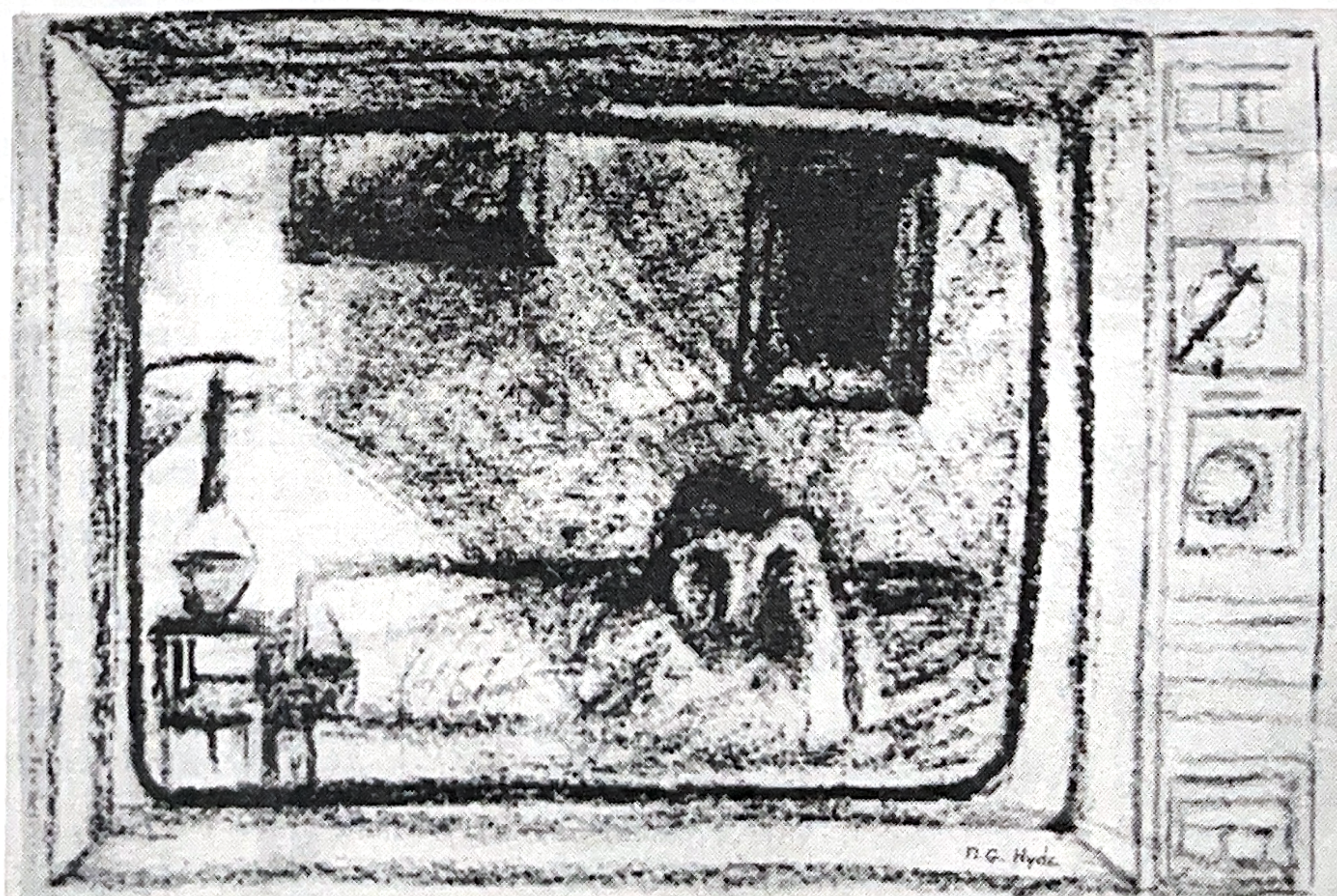
First person accounts found in the recovery literature basically call upon us to adopt a language for helping that communicates that the most powerful force for change is contained within the self. Yet while internal resources are necessary for personal empowerment, it is the interaction between the person and external resources (e.g. social support, meaningful activity, appropriate housing) that ultimately maximize personal control and impact. For us, as nurses, application of a recovery model will necessitate a focus on our clients' capacities, not on their deficiencies and a shift away from an illness model onto one which emphasizes that healing is both an internal and an external process. It is up to us within the context of a therapeutic relationship to assist our clients to gain or regain personal control and illness/symptom control. And as advocates for persons with psychiatric disabilities we need to work towards the eliminating the discrimination, which is alas still alive and well.

*Adjusting medications
Therapy
And calm interactions
Reality comes
Back
And I
Have survived.*

*Thank God
I have survived
For not
All do.*

(Excerpted from a poem titled
'Survival' by Paul Dupuis)

Then and Now by N.G. Hyde



N.G. Hyde is an "Artist in Residence" at the Art Therapy Program run by the B.C. School of Art Therapy at the Victoria Mental Health Center. She has struggled with her mental illness for over 15 years. For her, involvement in art broke the prison of her isolation that her mental illness put her in. It gave her the courage to express what she was feeling inside. As she puts it "Art helps me to find my voice and honour my own reality, and it brought me self-respect."

British Columbia

Alice Chan

The Ministry of Health has drastically reduced the number of Health Authorities from 52 to 6 in the Spring of this year. All the hospitals in this province are impacted directly. Some hospitals have closed/are in the process of closing. Some are transferring to sub-acute care. Some services within hospitals have closed.

In mental health, the Mental Health Advocate position was deleted in December, 2001. The individual now fulfilling that role is the Minister of State for Mental Health, Dr. G. Cheema.

The new Regional Director of Mental Health for Vancouver Coastal Health Authority (that is the HA that has the two major teaching hospitals with the majority of the non-provincial mental health beds and psychiatric emergency services) is diploma prepared with no undergraduate degree.

A number of professional services within the group homes in the community are deleted (eg: nursing). And, some of the support agencies for the chronically mentally ill population are closing (eg: drop in centres).

There is a \$74 million (over 4 years) Primary Health Care Transition Fund project happening. Its intent is to examine a range of practice models (eg: networks of GP practices, primary health care organizations) to improve health care outcomes (eg: Shared Care, Chronic Disease Management) and to institute evidence and evaluation based practices in organizations. It would be up to each of the 6 Health Authorities (who each receive a portion of the total funding) to consider any initiatives related to mental health.

That's it for B.C. Looks like we are living in some very interesting times!

Alberta

Carol Ewashen

For this report, I highlight what has become known as the Mazankowski report titled: A Framework for Reform: Report of the Premier's Advisory Council on Health. This report heralded a renewed focus on health care reform with implications for reform of the mental health system. A key message included the statement that mental health is not well integrated with the health system: "There is currently no framework for an integrated, coordinated and comprehensive system of mental health services for

children, adolescents, and their families, either at a provincial or a regional level" (p. 20).

Recommendations for reform of the health system included:

1. The first reform is to stay healthy.
2. It's time to put "customers" first.
3. Redefine what we mean by "comprehensive".
4. Invest in technology and establish an electronic health record.
5. Re-configure the health system and encourage more choice, more competition, and more accountability.
6. Diversify the revenue stream. Instead of rationing health services, we need to find better ways of paying for the health services Albertans want and need.

Discussion included some suggested options and alternatives such as: reducing the number of regional health authorities and clarifying their roles; expanding comprehensive models of primary care, introducing new comprehensive care or disease management models; unbundling the system and introducing more choice and competition; and, expanding options in the private sector. The improvement of integration of mental health services in communities was advocated with the suggestion that "community mental health services are sorely lacking" (p. 25).

Currently, implementation teams are being formed and beginning to look at integration of services within regions. The AMHB retains direct responsibility for four specialized provincial programs: forensic psychiatry, adult tertiary care, brain injury rehabilitation, and geriatric psychiatry; and four mental health facilities including Alberta Hospital Edmonton, Alberta Hospital Ponoka, Claresholm Care Centre, and Raymond Care Centre. At present, there are approximately 70 community mental health clinics, a telemental health service; and services for substance abuse and mental illness concurrent disorders.

A climate of reform and change is not new to Albertans. We continue to need committed people willing to advocate for and work toward better mental health services. The questions remain: Who benefits most and for whose purposes?



Research Report

Carol Ewashen

In the October 2001 Research Report, I mentioned I wrote a letter of support for a CIHR Gender and Health Institute Opportunity Grant. Well, funding was received and subsequently I became part of a coordinating group to plan a national symposium on women's mental health research. Dr. Marina Morrow, Research Associate/Post Doctoral Fellow, BC Centre of Excellence for Women's Health became project leader and, thanks to her tireless efforts, organized an invitational symposium of researchers and policy makers. The symposium was held on June 1-3, 2002 in Vancouver, British Columbia. The Institute of Gender and Health and the Institute of Neurosciences, Mental Health and Addiction of the Canadian Institutes of Health, the Women's Health Bureau, Health Canada, and the Vancouver Coastal Health Authority all contributed funds for this event.

The purpose of the symposium was threefold:

- ❖ To assess the current state of research on women and mental health in Canada.
- ❖ To identify innovative cross-disciplinary research methodologies and strategies that will contribute to better understanding of the influence of sex, gender and social stressors on women's mental health.
- ❖ To ensure the relevance of future research to clinical practice.

The desired outcome was to develop programs of research including a research agenda that could be used by the Institute of Gender and Health, the Institute of Neurosciences, Mental Health, and Addiction, the Institute of Aboriginal Health, and the Institute of Health Services and Policy Research. The intent of the identified research programs would be to assist in building capacity for interdisciplinary research on sex, gender and mental health.

Robert Hartfield, Marina Morrow, and Tasnim Nathoo distributed a discussion paper for the symposium: Sex, Gender and Mental Health in Canada: An Overview of Research and Policy. This discussion paper is extremely well written with an extensive overview and synthesis of a vast array of relevant literature, research and policy documents. Appendix B contains a comprehensive list of national policy documents as well as for each of the provinces including the Northwest Territories. (I will see if I can get this information available through our website).

Several themes emerged from the discussion. These included that need for research in the following areas:

- ❖ The conditions of women's lives and women's roles (i.e. issues related to poverty, mothering and mental illness, trauma and violence and the relation to mental illness)
- ❖ The predominance and the limitations of the western, bio-medical paradigm for understanding women's mental health
- ❖ The invisibility of consumer survivors and the "knowledge of experience"
- ❖ The role of complementary and alternative therapies
- ❖ The linking of health and mental health, mental health promotion/wellness, and resilience paradigms within a social lens
- ❖ Policy development linked to research

This conference proved to be very valuable for identifying researchers and policy makers in the area of women's health/mental health. Additionally, valuable networking occurred with identification of avenues for future interdisciplinary research collaboration.

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The advertising rates for the Newsletter are as follows (Cdn. funds):

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Dare to Tell

...Real Stories About Real Nurses
an interview by Ann Greene with Sharyn Chapman

As told to Ann Greene by Sharyn Chapman on a muggy day in late June in Toronto.

Let's start with what you do.

I work as a Community Mental Health Nurse on a Multidisciplinary Team in Dartmouth, NS. My caseload consists of about 60 patients, with a variety of issues. Most of my patients experience serious and persistent mental illness, predominantly Schizophrenia. One third of my patients are from the Sheet Harbour area, a rural district 2 hours from metro. I spend 1 or 2 days per week there and see a little bit of everything as I do assessments and follow people as required. My work is very rewarding! Because of the chronic nature of mental illness, I have been working with some of the same people for ten years. I see many patients in their homes and in doing that, really get to know the families. They call me when things start to go awry. Early detection of relapse and swift intervention with makes all the difference and can actually be empowering for patients.

I often find myself in very different situations. From role playing 'how to be assertive with a teenager', to attending the university graduation of a patient who once said "I'll never get out of high school", to administering a long acting injection in the male wash-room of a local gas station. Helping patients meet their goals becomes my goal. One of my patients, a 38 year old man, wanted to go to a 'rock star concert'. We worked together to make that happen. I will always treasure the memory of him calling me the next day to tell me, excitedly, how he had enjoyed himself 'to the fullest' and he had even danced in the aisles with everyone else.

Some nurse would say that working with chronically ill patients over time is boring or not very challenging. How would you challenge this thinking?

I would gracefully disagree. I have hope. I never see any patient or situation as hopeless. I can rarely predict what my day will look like but it is absolutely never ever boring. My critical thinking and problem solving skills are constantly engaged. The greatest challenge for me is to be patient. Positive change often happens slowly.

Tell us how you maintain balance in your life between work, play, and personal commitments.

I laugh (alot). I have many wonderful friends (who let me know when I need to lighten up). I have a wonderful family (who love me, no matter what). I also love to read, garden, and entertain. I do make time to be on my own to reflect. Oh yes, I also love to dance and listen to music.

I don't take myself too seriously. I accept that I make mistakes and know that I am generally doing the best that I can do.

Do you have some advice for our readers?

Treat everyone, without exception, as you wish to be treated. Be genuine, warm, and respectful. Cherish your ability to truly care.

Sharyn, can the principles that you apply in your work be used in other clinical settings?

Yes. They are universal.

Last words.....

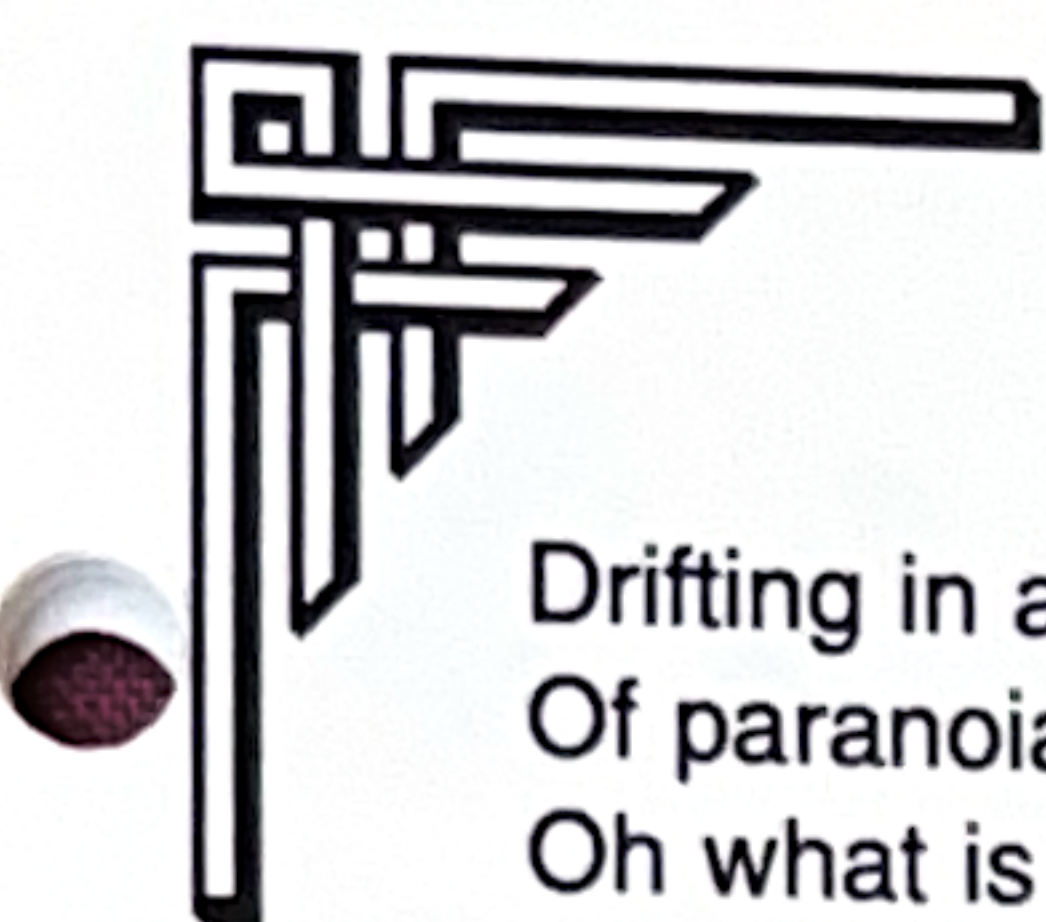
In order that people may be happy in their work, these three things are needed: They must be fit for it. They must not do too much of it. And they must have a sense of success in it. ~John Ruskin



Sharyn Chapman

Sharyn is a Community Mental Health Nurse, practicing on the Eastern Shore of Nova Scotia. She grew up in rural Newfoundland and graduated from The Grace General School of Nursing in 1985, one week before marrying Mark and moving to Nova Scotia. In 1988, she began working at the Nova Scotia Hospital, the largest Psychiatric Facility in Nova Scotia. Sharyn worked in acute care, rehabilitation, and research and community education before her current position. She obtained her degree, through distance, from St. Francis Xavier University in 2000.

Sharyn presently lives in Dartmouth with Mark, two gorgeous sons and Golden Retriever, 2K.

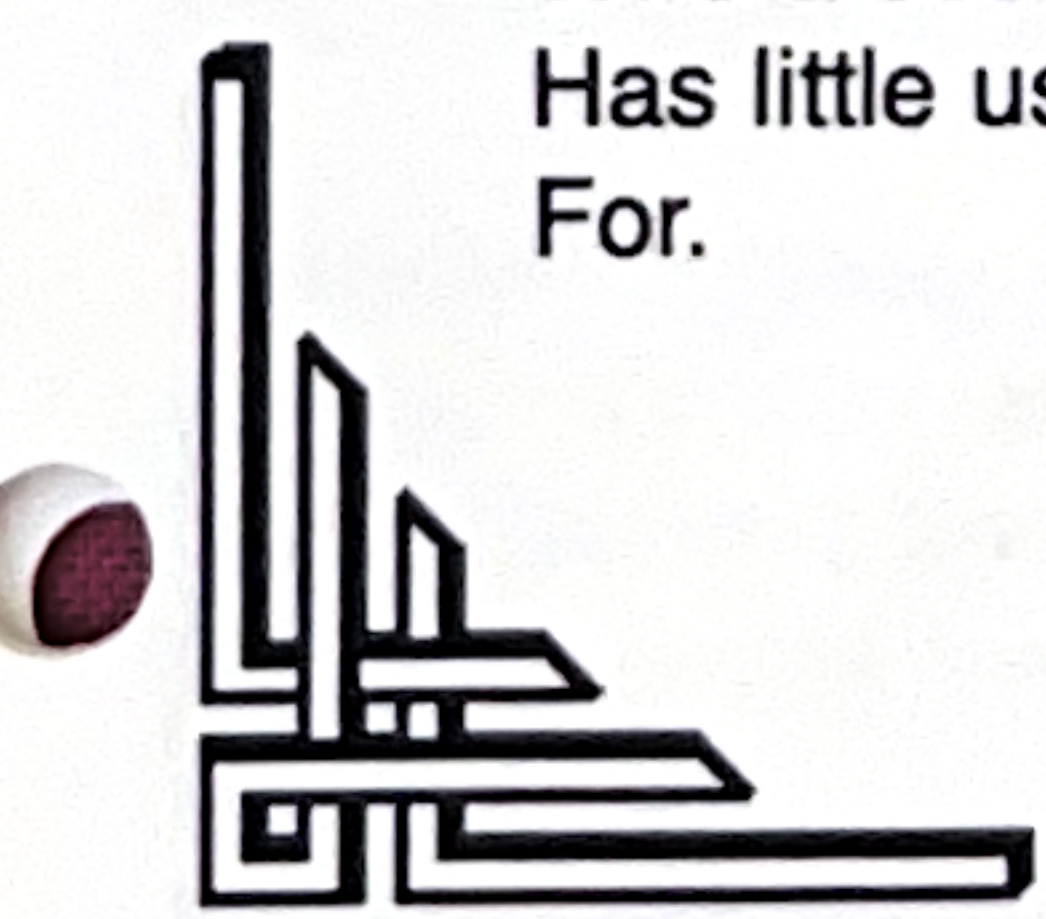


Drifting in a world
Of paranoia and delusion
Oh what is my call
A world so full
Of devastation and destruction
Unjust
Belligerent
To the brotherhood
Of man.

A mindless public
Struggling
And fighting
To achieve
A sense of happiness
Or peace
Which is
An exclusive extreme
Barren to the
Common heart
And ideal dream.

I
But a madman
Supporting equality
And love
Am but of little
Purpose
To the universal
Harmony
Which hides away
Escaping all
Reaches of my grasp.

Ah but there
Is more than
Hope in faith
For my words
Are felt in
The fellow
Of those
Blatantly
Labelled insane
And those
Few of the norm
Who advocate support
For we
Who a society of majority
Has little use
For.



THE RAVINGS OF A MADMAN

by Paul Dupuis

The day will come
For a better way
Which is truly
Obtained by collective
And individual effort
Which shall bring
With it
A consistent
Harmony
At last
Of true equality
And peace
Born of the effort
Of
Faith
Hope
And action
Which shall deliver
A glorious
Glorious day
Received from
God

Oh but sad
'Tis the ravings
Of
A madman.

About the Author

My name is Paul Dupuis. I have been in 'recovery' from substance abuse for over 12 years, and cope well living with schizophrenia. I have received grants from Astra Zeneca Canada and Lundbeck Canada to publish my book *The Ravings of a Madman*. I have also done an audiocassette *Ravings Electrified*, which teaches how to turn a disability into an ability by turning a delusion into fiction. My other works are a documentary film done with Judy Buchanan titled *Paul: Living in Recovery*. This educational video was made possible through a funding grant from MindCare NB. I have several other publications, but for today I have stepped away from writing about mental health. I do light articles and poetry for a local newspaper. I have done numerous talks and workshops, but will no longer fight a battle that few believe in. I now do volunteer work and work in a video store. I live with my wife and our 8-year-old son in Oak Bay, New Brunswick.

Canadian Nurse Leader

Arlee Hoyt McGee¹

"She is gift to us - an exemplar of care, caring, and trail-blazing"

These words, spoken by a mental health nurse, express the warmth and respect which countless members of New Brunswick's nursing community feel for Arlee Hoyt McGee, nurse, advocate, educator, poet, playwright, researcher and historian. I would be remiss if I didn't mention that she is also a devoted wife and mother and a grandmother extraordinaire.

It is difficult to describe Arlee's education in simple terms, for she has regularly returned to various schooling opportunities throughout her life. Her first formal diploma was in nursing from the Victoria Public Hospital - at the time a three-year program. She subsequently earned a diploma in Psychiatric Nursing from Western University, a Bachelor of Science in Nursing and a Master of Arts both from the University of New Brunswick. For the latter degree she wrote *The Fatemakers: Caregiving in Saint George, Charlotte County, New Brunswick, a Granite Town, 1875-1975*. Other formal education includes courses in addiction, law, play writing and archival study.

Arlee Hoyt McGee began her lifelong association with nursing and caregiving in psychiatric nursing. Most recently she has devoted her attention to working with the Nurses Association of New Brunswick as an archivist and historian, being the acknowledged founder of the Nursing History Centre at NANB. Between those two aforementioned points lies a career of public health nursing, addictions nursing, independent practice, patient advocacy, teaching and research. In terms of the last mentioned, it is suggested that her research in fact "defines nursing".

In 1991 she published *The Visionaries*, a term she could aptly apply to herself - one who was/is often ahead of her times. She was a pioneer in the province for the many nurses who now work in independent practice, in the field of addictions and in formal patient advocacy. Her publications and presentations in the areas of addiction and patient's rights are legion. Of additional note is that she was the first nurse and the first woman named to the Inaugural Board of the Alcohol and Drug Dependency Commission of New Brunswick, a seven year appointment.

In all aspects of her career she has shown a humanity and competence which characterize the true art of caring. That humanity is also evident in her literary pursuits. These have led to the publication of many poems, some of which have appeared in *Revolution: The Journal of Nurse Empowerment* (a particularly 'not-for-the-weak-willed' journal!). Her play *Extraordinary Women of New Brunswick* depicts the lives of six female caregivers in the 1800's. This was recently performed at a Dinner Theatre at historical King's Landing, and again at the 13th annual Meeting of the Canadian Association for the History of Nursing.

Arlee Hoyt McGee has had the foresight, and hindsight, to know the importance of understanding and disseminating "memory". She has written three books (including *The Visionaries*) and numerous articles, prepared courses, and given many seminars on the history of nursing, the iconography of the nurse and nursing images in the media. Her work on the annals and iconography of nursing has been a powerful tool for education and has provided the means for nurses to identify with and celebrate their caring past. You are encouraged to visit the NANB website (www.nanb.nb.ca) and click on History Resource Centre to get an idea of the legacy that Arlee Hoyt McGee leaves to the nurses and to the citizens of New Brunswick. *The CFMHN salutes you Arlee!*

I'd like to leave you with one of Arlee's poems that cuts into the heart of communication within a therapeutic relationship, the cornerstone of psychiatric and mental health nursing.

¹ The lion's share of this piece is lifted from or adapted from the citation prepared by Dr. Thomas Goud, campus orator, for the occasion of Arlee Hoyt McGee's award of Honorary Doctor of Science Degree given by UNBSJ in May of 1977. This is done with Dr. Goud's generous permission



Arlee Hoyt McGee

Nurses today use computers and sophisticated machines for patient care. Only one of the nurses' tools does not become obsolete - *the art of listening*.

HEALING POWERS

Childlike

A lamb among the lions.

There is no worship in my eyes but -

She is wise

Beyond her years.

Not a conduit for drugs but

She leaves openings

For me to speak my mind

And quickly noticed

That my "not really's", meant "yes".

In this issue
These are he
and mental h
Qigong, Cran
Technique, L

What is clear
held intact by
which the ph
sense of emo

I am a studen
Healing certifi
exercises, cer
motion and m
multi-sensory

In each subse
To get a sense

"When
When

I've always w
meditative mo
gy centre of th
down into you
nurses usually

I'd like to shar
part of the Da

Three clients a
crying "I'm no
arms, still sho
the wild swing
the session sho

Doing the Qig
angry, they we
her concerns. I
seeping into th

Multi-Sensory Musings

Gwen Van Schaik



Arlee Hoyt McGee

In this issue of the CFMHN Newsletter I am proud to introduce what will be a regular column centered on alternative treatments. These are healing modalities that use the manifestation and application of "energy" as the underlying principle. Many psychiatric and mental health nurses are familiar with Therapeutic Touch, but there's also Healing Touch, Reiki, Acupressure, Acupuncture, Qigong, Cranio-Sacral Treatments, Energy Healing and Chakra Healing, Bio-Energetics, Feldenkraus, and the Alexander Technique, Lomilomi The list is endlessly confusing.

What is clear, is that they all operate from a multi-sensory perspective. That perspective holds the notion that our physical world is held intact by underlying worlds of energy and consciousness; that the aura or human energy field is the energetic framework upon which the physical world/body rests. And that over and above the well-known five senses, we have intuition, direct knowing, the sense of emotions, and the sense of love.

I am a student of energy healing through Langara College Centre for Holistic Health, specifically the three year Integrative Energy Healing certificate program. At our retreats we study, play, and experiment with energy through energy healings, mindfulness exercises, ceremony, meditation, yoga, study of and exercises for the chakras, and energetic anatomy and physiology through motion and music. The program is a training ground for learning how to grow from a five-sensory human being into a multi-sensory person.

In each subsequent issue of the CFMHN Newsletter we will look at one of the alternative modalities from a practical perspective. To get a sense of what this rich field holds I'll introduce you to Qidong.



"When the energy of the soul is recognized, acknowledged, and valued, it begins to infuse the life of the personality. When the personality comes fully to serve the energy of its soul, authentic empowerment /personhood is achieved."
(The Seat of the Soul, by Gary Zukav)

I've always wondered about the application of alternative healing strategies with the mentally ill. Qigong is a series of gentle meditative movements popular and practiced in China since ancient times. It teaches how to centre, to find your 'tan-tien' (the energy centre of the body). Qigong is about aligning your spine with the universal energy that flows into the top of your head, and down into your feet to connect with earth energy. QiGong however does not deal with principles and ideas that psychiatrists and nurses usually talk about.

I'd like to share my experience in participating in a QiGong class given for half an hour every day of the week by Anne Casey as part of the Day Hospital program at Victoria's psychiatric hospital, the Eric Martin Pavilion.

Three clients and I were in the middle of following one of Anne's gentle movements, when in bursts a very angry client loudly crying "I'm not going to take those meds." Flinging her shoes in a corner she takes her place in the group and wildly swings her arms, still shouting. Calmly Anne tells her that now that she's here, she could just do what we're doing. Immediately, her arms stop the wild swings and go up slowly, like ours. She adjusts herself to our movements and visibly relaxes into her moves. At the end of the session she is no longer angry.

Doing the Qigong exercises lifted the client's energy to a different level. Wherever her energies were stuck when she burst in so angry, they were distributed and balanced throughout her energy field by the end of the session when she could talk calmly about her concerns. I find it very encouraging that these self-healing practices and the ancient principles of health and well-being are seeping into the lives of the mentally ill.

Partnering With Families of the Mentally Ill

Julie Gordon, RN, B ScN, M Ed

Like other nurses working in our specialty of psychiatric/mental health nursing, I talk daily with families, friends, and significant others who share the lives of my clients with mental illness. Over the years, I have made a point of connecting and talking with them about their experiences with ill family members. I welcomed and needed the valuable perspective regarding "what really happens at home" and "how families have tried to help their loved ones". In the mid to late 90's, as a clinical nurse specialist in mental health/psychiatry in an acute care facility, I had the opportunity to "put courage to these convictions" and establish a Family Program in the Department of Psychiatry, Ottawa Civic Hospital (now the Ottawa Hospital, Civic Campus). I would like to share highlights and learnings from this memorable journey.

So, I asked myself, What was the state of the art out there? Who had done this before and what were the results? In the last 15 years, I found there has been an increasing focus on this subject in the mental health literature, and a consistent acknowledgement that "families have not been well served by the mental health system, and that mental health professionals need to work more effectively with them." (Bernheim and Lehman, Peremelj-Taylor) This kind of collective collaboration with families has been hampered by the outdated myth that families cause mental illness, and therefore should be "treated" along with the client. Other dilemmas that have interfered with this alliance are the obvious risks and challenges in working with what may be difficult families at times, conflicting loyalties to patients and families, confidentiality vs. cooperative alliances with families, biased views of family by mental health providers, and the issues of professional and emotional rewards of family education and support. And finally, there is a repeated call from consumers and families for a more equal alliance between mental health professionals and themselves, where each are viewed with expertise and problem-solving abilities to address issues of managing the impact of mental illness.

GETTING BUY-IN - "WHY DO YOU WANT TO DO THIS?"

Getting both administrative and psychiatric support for a Family Program that worked on the philosophy as "family as partner" (rather than client) was the first step. It was important to me that family not be "pathologized" but rather allied with by bringing their experiences and successes to the table. A six week time frame was allotted to develop a working proposal, to survey the multidisciplinary staff, to carry out a needs assessment with selected families, and to ensure staff and patient investment in the program.

When circulating beginning thoughts on this project with staff, I received a variety of responses, from "we teach families already", to "no time", "sounds like a much needed idea". One

comment made by a psychiatrist in a leadership role shocked me. "Why do you want to do that? We all know families cause mental illness!". I responded that we now know families do not cause mental illness, although poor family communication, interaction and abuse are often significant contributing factors in the development of some illnesses. I explained that families were asking to partner with us to help their loved ones, and that a Family Program could have numerous benefits on both sides of the partnership, and at the very least reduce the patient's length of stay in hospital. I could see that such a program could sell itself, given half a chance.

The multidisciplinary STAFF SURVEY revealed an interest in helping families to cope better, but revealed less understanding of the degree of subjective and objective burden that families carry. There was also a spirited debate about what staff could tell family members without violating confidentiality. In setting up the program, this issue would have to be dealt with in a clear way for staff, patients and families. We discussed the many interventions nurses make every day to help and support families - when we began to acknowledge these AND celebrate them - this started the momentum to change!

The FAMILY NEEDS ASSESSMENT conducted with 4 families (two familiar with the system and two new to it) spoke volumes. There was relief and gratitude (and yes surprise) that the Department would do this for families. Consistent themes emerged. The first was an informational/knowledge need about what mental illness is and how it is treated, what can be expected from hospitalization, drug treatment, etc. The second theme was a strong recognition that family needed support coping with someone who was mentally ill, and needed clarification on what was family and staff's role in this assistance. Families really wanted to hear how other families dealt with someone with a mental illness, so they "could help better". Initially, families wanted to meet without their ill family member present, as this would enable them to voice their situation more openly and get the needed support.

The PATIENT GROUP interviewed thought the Family Program an excellent idea, and that "boy, could their family use some help". To allay any patient anxiety and fears re confidentiality, we assured them that the content of the program was educational and general in nature, and not about their individual treatment programs or issues. We then enlisted their help in inviting their family and significant others to this program. In the words of one patient whose family attended the 6 week evening Family Program, "invite your family, it gets them off your back".

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GETTING CREATIVE - START-UP AND RUNNING

One of the joys of doing a broad literature search is the rich knowledge and previous practice that comes to light. I did not have to 'reinvent the wheel'. The work of American nurses Mary Moller, Susan Reinhard, and psychologist Carolyn Bisbee, and Canadian nurse Cindy Petermelj -Taylor in this field was a small gold mine! Combining some of their valuable insights, we designed a 6 week Family Program, meeting on Wednesday evenings for 1 1/2 hours with the following program goals.

- to improve family knowledge and understanding re mental illness
- to decrease family stress by providing support, acceptance
- to learn ways to cope with the mental illness
- to assist families in establishing a support system
- to help families understand their special role in the management of mental illness

The 6 week Family Program took shape as families requested, and was built on the spirit that it was a needed complement to existing programming, that it would not be offering therapy, assessment or diagnosis, and that individual treatment issues would be directed back to the appropriate staff. A program evaluation piece was designed, and on the last week, families completed a one page evaluation and commented on the value of their 6 week journey. There was a general outline to be covered each week, and handouts to reinforce what was discussed that could be shared with family members who could not attend. As the facilitator, I chose to promote the Program as their opportunity to have a voice and get answers from each other and professionals for their dilemmas.

WEEK 1 - "Learning the Ropes" - Introduction to the Family Program

WEEK 2 - "Treatment - What it is and Isn't - What to expect"

WEEK 3 - Rights, Roles and Responsibilities of Clients, Families and Professionals Gordon Responsibility Triangle

WEEK 4 - Coping and Survival Skills for Families

WEEK 5 - Impact of Illness

WEEK 6 - Moving on - Shopping for Supports

LESSONS LEARNED - FOR FAMILIES

Over 300 family members attended the Family Program in a two and a half year period. Families were consistent in their attendance and investment. Attendance was always over 85% of registration, which was somewhat surprising given the winter weather for some programs and the long distances some travelled (Ottawa Valley, Montreal, Hawkesbury, etc). Program evaluation data revealed that an overwhelming majority of families rated the program as "very helpful", 4 or 5 out of 5, (with 0= helpful to 5= very helpful). They "most enjoyed" the partnering philosophy and the open, interactive manner in which the program was conducted. Also "learning from others", "interaction and sharing with others" and learning about treatment and resources were rated highly helpful.

It was rewarding to see family members come together to respond to loved ones in healthy ways. Several stories speak loudly to this. One story involved the brothers and sisters of a young woman with a personality disorder, who were 'at their wits' end' because their sister frequently left letters around the home threatening to harm herself. Using the Responsibility Triangle they were able to identify who was responsible for her safety, ie herself, and that their responsibility to keep her safe came when SHE indicated to them she could no longer keep herself safe. After the class, the three family members went home and in a firm, clear, caring manner explained that they felt it was her job to ensure her safety, not theirs, etc... They returned to the Family Program the following week to report that their sister had returned to work the following day! (secondary gain eliminated).

One young man stood out to me. In telling the participants why he had come, he stated that he was planning to marry a woman with an extensive mental illness history, and that her family had suggested he attend the Family Program to hear what he would likely experience if he married her. With his "shopping" agenda out in the open, he participated actively in discussions and tried to learn from the experiences of others. At the end of the Program the families asked him what his decision was. He told them that the course was a real eye-opener, but that he had learned enough of how to be a support to her and how the "system worked" that he was now attending outpatient appointments with her, and had decided to marry her.

A last story. In one Family Program a young husband attended, whose wife had been AWOL from the hospital for several days. There was a lot of staff concern for her safety due to her high level of impulsivity and self-harm behavior, and the police reported that she could not be found at their home. The husband was not cooperative. In response to my usual question asked at the beginning of the group "Anything happened since last week that you would like to talk about?", he immediately said "Well, I guess you know that my wife is AWOL? I'm hiding her from the police." I responded that I was aware of the situation, and although we were not going to be discussing that particular situation in the Family Program, I thought it would be helpful to talk about these issues generally, because many families really struggle with the Mental Health Act, and feel caught in a conflict regarding how best to help their loved one when there are issues of safety. We examined the Mental Health Act and all aspects (staff, patient, and family) of this kind of dilemma. Not once did anyone tell this young man what to do, except express their concern for his wife and him. The next morning, on coming to work, I learned that this young man had brought his wife back to hospital at midnight, several hours after the Family Program had ended! The staff were relieved and amazed, and we decided that this was one of the rewards of doing good work together - interestingly, with the end of the "control battles" going on around this patient, the staff believed her length of hospital stay was shortened considerably.

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LESSONS LEARNED - STAFF

It was a revelation to many staff that holding a Family Program could benefit the patient and themselves, as well as family. Patients who were anxious and concerned for their stressed family members seemed to relax because "someone was supporting their families". Many staff began to feel a greater alliance with families who made a point of searching out the primary nurse working with their loved one. The staff nurses announced the Family Program each week in the ward meeting, and invited patients to share the Family brochure with their families. When some patients decided that their families would not be interested in attending, the staff clearly reminded them that this decision was to be made by their family members, rather than them. Of note, over the 21/2 years we ran the program, there were no patient complaints of confidentiality being violated. Staff became aware that most families already some kind of diagnosis on their loved ones, and that indeed families had been told much about the patient's condition, by the patient himself or the psychiatrist or social worker (with the patient's permission).

On occasion, some family members endeavored to discuss specific treatment details with me, knowing that I was involved in on-unit programming. I would remind them of the "treatment lines" which did not let me discuss patient specific information, but we always went on to discuss the issues of identifying behaviors and general steps that help and hinder in response. We discussed as staff the danger in making the "confidentiality walls" so high that we inadvertently failed to teach around the "how to manage" piece. I stressed that family had a right to generic information re the illness and what interventions were helpful and what were not, in "managing" the illness process.

One of my professional dilemmas involved what my role was in running this Family Program. Was I a nurse, educator, resource person or consultant? Since the families were not my clients (there was no nurse-patient relationship), nor was I responsible for their outcomes in the program, I resolved that I was not "nursing" families but rather offering an education, information and support program from which they could take what they needed to help themselves and their loved ones. So this 'hat - change' for me meant that I was first and foremost a facilitator,

and resource person, and I would use my nursing background to do that effectively. Any participants who asked for family therapy during the program, were referred on to community resources. I developed a "rule-of-thumb" that significant family events revealed in the course of the 6 week period needed to be taken to the treatment team by the family members concerned, to ensure that the communication flowed well around the Responsibility Triangle of patients, staff and families.

We frequently discussed the UNIQUE role of families in managing home base in as stress-free a way as possible, supervision their loved ones, transportation, etc. - often it was not until their unique role was discussed that families even recognized their efforts as valuable.

The most lasting impact on me was a renewed conviction that it is appropriate for us to assume that families are doing the best they can, and that what works best in the mental health context is what works well in any family education program, an alliance built on "the expectation of a working relationship in which neither party is to blame, and both have some expertise to work toward common goals" (Bernheim and Lehman). It follows then, that in action, the power distribution looks more like stockbroker/client than doctor/patient, and includes a consumer orientation to service (B&L) .

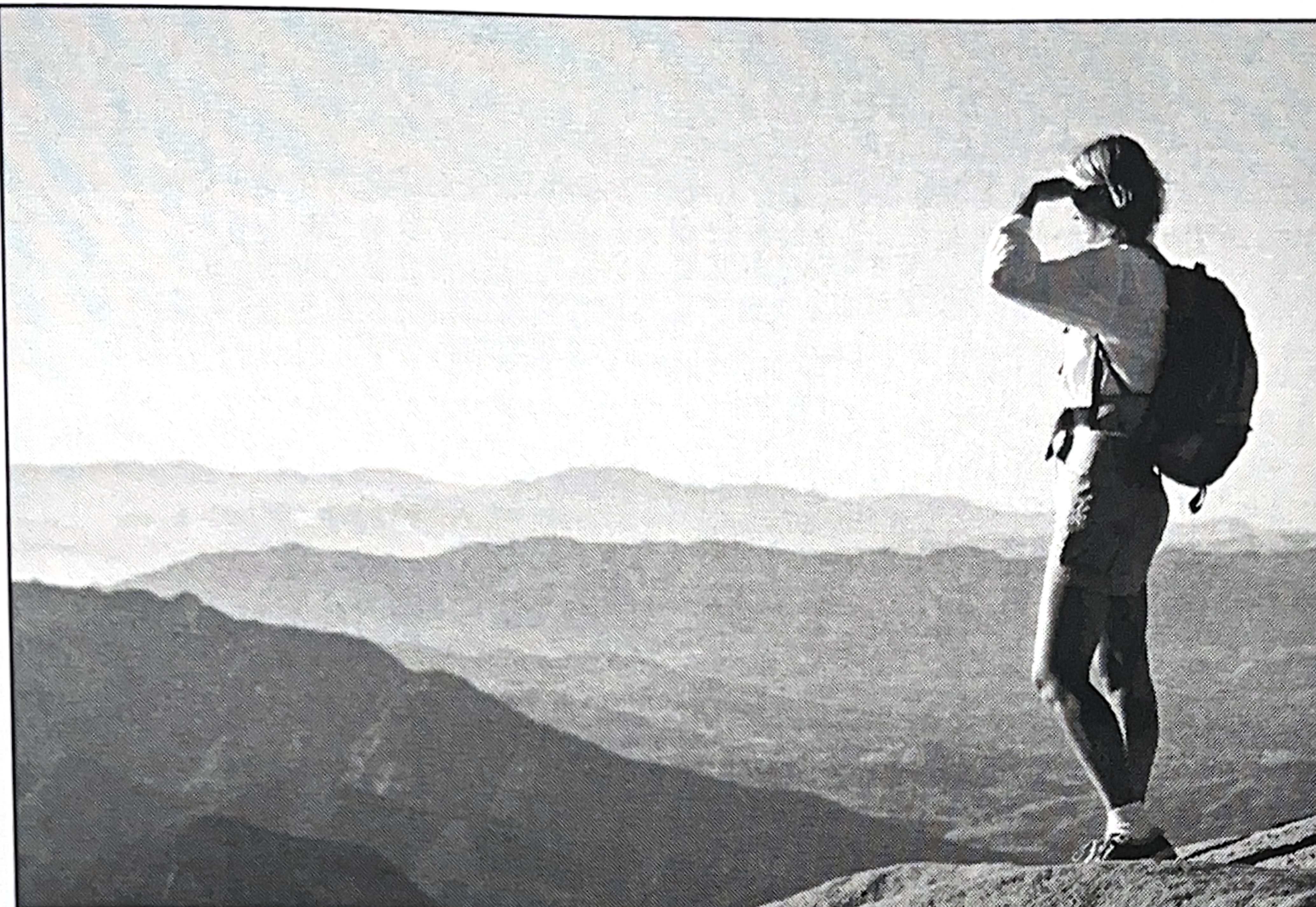
It was a privilege to walk along with family members and share their stories and struggles. Only at one meeting did the anger and blame directed at me and the mental health system threaten to derail the session. A quiet and clear response asking for this to stop because it was not fair to me or the group, nor was it what we were there to discuss, allowed us to move on - one family coming up afterward to apologize. The other family took themselves out of the Program.

While running this Family Program, my beliefs and attitudes were challenged. Families clearly let me know they valued and needed a partnership with mental health care providers. As nurses, whether we work with families in an informal way, or in a more formalized program, it is a non-negotiable ingredient in comprehensive psychiatric mental health care. Long may we invest in this important work.

Julie Gordon

Julie has nursed over 25 years in the mental health field as staff nurse, educator, clinical nurse specialist and consultant. Her career has remained focused on making a difference for patients, families and staff in this area, and de-mystifying mental illness for health care professionals and the general public. In the 1980's, Julie was one of the founding members of the first national psychiatric nursing movement, The Canadian Foundation for the Advancement of Psychiatric Nursing, a precursor of the Canadian Federation of Mental Health Nurses. She keeps happily busy with family (a husband and 8 year-old daughter), and runs a part-time independent practice, Newglue, that focuses on body, mind and spirit in offering supportive counseling. As well, she designed and currently teaches the undergraduate psychiatric/mental health nursing program at the University of Ottawa School of Nursing. Her other passion is piano, and she currently accompanies a children's choir, an involvement that really 'lifts her spirit'.

Part of Julie's practice is consulting with front-line professionals interested in building an alliance with families of the mentally ill, and she would be happy to speak, consult or chat with nurses interested in broadening broadening their interventions with families. She can be reached at home at (613) 728-8571.



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Book Reviews

The Noonday Demon: An Atlas of Depression (2001)

by **Andrew Solomon** New York: Touchstone. ISBN 0-684-85467-8(Pbk). 569 pages, \$34.50

For someone who has wrestled with depression for 20 plus years, I have found that a major bi-product of the condition is the need to hide such from others, and even sometimes from myself. The reason for this secrecy is that depression robs us of our sense of self-confidence and even more importantly, robs us of the feeling that others have confidence in us. Solomon's candid self disclosure of his own serious bouts of depression reminded me of this 'questionable confidence thing' as he places one fact after another through this rather thick book (weighing in at 569 pages). The mixture of researched data and anecdotal exposures are combined in a way that makes for an excellent reference source or that special coffee table item if you are so inclined. This truly is an atlas offering us the measure of the trench that depression cuts through the human experience.

Two chapters stand out in my mind as a clear demonstration of depressing reminders of some aspects of life and not just the impact of depression. In chapter IX POVERTY, Solomon doesn't bow to the old mental health cliché that depression is no

respector of socio/economic strata. Rather, he cuts into the heart of how poverty can make for a depressing existence in which those infected by an unending series of unrelenting injections of pain and loss know nothing but depression. In the company of this kind of world people are depressed and see it as the standard for everyone. Caught in the cycle of poverty is just as depressing as it sounds!

In chapter VII Suicide, Solomon describes his mother's suicide as clearly as clear as the eyes and the heart can bear. Although more on the theme of euthanasia than suicide the description of this woman's deliberate good-bye is something I had to read twice to get it down even before digestion started. Again, if the reader had experienced depression the detail of this chapter is recognizable since most of us depressed folk have visioned such an ending.

When a book like this becomes a bestseller it speaks of our times when a courageous author has the freedom to describe his own condition and be heard. Also it indicates the number of people willing to let their eyes rest on something we all want to turn away from.

Reviewed by David Buchanan

The Professor and the Madman: A Tale of Murder, Insanity, and the Making of the Oxford English Dictionary (1998)

By **Simon Winchester** New York: Harper Perennial. ISBN 0-06-099486-X(Pbk), 242 pages, \$19.95 (Cdn)

Although true crime stories do not usually appeal to those of us who enjoy books of the literary-murder mystery genre, The Professor and the Madman proves to be the exception.

As the cover says this book is "A Tale of Murder, Insanity, and the Making of the Oxford English Dictionary." It tells the story of James Murray, a polymath by any definition, and his life's work as editor of the Oxford English Dictionary (OED). The book tells the parallel story of Dr. William Minor, an American physician incarcerated in Broadmoor, the Asylum for Criminal Lunatics in England, featured in so many Victorian novels.

The author, Simon Winchester, skillfully describes the making of what is probably the most important reference book ever compiled. The OED took 70 years to create and defines over half a million words. The author also provides the historical backdrop to the dictionary. While there had been dictionaries before 1858, Winchester says "The 'English dictionary,' in the sense that we commonly use the phrase today - as an alphabetically arranged list of English words, together with an explanation of their meanings - is a relatively new invention. Four hundred years ago there was no such convenience available on any English bookshelf."

The OED aspired to provide not only the definition of every word in the English language but quotations showing how the meaning of each word had changed over time; an incredible task in pre-computer database times. James Murray appealed for volunteer readers from anywhere in the English speaking world to collect and submit these quotations. These volunteers were to read books from designated periods - from 1250 on - and were to look for certain 'target' words with the quotations showing how the word was used.

It was in the early 1880's that Dr. William Minor found one of these appeals and began, from his book-lined cell in Broadmoor, what was to become a 30 year relationship with the dictionary and eventually a personal relationship with James Murray. William Minor was an American surgeon, a Civil War veteran, retired out of the US Army clearly as a result of mental illness. In 1871, in England, he murdered a man, was found not guilty by reason of insanity and was taken to Broadmoor to be detained at Her Majesty's Pleasure.

The author provides details of Dr. Minor's background, his crime, symptoms of his obvious mental disorder and his care and surroundings at Broadmoor. The author communicates his love of words and scholarly research and makes The Professor and the Madman a great read for anyone who is interested in the historical diagnosis and treatment of psychiatric forensic cases, anyone who loves words, and anyone who is interested in how material for this type of book may be researched.

Reviewed by Pat Mallory

Media Awards

for Excellence in Health Care Reporting

The Ballroom of the Chateau Laurier Hotel in Ottawa was the site for the Canadian Nurses' Association (CNA) 2002 Media Awards. The evening began with cocktails for the approximately 200 media, nurses and political representatives in attendance. Dr. Ginette Lemire Rodger, CNA President, gave the welcoming remarks, followed by dinner and the awards.

The Media Awards were presented to some very talented professionals for their contributions to a better understanding of health care and the work of health care professionals. The categories for the awards covered print, radio, television, photography and on-line reporting. Each award was preceded by a film or video clip giving a sample of the depth and insight of the report. Pat Senson won two awards for radio broadcasts on Quirks & Quarks, CBC Radio. One dealt with auto-immune diseases (Feb. 24) and the other with vitamin A deficiency (Apr. 7). Andre Picard was another dual winner, and he has been a previous CNA Media Award recipient. His Globe and Mail series (July 21-16), "Fattest or Fittest?" was a comprehensive report on the obesity epidemic in Canada. A special On-line report by Andre "The Plague at 20: Didn't Someone Say The War Was Over?" took a look back at the history of the HIV-AIDS epidemic in Canada. Three awards were of particular interest in the area of mental health. These were; Cathy Lesage "Journey into Darkness" Ideas, CBC Radio, dealing with the debilitating disease of depression; David Tucker "Amanda's Choice" The Nature of Things, CBC Television, about early onset Alzheimer's Disease; James Heer "Me, My brain and I", The Nature of Things, CBC Television, exploring aspects of the frontal lobe.

We can be proud of our National Nursing Association for a most impressive evening. We are also most fortunate in the caliber of our journalists in health care reporting.

**** Enid Robins-Holm and Hazel Alexander-Tate represented the CFMHN at this gala event.**



Internet Cafe

Carol Ewashen

Some valuable websites to check out

Health Canada - The Mental Health Promotion Unit
"Promoting Mental Health Means Promoting the Best of Ourselves"
www.hc-sc.gc.ca

- ✓ Link to the mental health promotion unit
- ✓ Also valuable is the link to the International Network for Mental Health Promotion
- ✓ You can enter your name in this directory - a searchable database - and join some fellow kindred spirits!

Canadian Institutes for Health Research www.cihr.ca

- ✓ Strategic Programs Announcement - a new research initiative is being announced. Project grants are being offered for research activities and training in the area of building healthy communities through rural and northern health research
- ✓ CIHR Call Request for Proposals - priority areas include child and youth health, HIV/AIDS, fetal alcohol syndrome and fetal alcohol effects, aboriginal capacity and development, new perspectives on gender and health, improving access to appropriate health services for marginalized groups.

Canadian Mental Health Association www.cmha.ca

- ✓ Research activities include:
- ✓ A 26 month project on early psychosis intervention
- ✓ A national study of the mental health needs of Canadians aged 65+ and the role of home care
- ✓ Canadian Alliance on Mental Illness and Mental Health
- ✓ A Call For Action - a collective vision that begins to position mental illness and mental health prominently within the health and social policy fields. This document calls for a significant increase in attention to mental illness and mental health promotion with four main issue areas for change: public education and awareness, a national policy framework, research, and information/data systems. This is a very readable, comprehensive and timely call for action across a wide spectrum of stakeholders. The entire document is available through the website.

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Quebec - Vacant

Newfoundland & Labrador - Vacant

Northwest Territories - Vacant

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Canadian Federation of Mental Health Nurses MEMBERSHIP APPLICATION

The Federation is an interest group of the Canadian Nurses Association (CNA) whose purpose is to further the standard of mental health nursing in Canada.

Please print the information on the application form in ink.

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Current Position - Please check one item from the list below:

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☐ C: Case Manager	☐ F: Manager/Administrator	☐ I: Other

Areas of Expertise - Please check up to three items from the list below:

☐ AV: Abuse/Violence	☐ GT: Group Therapy	☐ AD: Administration	☐ AL: Adolescence	☐ AU: Adults
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☐ MC: Marriage Counselling	☐ RE: Research	☐ SC: School Health	☐ SX: Sexuality	
☐ WM: Women's Issues	☐ OT: Other _____			

☐ Check here if you DO NOT want your name included in the Canadian Federation of Mental Health Nurse's Directory.

Remember to enclose \$30 application fee! Fee ensures membership a year from the date of application.

Please print out and mail completed form including cheque or money order payable to CFMHN to:

Sharyn Chapman, 97 Driftwood Crescent, Dartmouth, Nova Scotia B2V 1S6

Visit our web site at <http://www.cfmhn.org>