



# CANADIAN FEDERATION OF Mental Health Nurses

Number 15

Winter, 1995

## President's Message

On January 18 a goal set years ago in a meeting room in Montréal hotel was realized: nurses across Canada wrote the first Psychiatric and Mental Health Nursing Certification exam. We've come a long way since that day when, at the invitation of Dorothy McGee, mental health nurses met to discuss an idea for a national interest group with certification as its first goal. And we've done it! Congratulations to all who made it possible — and particularly to those brave souls who put time, effort and money into writing this first exam. I can't tell you how many nurses earned that recognition, as it is kept confidential by the CNA, but soon we will know the number of Canadian mental health nurses who may declare themselves certified — and a part of nursing history.

The meeting in Montréal, where the Federation was born, took place during a mental health nursing conference. I think few of us then would have imagined that this new organization would also be hosting an international conference the same year certification was realized. But, here we are, Rozsa Gyulay and Patricia Robinson continue to coordinate this joint venture with the Clarke Institute of Psychiatry. I hope that, despite these difficult economic times, many of us will be there in Toronto this October.

Difficult economic times were certainly a major consideration this month when I responded to a CNA request for Federation input into the strategic planning process. I was asked to identify key health and social issues that will significantly impact the health care system. I want to inform you of the response made on your behalf. (Unfortunately, the time frame did not allow for even a brief survey of the membership.) I did have opinions from nurses in the East via Judy Buchanan and room nurses in the West via Marg Osborne and the Alberta Mental Health Nurses Interest Group for consideration. My thanks to them. This is a synopsis of the response.

*The health issues:* "forced" movement to self-care without a shift in resources or appropriate support; public dissatisfaction with the Western medical model and a move toward complementary ways of healing; poverty as the major obstacle to health.

*The social issues:* health care reform that endangers prevention and health promotion initiatives; increased unemployment at a time when social programs are being actively dismantled; increased violence in Canadian society.

*The other issues:* changing demographics of Canadian society (e.g. aging population); the deregulation and deskilling of health

care workers; monies allocated only to projects with immediate measurable outcomes, placing health promotion projects at risk.

Also drawn to the attention of CNA were these issues; loss of the Principal Nursing Officer increases the need for CNA to speak directly to government; the role of the nurse in health care is in jeopardy, as is our voice in health reforms; the increasing unemployment of nurses and the increased stress on those who remain in the workplace is affecting the needs of the membership.

I hope that this reflects, at least in a generic way, your concerns. The Policy and Development Committee is working on a process to access members' opinions quickly. This will be of great benefit to us as we grow as in our role as advocates for quality mental

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## An Adapt Concept

by Nan Dufour, R

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# An Adaptation of the Reflecting Team Concept for Group Therapy

by Nan Dufour, R.N., B.N., M.Ed.

In Prince Rupert, isolated on the northern coast of British Columbia, the demand for therapy is high and the resources limited. An organic solution evolved in connection with a time-limited, closed adult psychotherapy group and the co-therapists' belief that group members would benefit from exposure to the processing occurring in post-group discussion with the observers. An adaptation was made of the Reflecting Team approach currently used by some family therapists.

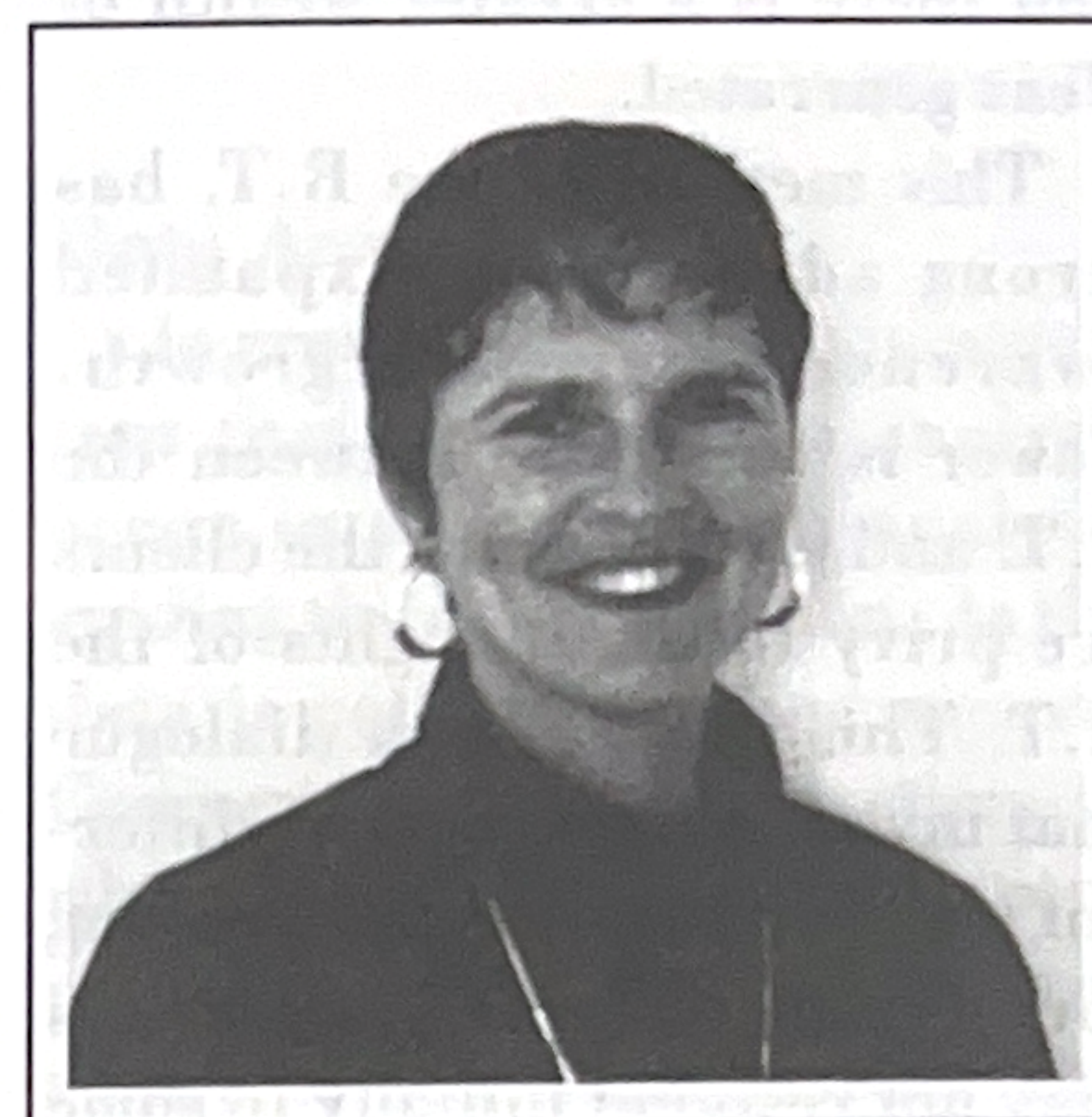
The composition of the Reflecting Team (R.T.) changes annually. The team is composed of three persons from various community agencies, schools, or churches who wish to learn about or improve their group therapy skills. Assigned readings, with a strong em-

phasis on Yalom's work, are discussed in pre-group. The one and a half hour group is then observed by the R.T. which is followed by provocative and lively post-group discussions. The diverse perspectives of the team enhance these discussions.

The R.T. concept was originally developed by experienced family therapists who were supervising less experienced therapists, particularly those who were "stuck" in a family counseling situation. The pioneering Norwegians acknowledge and give credit to the work of others who have influenced them, in particular Gregory Bateson, the Milan group, The Ackerman Institute of New York and the Galveston Family Institute of Texas.

In Prince Rupert, our R.T. views each group from behind a one way mirror. Every five to six weeks the team exchange rooms with the group and the two facilitators. Following the guidelines noted below, the R.T. is then observed by the group and facilitators, as it shares its' thoughts and ideas regarding the group members' interactions over the past weeks. Placed at the beginning of the group session this process takes about twenty minutes. Rooms are again exchanged and group members are asked to comment on what they have just heard from the R.T. Once the clients have fully responded, the facilitators may also share their reactions and ideas.

The content of the reflections includes observations, hunches, wonderings about behaviour pat-



Nan Dufour, R.N., B.N., M.Ed. (Counseling Psychology) is the Child and Youth Coordinator at the Prince Rupert Mental Health Centre. She has several years experience as a group therapist.

terns, and changes seen during the course of therapy.

The R.T. use some key guidelines. Comments should be speculative, tentative, gentle, and cautious. Remarks are ideas, not mandates for change. All ideas are equally valid. The task is to create new ideas even if some are rejected. The R.T. should not direct the focus of topics to be discussed. Pacing is important; both clients and facilitators need time to process. It is better for each person to leave the group with a few key thoughts than to be flooded with too many. The R.T. avoids giving advice, interpretations, and opinions. In other words, describe rather than prescribe. Hunches and intuition are valuable and should be identified as such. Since the process of observing tends to magnify criticisms, the R.T. is encouraged to think of the potential impact of its' chosen words.

While behind the mirror, the R.T. is encouraged to remain silent and avoid discussion; it has been found that with less discus-

*continued on page 4*

*President's Message ...from page 1*  
health care. We've come far in six years – but we still have miles to go!

To end on a happy note I send our congratulations and best wishes to Elinor Spencer on the birth of a son, Callum Hugh, on January 3, 1995. Callum weighed in at 8 pounds, 12 ounces. Ellie was the second President of the Federation and has been the Manitoba representative on the Board from the beginning of CFMHN until recently when her creativity branched in another direction!

Doreen Papineau, who is also a founding member of CFMHN is the new Manitoba representative on the Board. Doreen, we welcome you and look forward to working with you.

Wendy Austin



*An Adaptation ...from page 3*

sion there is a greater wealth of ideas generated.

This method of the R.T. has strong advantages. Expanded awareness increases growth. Power is equalized between the R.T. and the clients as the clients are privy to the thoughts of the R.T. This process is a dialogue that invites comparison of different viewpoint rather than looking for one right answer. While clients may not respond initially to some of the reflections offered, they are frequently "stored" for use in the future. The process is also empowering since clients know they have the freedom to accept or reject ideas and permission to experiment with new behaviour.

Clients are enthusiastic about the process, listening intently, and considering thoughtfully as they mull over the reflections of themselves and each other. At times they disagree or dislike a particular phrase and say so. At other times clients are amazed at how well the team listen and seem to understand what has been happening. Clients often comment that it validates them to have this encouragement. Group notes, mailed out weekly, provide clients with written summaries of the key point to ponder in between sessions.

The R.T. members also have positive reactions to the process. They find the method helpful for personal learning. They feel connected to the group members. There is a strong sense of personal responsibility to really concentrate when behind the mirror so that reflections will be as helpful as possible. As one team member stated "we were the fly on the wall that could reflect with openness and honesty what we observed and thought". This process also stimulates the team to critique facil-

itators' styles and interventions.

The facilitators are excited with the process and continue to use it. It has added a valuable dimension as the observers' rich thoughts are now incorporated into the therapy process on a regular basis. In this time of fiscal restraints, it also appears to nudge the therapy process along more quickly, while extending group skills training into a community with insufficient counseling resources. Furthermore, the possibilities of adapting this process to other group situations are endless and will be fun to try.

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### Guidelines on Evaluation and Care of Victims of Trauma and Violence.

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### Nurses and Families: A Guide to Family Assessment and Intervention

by Lorraine Wright and Maureen Leahey

2nd ed. 233 pp. Philadelphia, PA, F.A. Davis Co., \$19.95.

### Child, Adolescent and Family Psychiatric Nursing

by Barbara Schoen Johnson.  
490 pp. Philadelphia, PA, J.B. Lippincott Co., \$39.95.

### Pain Research and Management

the Journal of the Canadian Pain Society. Launch date: Spring 1996. For subscription information and instructions to authors contact Pulsus Group Inc., 2902 South Sheridan Way, Oakville, Ontario, L6J 7L6. Tel: (905) 829-4770 Fax: (905) 829-4779. (A CFMHN member, Judith Watt-Watson is on the Editorial Board of this journal.)

### Innovations and Research

Published quarterly by the National Alliance for the Mentally Ill and the Center for Psychiatric Rehabilitation, Boston University. Annual subscription \$22 U.S. Send to Innovations and Research, 730 Commonwealth Avenue, Boston, Massachusetts, 02215 U.S.A. Tel: (617) 353-3549, Fax: (617) 353-7700.



# The How-To's of Grounded Theory

by Olive Yonge, R.N., Ph.D.

This article on grounded theory is the second one in a series featuring a method in qualitative research. If little is known about the context, consequence, conditions or causes of behaviours, grounded theory is employed (Chenitz and Swanson, 1986). It is a method of qualitative research which uses both inductive and deductive approaches to theory construction (Field and Morse, 1985). Hypotheses and concepts arise out of the data being collected, rather than being conceived prior to the study, and thus are 'grounded' in this data (Leinenger, 1985). These hypotheses are continuously tested against new data to ensure that they remain grounded and are accurate descriptions and interpretations of the phenomena under study.

Grounded theory assumes the existence of processes underlying social phenomena, and attempts to discover and explicitly identify these processes. As a method it differs most dramatically from quantitative research methods in that the steps in the research process generally occur simultaneously, rather than sequentially. Thus, as data is collected, concepts and hypotheses are developed from this data, and the direction of further data collection is determined by this theory generation (Field & Morse, 1985; Glaser, 1978). This reflexive process is one of the hallmarks of grounded theory research.

## Method of Data Collection

Data is usually collected using semi-structured, longitudinal interviews, guided by the following types of questions: exploratory,

contrasting, ubiquitous, descriptive and focused. The interviews are approximately one hour in length and begin with broad, general questions becoming more focused as the data analysis progresses and the relationships among the concepts within the data are identified (Field & Morse, 1985). Each informant is usually interviewed a minimum of three times in order to determine a process. Interviews are audiotaped and transcribed. Immediately after the interviews are completed, field notes are made to describe the informant's nonverbal behaviours and the environment in which the interview took place. The field notes are used to capture the researcher's impression of the experience and when reflecting on the analysis of the data.

## Sample Selection

The sampling process used in grounded theory studies is known as purposeful, or theoretical sampling. In quantitative studies, emphasis is placed on the representativeness of the sample with respect to the population as a whole. In purposeful sampling, the participants are selected according to the needs of the study (Morse, 1989). Initially, informants with a broad and general knowledge of the phenomenon being studied are chosen. As the research progresses, and categories and theories emerge from the data, participants who possess more specific information are selected. In addition, it is important to select some informants who are atypical or negative cases, to add information about the range of experiences and increase the breadth of data collected.

## Data Analysis

In grounded theory, it is important that sampling and analysis occur in tandem, with analysis guiding the data collection. As the data is collected coding occurs. Coding refers to the operations in which data is broken down, conceptualized, and put back together in new ways (Strauss and Corbin, 1990). This process of categorizing and conceptualization occurs almost from the beginning of the study (Field and Morse, 1985). In this stage the researcher labels the phenomena identified in the data, discovers categories for these phenomena, names these categories, and searches for conceptual links between these categories. As this process continues, the researcher searches for a core category, a central category around which the remaining theory can be pulled together. Throughout this process, it is important to continue checking the emerging theory for its fit with the data and to refine this theory to form a better fit whenever possible (Corbin, in Chenitz and Swanson, 1986). To assist with the sorting of data, a computer program called the Ethnograph (Seidel, 1985) can be used. It is a program designed to manage and code numerous transcripts.

Coding is an ongoing process in which data continue to be collected until the saturation point is reached — that is until no new or relevant information is being generated. Memoing is an important step in the research process; it involves writing down and saving all ideas or insights about the process under study in memo form as

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*The How-To's ... from page 5*

they occur to the researcher (Glaser and Strauss, 1967). In this way notes are not lost during the course of the study, and can be useful in the evaluation process.

Once a hypothesis has been developed, it needs to be evaluated for its effectiveness. For a hypothesis to work "... it should be able to explain what happened, predict what will happen, and interpret what is happening in an area of substantive or formal enquiry" (Glaser, 1978, p. 4). The categories must fit the data, and the hypothesis must be relevant to the action being observed. Glaser and Corbin (1990) describe a well-constructed grounded theory as being one that will meet the following criteria: a good fit of data to concepts and hypothesis is generated, the theory provides an understanding of the process occurring in the study, and the theory can be generalized to provide some enlightenment on similar processes and situations.

### Reliability and Validity

Grounded theory methodology generates theory rather than verifying it. Reliability and validity is thus addressed differently in qualitative research than in quantitative research (Field & Morse, 1985). Validity can be established during data collection and analysis (Field & Morse, 1988). Generalizability is not the purpose of qualitative research (Field & Morse, 1986), however the essence of grounded theory can be generalized to other informants engaging in similar behaviours. During sampling, a range and variation of informants need to be selected to improve validity. Negative cases which do not fit into existing categories also need to be included to increase validity (Chenitz &

Swanson, 1986). Typed transcripts of data provided to informants for review assists in verifying accuracy.

Reliability is a constituent element of validity (Field & Morse, 1985). The researchers doing a study need to be good interviewers, have the ability to establish rapport with the informants and keep field notes. Having the interviews audiotaped, and then transcribed verbatim increases reliability. The findings from grounded theory may be useful to other informants in similar situations and time period, making the process understandable and to a certain extent, predictable.

### Bias

All researchers regardless of method employed have to be aware of the effects of bias. Personal values need to be bracketed. By engaging in self-reflection in entries in the memos and field notes and articulating any biases, value clarification will occur. Informants also need to be encouraged to give honest descriptions of their feelings and thoughts when describing the behaviours. Researchers need to strive to be non-judgmental and present themselves as researchers with no connection to the informant's place of employment so they will feel safe in disclosing sensitive information.

### Summary

This short article gives an overview of the methods in grounded theory. Unfortunately, the types of research questions used in this method or the ethical considerations are not addressed. If you would like more information, please contact me directly.

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## Past President & Quebec Report

Over the past few months, I have had the opportunity to review for the Canadian Nurses Association, a draft report from the invitation conference on *Developing Flags of Quality: Development of Mental Health Clinical Indicators* co-hosted by the Canadian Psychiatric Association and Canadian Council on Health Facilities Accreditation. I have also been invited to submit my C.V. to participate in a Health Canada project that will identify professional practices that support self-care. These two projects, emphasize multidisciplinary planning and recognize the contribution of nursing in meeting the requirements of Canadian health care needs.

Quebec is facing similar challenges, which are occurring in the other provinces. Shorter hospitalizations, fewer hospital beds, transition from hospital to a community-based focus and increasingly, value for money within available resources. The changes, require that as registered nurses we be able to demonstrate quality and value for our services. In Quebec, the health care system is shifting and it is in the gaps created by the movement that we as registered nurses can better demonstrate our knowledge, skills, and potential. Across Canada, almost three hundred Registered Nurses wrote the first certification exam — an excellent beginning.

*Karen Finestone, R.N.*

## Ontario

### Conference Update

The upcoming International Conference entitled *Mental Health Care: The Challenge of Change* is rapidly moving closer. This is the year — 1995, October 18-21!

Since the last report the number of abstract submissions has increased to 192. Just try to imagine the task faced by the Abstract Committee members — but we did it!! All the submissions were received, sorted, and the letters of confirmations/rejections (sorry) were sent out.

In order to increase the number of presenters we have elected for lunch hour symposiums — three on Thursday and three on Friday. The availability of "Brown Paper Bag Lunches" will facilitate these events.

Soon you can expect the registration forms along with the daily schedule of the conference to arrive. All conference participants may look forward to a very special three-day program. Each day of the conference will offer something very unique and exciting. "Interesting", "controversial", "powerful", "thought provoking" speakers and panelists will enrich the days.

We could not have planned this conference at a more opportune time to examine, debate, envision and engineer the desired outcomes for the changes occurring in the health care field locally and globally. What we are excited about is the collaborative work with consumers and family members. It has been a positive, stimulating and learning experience for all parties concerned.

The facilities offered by the

downtown Hilton Hotel are excellent. The prices we have negotiated are very competitive. Entertainment — you will be the judge of it!

Information for poster presenters will be mailed soon. If you have any pressing questions or comment before you receive the program outline and registration please call:

Rozsa Gyulay or Trish Robinson  
Conference Co-chairs at  
(416) 979-2221.

### Certification

On January 18, 1995 the first Certification exam for Mental Health/Psychiatric Nurses took place nationwide. It is a major landmark in our history and a tremendous accomplishment by the CFMHN.

Twelve of us from the Clarke Institute of Psychiatry wrote the exam. The study sessions we organized at the Clarke proved to be very beneficial. The feedback from the evaluations was positive. In comparing notes most of us felt the examination questions were relevant, comprehensive and altogether challenging. Since the writing more and more colleagues are expressing interest in writing the next exam.

### Correction

In my previous report on Certification (CFMHN Newsletter, Autumn, 1994) I neglected to mention that in collaboration with the Nursing Department of the Clarke Institute of Psychiatry, the Nursing Department of the Wellesley Hospital, represented by Kathy Wong, helped plan, prepare and facilitate the study sessions for the Certification exam.

*My sincere apology  
Rozsa Gyulay*



## Support from Janssen Pharmaceutica

Peter Sansom, B.A., A.P.M.R., a professional product specialist with Janssen, is a new representative in Toronto replacing Susan Fenewick. Mr. Sansom expresses interest in a continued association with the Federation and I am optimistic for the ongoing support and professional collaboration with Janssen in the future.

Rozsa Gyulay, R.N., M.S.  
Ontario Representative

## Prince Edward Island

Leah Mayne reports that the fledgling group in P.E.I. is struggling to get established. (Don't lose heart Leah — we experience the same struggle to keep developing in B.C.!)

## Newfoundland and Labrador Report

Psychiatric and Mental Health Nurses in Newfoundland and Labrador are preparing for significant changes in the way that mental health care is delivered. *Regional Community Health Boards* have been established in four of the six health regions in the province and this marks the official beginning of a community mental health system. Funding for community mental health services will be redeployed from the hospital sector. Psychiatric Mental Health nurses are expected to provide significant services within the new system particularly since a primary health care framework has been promoted by the provincial government. Regional mental health coordinators are hired in three regions and regional planning is underway.

To highlight the potential contribution of PMH nurses in the community, the provincial nursing

association (ARNN) struck a committee to develop a discussion paper. This paper entitled *The Role of the Psychiatric and Mental Health Nurse in the Community* involved significant consumer input and was distributed to all the Regional Community Health Boards to assist in health planning.

Hospital Reform — Hospital boards are merging to centralize services within regions. In St. John's, for example, where the majority of mental health services exist, one hospital board will govern eight acute care and rehabilitation institutions. The newly formed Health Care corporation has announced that it will move to a program management model of service delivery, thus eliminating departmental structures within hospitals. Nurses are anticipating that this will mean more reductions in inpatient services.

The Waterford Hospital the provincial psychiatric hospital, experienced its first nursing lay-off this past fall as a result of ongoing downsizing. A second group of nurses was laid off early in the new year to bring the total to 21 nurses.

The revised but yet unenacted *Mental Health Act* will hopefully be addressed by the House this Spring. It is anticipated that public consultations will be held in the fall.

Joy Maddigan  
Newfoundland and Labrador  
Representative

## Saskatchewan

Fund raising for the Federation is being actively pursued in Saskatchewan. A membership drive is underway to aid in fund-raising. Dr. Lou Heber hosted an International Dinner at her home at the beginning of February. The funds raised by donation at the dinner will be shared by the Uni-

versity of Saskatchewan College of Nursing Advancement Fund and the Canadian Federation of Mental Health Nurses.

A Selection Committee has been established to select a Saskatchewan nominee (a consumer or group of consumers) for the *Courage to Reach Beyond Award* to be given at the First International Psychiatric/Mental Health Nursing Conference in Toronto in October, 1995.

The committee members are: Monique Beneteau, Women's Mental Health Networks; Yvonne Brown, Dean of Nursing, University of Saskatchewan; Val Hartley, Registered Psychiatric Nurses Association of Saskatchewan; Lou Heber, College of Nursing, University of Saskatchewan; Peter Matthews, Head of Child Psychiatry, Royal University Hospital; Glen Rutherford, Mental Health Services, Saskatoon District Health Board; Joan Sawatsky, Saskatchewan Registered Nurses Association.

Dr. Lou Heber per Win Miller  
Saskatchewan Representative

## British Columbia

The Upper Vancouver Island Chapter of the provincial Psychiatric/Mental Health Nurses' Group sent me a letter in December. Paula Horky, chair of the Chapter, wanted to convey the reactions of the members to the recently published Standards of the Canadian Federation of Mental Health Nurses. Her letter states:

*We want to commend the C.N.A. Standards Committee on a job well done and acknowledge all the hours of work it must have taken to produce a document of such high quality. All members who participated in the dis-*



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cussion were very excited  
about now having these  
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described our clinical prac-  
tice. We now have a means  
for describing the aspects  
that are so salient to our  
unique practice of nursing.

The letter further articulates  
some questions to help address  
how the Standards can become  
more widely used. This is an area  
the provincial group will be pur-  
suing this year. As a beginning, we  
are forwarding the letter from the  
Upper Island Chapter to Wendy  
Austin, and we are seeking input  
from the CFMHN. We also de-  
cided to ensure key individuals at  
the provincial association are  
aware of the Standards, and we  
are having the Standards as an  
agenda item at the provincial  
group's Annual General Meeting.

It would be useful to know how  
other areas are approaching dis-  
seminating information about the  
standards, and how they are be-  
ing utilized.

*Katherine McIndoe*  
Representative from British  
Columbia

## Letter to the Editor

Dear Ms. Miller,

I am writing today to inform you  
of our current activities at the Clarke  
Institute of Psychiatry. A group of  
nurses have joined together to form  
a Writer's Club, inspired by Nancy  
Johnston, Executive Director of  
Nursing. All nursing staff were in-  
vited to participate following an ad-  
vertisement in our nursing newslet-  
ter. Core membership has been estab-  
lished. However, the group will re-  
main open to new members and ob-  
servers at anytime.

The purpose of the group is to  
provide a structure to support the  
publication of research and scholarly  
work by members of our nursing de-  
partment. It is hoped that actions  
taken by membership will stimulate  
the planning and development of  
unique interest(s) presented by par-  
ticipants. The aim is to encourage an  
environment that will promote an in-  
crease in the number of articles sub-  
mitted for publication. The content  
of articles will involve many issues re-  
sponding to research, education and  
clinical care. The group meets once  
per month. The current members are  
enthusiastic and have many varied  
interests and expertise. The challenge  
is promising and exciting.

At our initial discussions, we ex-  
changed ideas, notions about content  
and style, and what we knew about  
print media. One concern was shared

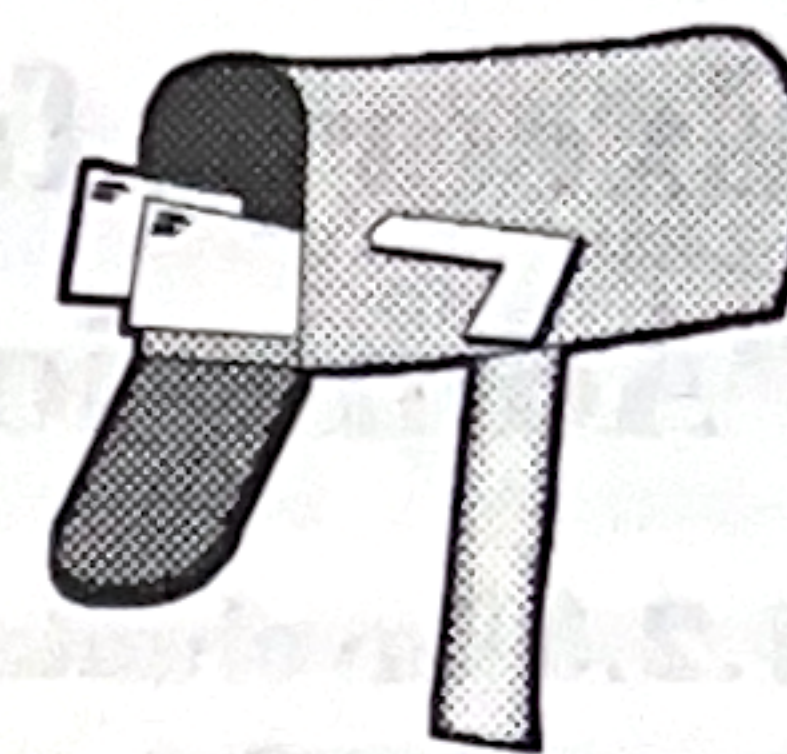
by all present . .  
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identified a known sense of apprehen-  
sion . . . facing the published printed  
page for all to see! We summoned as  
much courage as we were able. We  
were pleased to learn that some mem-  
bers had previously published arti-  
cles. They promptly shared their ex-  
periences which included anecdotes  
of failures and successes. Truly it was  
what the group needed to hear, pro-  
moting confidence and inspiration.

I would like to request from your  
readership if they have any experi-  
ences of this kind (writing and writ-  
er's clubs) that may be shared with  
us perhaps by means of a short mes-  
sage in the newsletter. It would be ap-  
preciated if individuals could com-  
ment upon topics or content of arti-  
cles with respect to their needs in de-  
velopment of practice, knowledge or  
interests.

I hope this meets with your ap-  
proval. Thank you for your kind in-  
terest and valued contribution to  
CFMHN.

Yours truly,  
Helena T. Heesen, R.N.  
23 - 1801 Lascelles Blvd.,  
Toronto, Ontario M4V 2B9

*Helena Heesen is a Nursing Supervisor  
at the Clarke Institute of Psychiatry*



## Announcement

The Canadian Federation of Mental  
Health Nurses (CFMHN) is searching for  
and wants to recognize a consumer, or  
group of consumers, who have overcome  
the limits of mental illness. The *Courage  
to Reach Beyond Award* will be given to  
the selected consumer, or group of  
consumers, during the First International

Psychiatric/Mental Health Conference in  
Toronto in October, 1995.

Information regarding the award, including  
criteria for selection of nominees, will be  
sent to Provincial Representatives in the  
near future so that a nominee may be  
chosen from each province.



# Excerpt from the Australian Mental Health Act (1986) "Admission for Psychiatric Treatment and Care" Section

## 1.2.3 Involuntary Patients from the Community • Section 12

Involuntary detention of a person for the treatment and care of a psychiatric illness can only occur in a publicly funded psychiatric in-patient service which has been gazetted for that purpose. Admission to private facilities is always on a voluntary basis.

## Mental Health Act s.8(1)

A person may only be detained as an involuntary patient provided they meet the five criteria set out in the section, that is

- (a) the person appears to be mentally ill; and
- (b) the person's illness requires immediate treatment or care and that treatment or care can be obtained by admission to and detention in a psychiatric in-patient service; and
- (c) that person should be admitted and detained as an involuntary patient for that person's health or safety or for protection of members of the public; and
- (d) that person has refused or is unable to consent to the necessary treatment or care for the mental illness; and
- (e) the person cannot receive adequate treatment or care for the mental illness in a manner less restrictive of that person's freedom of decision and action.

Mental illness is not defined in the Act but certain behaviours which are not to be considered evidence of mental illness are listed in s.8(2). Those behaviours are

- holding a political opinion or belief;

- holding a religious opinion or belief;
- expression of a particular philosophy
- expression of a particular sexual preference;
- engaging in a particular political activity;
- engaging in a particular religious activity;
- engaging in sexual promiscuity;
- engaging in immoral conduct;
- engaging in illegal conduct;
- being intellectually disabled;
- taking drugs or alcohol;
- having an anti-social personality.

## Admission process

A person meeting all of the criteria in s.8(1) may be admitted to a psychiatric in-patient service by the following process.

## Request and Recommendation

There are two forms which must be completed.

- A Request form can be completed by any adult person 18 or over including a relative of the person about whom the request is made.
- A Recommendation form must be completed by a medical practitioner following examination of the person. This recommendation will usually be based upon personally observed facts, however, another medical practitioners' observations made in the preceding 28 days may be relied upon in some circumstances.
- The Recommendation must refer to the facts which indicate the presence of all the criteria for detention.

- The Recommendation is valid for 72 hours.

The completion of a Request and Recommendation is sufficient to ensure that the person may be admitted to an appropriate psychiatric in-patient service.

## Transportation

The Ambulance Service have primary responsibility for the emergency transportation of psychiatric patients.

Where a Request and Recommendation, and the parts of the Recommendation dealing with sedation and restraint, have been completed the person may be restrained or sedated if necessary for being safely transported to hospital. If a person is restrained or sedated prior to the correct documentation being completed then a medical assault or unlawful assault or unlawful restraint has occurred.

Only members of the police force, the ambulance service or employees of psychiatric services are able to restrain a Recommended person. Any use of restraint must be documented on the Schedule IIA. Not every psychiatric patient transported to hospital may be restrained, only those people who cannot be transported safely without it.

Only certain medical practitioners are authorised to prescribe sedation for a Recommended person. These are

- a psychiatrist;
- a medical officer employed in a psychiatric service;
- a forensic physician;
- a head of a general hospital emergency department; and
- the person's regular treating



## Section

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medical practitioner in rural areas who has examined the person on more than one occasion in the previous twelve months have this authority. Only such sedation as is necessary for the purpose of safely transporting the Recommended person is able to be prescribed. The medical practitioner may administer the sedation or may direct another

- medical practitioner;
- registered psychiatric nurse; or
- registered general nurse

to administer it instead. If sedation is required both the person prescribing and the person administering the sedation must document this on the appropriate part of the Schedule IIA.

### Admission

Admission means the completion of admission forms by a doctor associated with the in-patient service following a mental state and physical examination. The admission will usually occur on hospital premises, although it may occur anywhere including the recommended person's home. The admitting doctor may be a doctor working in a community mental health clinic which is part of a psychiatric in-patient service.

### 24 hour examination

Within 24 hours of admission an assessment must be made by a psychiatrist. This psychiatrist must not be the person who assessed the patient upon admission and must not be the person who recommended the patient. At the examination the Authorised Psychiatrist determines whether the person is to be detained as an involuntary patient. Involuntary admission can only be confirmed if all the criteria for involuntary detention are present.

At the 24 hour examination the

person may decide to become a voluntary patient or may be discharged from the hospital. In these cases the person does not become an involuntary patient. On the other hand the psychiatrist may confirm the involuntary status of the person. A person is the admitted to the psychiatric in-patient service as an involuntary patient for treatment under s.12.

From the point of admission onwards the Authorised Psychiatrist should be considering the suitability of the patient admitted under s.12 for treatment as an involuntary outpatient on a Community Treatment Order (CTO).

If a patient absconds before the 24 hour examination or for some reason the examination does not occur, the stages in the admission process which have already occurred are void and the process must be recommenced should the patient present again for admission.

### Treatment

If the involuntary patient does not have a guardian the Authorised Psychiatrist will consent to treatment on behalf of a patient who either cannot consent or refuses to consent to treatment. In some cases the Authorised Psychiatrist will merely consent to the person being admitted to an in-patient service. In other cases the Authorised Psychiatrist will consent to specific forms of treatment and in yet others the Authorised Psychiatrist will consent to all forms of treatment given to a patient.

Chapter 1.1.7 contains more relevant information about the issue of consent to treatment.

### Leave

The Authorised Psychiatrist may allow an involuntary patient

to take leave from the in-patient service. The Authorised Psychiatrist can extend or revoke this leave. The Authorised Psychiatrist can also grant special leave for the purpose of gaining medical treatment.

If an involuntary patient leaves the hospital without permission she or he may be apprehended and taken back to hospital by

- a member of the police force who may enter premises; or
- someone such as an ambulance officer or an OPS worker requested to apprehend the person by the Authorised Psychiatrist; or
- a Departmental officer authorised by the Chief Psychiatrist.

### Transfer

The Authorised Psychiatrist may order the transfer of an involuntary patient to another psychiatric in-patient service if

- the Authorised Psychiatrist considers the transfer will be beneficial to the patient or is necessary for her or his treatment; and
- the Authorised Psychiatrist considers the transfer will be beneficial to the patient or is necessary for her or his treatment; and
- the Authorised Psychiatrist for the receiving in-patient service approves; and
- the Chief Psychiatrist is notified.

The Chief Psychiatrist may also order the transfer of an involuntary patient to another psychiatric in-patient service.

An involuntary patient subject to a transfer order made either by the Authorised Psychiatrist or Chief Psychiatrist may appeal the order to the Mental Health Review Board.



## Discharge

An involuntary patient admitted under s.12 may be discharged by:

- the Authorised Psychiatrist where the patient no longer meets all the s.8(1) criteria; or
- the Mental Health Review Board where the patient no longer meets all the s.8(1) criteria.

An involuntary patient who is absent from a psychiatric in-patient service for a continuous period of twelve months is automatically discharged unless the Authorised Psychiatrist or the Chief Psychiatrist appeal to the Board against this automatic discharge.

*Submitted by Judith Tompkins, R.N., R.P.N. (Assoc.), B.N., M.N. Ms Tompkins' article on Mental Health Nursing and Psychiatric Services in Australia appeared in the Autumn 1994 issue of the Newsletter.*

## Remember!



**It will soon be  
time to renew  
your CFMHN  
membership!**

## PROFILE

### Joy Maddigan

*Provincial Representative, Newfoundland and Labrador*

Joy Maddigan is the Psychiatric Mental Health Nursing Consultant with the Department of Health, Government of Newfoundland and Labrador. She has a Bachelor of Nursing and a Master of Nursing from Memorial University of Newfoundland. She has worked as a staff graduate and clinical nurse specialist in psychiatry and as a community mental health nurse. She has also been a

faculty member of the School of Nursing at Memorial University and the Faculty of Nursing at the University of New Brunswick. In addition to her role as consultant, Joy works as a Clinical Nurse Specialist with an adolescent counselling service affiliated with the Janeway Child Health Centre and maintains a small private psychotherapy practice.

## COMING EVENTS

### Youth for Youth Health Conference

March 20-24, 1995 in Vancouver, B.C. Sponsored by the Canadian Youth Foundation and Health Canada. Contact: Youth to Health Health Conference, Venue West Conference Services, 645 - The Landing, 375 Water Street, Vancouver, B.C. V6B 1B8. Tel: (604) 681-5226 Fax: (604) 681-2503.

### Beyond Prozac: Depression, Stress, Diet and Drugs

May 4, 1995 in Vancouver, B.C.; May 5, 1995 in Victoria, B.C.; May 8 in Burnaby, B.C. Instructor: Linda Pawlak, Ph.D., R.D. Contact: Biomed, Suite 877, 810 West Broadway, Vancouver, B.C. V5Z 4C9. Tel: (510) 450-1650. Fax: (510) 652-1859.

### Geropsychiatric Nursing Conference, "Mentally Ill Elders: Current Approaches to Community Care and Mental Health Training in Long Term Care Settings"

June 20, 1995 in London, Ontario. Featured Speaker: Kathleen Buckwalter, R.N., Ph.D. Fees: \$50. Contact Brenda Farnel, Tel. (519) 455-5110.

### 15th Annual Convention of the National Alliance for the Mentally Ill (NAMI) Insuring a Better Tomorrow

July 19-23, 1995 in Washington, D.C. Contact: NAMI '95 Convention, 2101 Wilson Blvd., Suite 302, Arlington, Virginia 22201, U.S.A. Tel: (703) 524-7600.