SOCIAL WORKERS' AND PHYSICIANS' EXPERIENCES
WITH REVIEW PANELS IN BRITISH COLUMBIA

by

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Abstract

In British Columbia, individuals with a mental disorder can be hospitalised against their will under the *Mental Health Act* (1999), when a physician determines that "protection of the person or others" is an issue. Involuntary psychiatric hospitalisation involves a major infringement of an individual's civil liberty. When patients or their representatives disagree with the treatment teams about their involuntary hospitalisation, they can apply for an appeal hearing named the review panel under the *Mental Health Act* (1999).

From a theoretical perspective, the traditional medical model and the social constructionist model, which offer different views concerning individuals with mental illness who are hospitalised against their will, are presented. This theoretical contrast underscores a major dilemma faced by mental health professionals in fostering client self-determination, while they are providing services on the principle of beneficent protection. An empowerment model of social work practice is then described to illustrate how services can be provided to help mental patients regain a sense of control over their lives. Concerns about the current legislation regarding involuntary hospitalisation are also discussed.

To supplement the limited number of studies currently available on review panels, a quantitative descriptive study was conducted at Riverview Hospital, the only

tertiary psychiatric hospital in British Columbia, surveying the experiences of 39 social workers and physicians with review panels. A questionnaire consisting of 22 Likert-type items was used. Four categories were identified: (a) patient-related issues, (b) effects of review panels on treatment teams, (c) role conflicts, and (d) operational issues. Despite the apparent lack of formal training, social workers and physicians generally reported having adequate knowledge of review panels. Social workers and physicians who were involved more frequently with review panels appeared to have more positive attitudes towards them. Their training pertaining to the *Mental Health Act* was also significantly related to their attitudes. Neither patients nor their families reportedly had adequate knowledge of the review panel process.

Although some positive effects of review panels were acknowledged, staff generally had mixed attitudes about review panels. Guided by an empowerment model, these findings have important implications for social work practice. These include the need for further professional training, improved communication between health professionals and legal advocates, education for patients and families, and the support of patients' collective action, so that review panels can be a more empowering experience for mental patients.

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CHAPTER 1

INTRODUCTION: REVIEW PANELS AND INVOLUNTARY HOSPITALISATION

In British Columbia, individuals with a mental illness can be hospitalised for treatment against their will under the *Mental Health Act* (1999, p. 171), if it is deemed that "protection of the person or the protection of others" is an issue. The *Mental Health Act* (1999) also provides a statutory basis for the review of the involuntary status of the patient through a review panel. In 1999, there were 1282 review panel applications, 462 (36%) of which proceeded to a hearing (*Mental Health Act Review Panel Statistical Report*, 1999).

The Committal Process

Certification, civil commitment or committal, and detention are used interchangeably in this thesis to denote the status of the patients who are admitted to hospitals on an involuntary basis. Under section 22 of the *Mental Health Act* (1999), a person can be admitted to a designated facility for examination and treatment for up to 48 hours on one medical certificate completed by a physician, who has examined the person within the last 14 day. Another physician may continue the detention and treatment of that person beyond the 48-hour period on the completion of a second medical certificate within 48 hours of the person's admission. Both physicians must be of the opinion that the person has a mental disorder, which is defined as "a disorder of the mind that requires treatment and seriously impairs the person's ability to react appropriately to the person's environment, or to associate with others" (*Mental Health Act*, 1999, p.164-165). Both

physicians must also determine that the person meets the following criteria under subsection 22(3)(c):

- (a) requires treatment in or through a designated facility;
- (b) requires care, supervision, and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others [sic]; and
- (c) cannot suitably be admitted as a voluntary patient. (*Mental Health Act*, 1999, p. 171)

The physicians carry the legal responsibility of certifying the individual who requires protection of the person or others. However, it is often the social workers or nurses at community mental health centres who maintain more frequent contact with the individual, and gather anecdotal information on the individual's clinical condition. Such information often provides preliminary or further evidence for certification, in addition to the physician's clinical examination.

The nature of involuntary hospitalisation implies an infringement of the individual's civil liberty. Two procedures are in place to ensure that the legal authority of a continual detention is exercised properly.

First, the medical certificates required for detention are reviewed and renewed at regular intervals under section 23 and section 24 of the *Mental Health Act* (1999). The first set of two medical certificates allows the individual to be detained for up to one month for treatment, at the end of which another certificate must be completed to extend the detention for another month. At the end of this second period of detention, the

detention of the individual can be renewed again for a further period of three months. When the detention for this three-month period expires, another certificate can be completed for six months. Further detention can be renewed at successive periods of six months. Second, when an individual disagrees with the treatment teams about his/her need for involuntary hospitalisation, s/he can apply for an appeal process via a review panel.

Review Panels

Section 25 of the *British Columbia Mental Health Act* (1999) states that a person detained under section 22 is entitled to a hearing by a review panel, at the request of the patient or a person on the patient's behalf. The purpose of the hearing is to determine whether the detention of the patient should continue because subsections 22(3)(a)(ii) and 22(3)(c) continue to describe the condition of the patient. As stated in the *Mental Health Act* (1999), hearing by a review panel must include:

- (a) consideration of all reasonably available evidence concerning the patient's history of mental disorder including:
 - (i) hospitalisation for treatment, and
 - (ii) compliance with treatment plans following hospitalisation, and [sic]
- (b) an assessment of whether there is a significant risk that the patient, if discharged, will as a result of mental disorder fail to follow the treatment plan the director or a physician authorised by the director considers necessary to minimise the possibility that the patient will again be detained under section 22 [sic]. (p. 11)

Involuntary patients in hospitals are visited by legal advocates each time the patients' medical certificates are renewed. The patients are advised of their rights to apply for de-certification via review panels. A legal advocate may also assist a patient in submitting an application to the review panel office, which is then required to schedule a hearing for the patient within 25 days. The panel consists of three members: a chairperson, a physician (usually a psychiatrist), and a mental health advocate. Decisions concerning whether a patient should be detained (i.e., kept in the hospital) or not, are made by a majority vote among the panel members.

Adversarial Nature of Review Panels

The unique legalistic stance of review panels poses an apparent challenge to the treatment teams, and puts the physicians and social workers in the position of a defendant. Resembling a trial, a review panel hearing is essentially adversarial in nature, although not quite as formal as a trial (Adams, Pitre & Cieszkowski, 1997; O'Reilly, Komer & Dunbar, 1999). Out of 462 review panel hearings, 94 patients (approximately 20%) were released by review panels in 1999 (*Mental Health Act Review Panels Statistical Report*, 1999). This reflects a disagreement between the opinions of the treatment team and panel members regarding the committal status of the patients. Several reasons may account for this discrepancy. It may suggest that either the physicians are being too cautious, or the review panels are not exercising enough caution, or both. It may also reveal a certain degree of ambiguity in the interpretation of committal criteria. In addition, members of different professional disciplines may have different opinions regarding a person's mental condition and behaviours. They may also

have different philosophies of care and utilise different models of service delivery. This may contribute to the discrepancy in determining whether a person should be continually hospitalised or not. Furthermore, the researchers Paredes, Ledwidge, Beyerstein, Cashore, and Higenbottam (1987) mention that a review panel may be more legalistic in its deliberations, seeking documented evidence that the patient is likely to require protection of the person or others. In contrast, a physician is likely to use evidence from psychiatric theory to predict what behaviours a patient with certain symptoms will display. Finally, “a physician who has reservations about a patient’s release, but agrees that the patient is not detainable under the *Mental Health Act*, may allow the patient to apply for a hearing and obtain release that way” (Paredes, Ledwidge, Beyerstein, Cashore & Higenbottam, 1987, p. 445).

Review panels are also called review boards in Ontario and in some states in the United States. These two terms will be used interchangeably in this thesis to refer to review hearings under the respective *Mental Health Acts* in different provinces or states. This should not be confused with the forensic review boards in British Columbia, which re-assess a patient's incarceration under the *Criminal Code*.

Social Workers’ and Physicians’ Involvement in Review Panels

Social workers and physicians in British Columbia are involved in different aspects of the review panel process. Patients and families learn about review panels primarily through mental health legal advocates and peers. Yet, it is unclear how much patients and families understand the process. At times, social workers, nursing staff and, perhaps to a lesser extent, the physicians are consulted by patients and families about the

functions and the mechanisms of the review panel process. This educational role for the social worker is expected to become more significant, as the new *Mental Health Act* (1999) stipulates that the patients' next-of-kin should be notified of their review panel applications.

As members of the treatment team, physicians and social workers are primarily responsible for the patients' clinical treatment and discharge planning. Furthermore, as per hospital policy, the physicians and social workers at Riverview Hospital are required to complete reports for review panels. These reports include: assessments of the clients' mental status, risks to themselves and others, treatment plans, level of psychosocial functioning, current discharge plans, and recommendations for release or detention. Although social workers in British Columbia are not responsible for renewing mental health certificates, both social workers and physicians at Riverview Hospital are required to report whether the individual continues to meet the criteria for certification or not. Some physicians will also act as hospital presenters to offer the opinions of the treatment teams to the review panels, or they may sit on the panel to make decisions regarding the release of patients. It should be noted that, while it is mandatory for social workers to complete review panel reports and to assist in discharge planning when patients are released by review panels, the physicians have some choices about whether they are involved in review panels or not. In general, the psychiatrist, instead of the general practitioner, on the treatment team will complete an assessment report for the review panel. Psychiatrists and general practitioners have the option of whether they want to act as hospital presenters in review panels or not. Furthermore, a psychiatrist can choose whether s/he wants to be a decision-making member of the review panel or not, for a

patient who is not under his/her care. A patient's treating psychiatrist is not allowed to be on his/her panel due to a potential conflict of interests.

As a result of the inherently adversarial nature of involuntary hospitalisation, social workers and physicians are likely to experience mixed feelings about the review panel process from a theoretical and a legal perspective. For this reason, a descriptive study was done by this author to explore social workers' and physicians' experiences with review panels.

A Quantitative Study

There has been no previous research study known to this author, that examined the social workers' and physicians' experiences with the review panels in British Columbia, despite their pivotal involvement in the process. Therefore, a descriptive design was implemented to investigate the following two areas:

1. Whether social workers and physicians have been provided with adequate knowledge of the review panel process, to fulfil their roles as educators and assessors.
2. The attitudes of social workers and physicians towards the review panel process.

This study identifies some of the potential difficulties faced by social workers and physicians in their multiple roles as therapists, educators, and agents of social control in the involuntary psychiatric hospitalisations of individuals with severe mental illness. The medical model and the social constructionist model of mental illness will be described in the next two chapters to illuminate the theoretical debate on involuntary hospitalisation.

CHAPTER 2

THE HISTORY OF INVOLUNTARY HOSPITALISATION:

THE MEDICAL MODEL OF MENTAL ILLNESS

It is estimated that 28.1% of the total population of the United States suffers from a mental or addictive disorder in the course of a year, with symptoms ranging from mild distress to severe cases of mental abnormalities (Cockerham, 1996, p. 1). In British Columbia, at least 20% of the general population develops one or more mental disorders needing treatment (Mitchell, 1994). Providing treatment for people with mental illness requires a significant amount of funding. Cockerham (1996, p. 1) reported that as much as \$67 billion was spent on treating mental disorders in the United States in 1992.

Historically, the reform movement to care for people with mental illnesses with humane care started towards the end of the eighteenth century at an asylum called La Bicetre in France (Davison & Neale, 1986). The nineteenth century saw the rising emergence of the medical model. The advancement in medical technology, knowledge, and procedures played a significant role in the treatment of the mentally ill in the United States (Cockerham, 1996). It was not until after World War II that legislation was passed for states to build "humane" asylums to provide for safe care for the mentally ill (Morris, 1995). Although such asylums were later criticised as being largely custodial care for the mentally ill, the hospital population continued to grow and peaked in 1950s (Davison & Neale, 1986). Early institutions were built on a medical model of mental illness, which will be detailed in this chapter.

The Medical or Physiological Model

The medical model is also called the disease model, or the physiological model.

As its name implies, the medical model postulates that mental abnormalities can be traced to some physiological or biochemical imbalances, or genetic causes. In other words, mental illness is seen as a disease that can be treated through medical means such as, psychopharmacology, electro-convulsive therapy, or psychosurgery (Cockerham, 1996). The medical model rests on three major assumptions: (a) the mechanical metaphor, (b) the physical body, and (c) the hegemony of normalcy. As a result, the aim of medical intervention for mental illness is to restore and to repair the body.

The Mechanical Metaphor of the Medical Model

A major assumption underlying the medical model is the use of the mechanical metaphor in examining the individual (Lupton, 1994). The person is seen as "a combustion engine with many complicated parts or systems" (Helman, 1997, p. 26). Each individual part is discrete and performs specific functions, while they are also interrelated to effect co-ordinated activities. A quick look at the lay person's language used to describe our mental health status in everyday life will illustrate how this model is ingrained in our minds. For instance, the everyday language refers to the "circuits" in the brains, how a person is "wired up," and how the body systems "break down." As a result, when a person exhibits abnormal or unexpected thoughts and behaviours, which are labelled as symptoms of mental illness, physicians are trained to track down the "parts" that are not working properly, and hopefully, to "fix" them.

The Physical Body

A second related assumption in the medical model is that the mind is controlled by body physiology. The effort of investigation and treatment is, therefore, focused on the physical body, in the belief that, if the physical body is treated, the mind will be “cured.” When a person with psychiatric symptoms is admitted to a hospital, a variety of blood tests are run routinely to determine if there are any physiological problems (e.g., chemical toxicity, essential mineral deficiencies, etc.) that might be the cause of the symptoms. Scans of the brain can be done to identify abnormalities such as haematomas, brain atrophy, and vascular disease.

Even when obvious physical causes are ruled out, the focus of treatment remains predominantly pharmacological. Medications are prescribed for controlling moods, perceptions, and behaviours. The correlation of the blood-levels of medications and psychiatric symptoms is monitored, and is used to determine whether medications have reached “therapeutic” levels to alleviate the symptoms of mental illness.

In other words, the medical gaze focuses on the body of the human being instead of the being of the human body. An individual is treated as a conglomeration of tissues and organs.

The Hegemony of Normalcy

A third assumption is that there is a hegemonic and objective view of “mental health.” The medical model is based on the scientific positivist assumption that there is an objective ultimate truth out there that describes a “normal” level of functioning. People are evaluated by medical professionals as “sane” or “insane” against sets of standards about behaviours and functioning. Psychologists are adept at devising and

administering various tests that compare individuals' cognitive, affective, and behavioural functioning against the norms (Burr & Butt, 2000). Such "objective normative" standards are then cross-referenced to statistical variations on chemical and physiological functioning, such as neurotransmitter levels, hormonal levels, mineral levels, genetic markers, and blood level of medications. Although such statistical relationships are in fact correlations, they are quite often used to "explain" the causes of behavioural and affective changes. Patients are then tried and maintained on medications for behavioural control based on the correlations between chemical and behavioural changes.

Restoration and Repair

Following these assumptions, the logical intervention in the medical model is, therefore, to restore functioning and to repair the body. Medications are administered and surgeries are performed to restore the balance of chemicals and to repair the organs, as they are perceived to affect our mood, thoughts, and behaviours. For example, anxiolytics or anxiety-relieving agents are used to reduce pacing and restlessness. Antipsychotic medications are prescribed to control delusions and hallucinations by regulating the levels of neuro-transmitters in the brain.

Contemporary Influence of the Medical Model

The medical model has continued to remain influential in psychiatry and to dominate the present-day search for the solution to mental illness (Cockerham, 1996). Although not all psychiatric problems fit the description of a disease model, they continue to be construed as disorders treatable by the medical model. Attempts to restore

a normal level of body functioning, and to bring emotions and behaviours under control through pharmacological interventions, are sometimes done at the expense of other forms of interventions, such as psychotherapy. The enthusiasm in developing psychoactive drugs and investigating their efficacy continues to grow, and it is fuelled by funding from pharmaceutical companies.

The medical model is also reflected in the language employed in the *British Columbia Mental Health Act* (1999). A person with a mental disorder is described as one who "has a disorder of the mind that requires treatment" (*Mental Health Act*, 1999, p. 3). Mental disorders are classified in diagnostic categories, and people with mental illness are treated in hospitals.

The medical model implies that individuals with mental illness are incompetent decision-makers, who require protection by medical professionals. This will be discussed in the next chapter. Social constructionism offers an alternative claim about the understanding of individuals with mental illness. They are seen as adaptive actors reacting to the oppression of the social order. The social constructionist model of mental illness helps to inform the understanding of the theoretical conflict in involuntary hospitalisations.

CHAPTER 3

THE SOCIAL CONSTRUCTIONIST MODEL OF MENTAL ILLNESS

Although there may be pathological processes underlying mental disorders, the evaluation of mental illness is inevitably a social process (Cockerham, 1996). The process of determining whether a person suffers from a mental disorder or not necessitates the assessment of behaviours, cognition, and emotions against the norms or standards held by certain groups of people in the society. Mental illness is essentially a socially constructed phenomenon. The theoretical position of social constructionism will be described in this chapter, providing an alternative analysis of an individual with mental illness who is deemed to require involuntary hospitalisation for the protection of the person or others. It casts suspicion on the medical model of mental illness, which is referred to as the self-justified meta-narrative, that dominates the construction of mental illness in the delivery of mental health services in North America (Fee, 2000).

Loseke (1995) provides a very good account of the issues of the homeless mentally ill from a social constructionist perspective, which will be applied in this chapter for an understanding of the mentally ill who require protection. In summary, Loseke (1995, p. 266) argues, "Socially constructed images of *types* of conditions and *types* of persons underlie social policies of all types [italics in original]; ...and justifications for policy depend, at least in part, on images." Morris (1995, p. 71) also states, "Highly visible cases of individuals with mental illnesses who appear to pose unusual threats to the community can shift public sentiment rapidly, with resultant implications for programming and policy." Furthermore, Loseke (1995) asserts that social policies raise questions about individual freedom and liberty.

This chapter will focus on two opposing types of socially constructed images of individuals with mental illness, namely individuals as incompetent decision-makers versus individuals as adaptive actors.

A Socially Constructed Image: Individuals as Incompetent Decision-Makers

Implications of the Medical Model

Two implications follow from the medical model of mental illness. First, when individuals with mental illness refuse treatment, they are seen as being irrational and incompetent to make reasonable decisions to look after their own interests. Second, health professionals, particularly doctors, have the knowledge and the expertise to make such decisions in the “best interests” of the patients.

Image of the Patients as the “Incompetent”

When mental illness is constructed as a disease, mental patients are seen as individuals requiring treatment. Halleck (1980, p. 112) states, “A person who is mentally ill cannot always make judgements as to the risks and benefits of a given treatment in a manner which services his own interests.” The assumption is that any reasonable person looking after his/her best interests under the circumstances will have made the decision to accept treatment for the disease (Stone, cited in Strong, 1993). Their refusal to be treated is, therefore, seen as irrational and unreasonable, and as a sign of sickness.

Elitism and Authority of Health Professionals

With the medicalisation of mental illness, the medical profession is accorded legitimacy and high esteem, sometimes even in the absence of a good explanation for a

condition like mental illness (Tausig, Michello & Subedi, 1999). The medical professions are organised as an institution that possesses expert or elite knowledge, which is beyond the reach of the layperson. Halleck (1980, p. 113) states bluntly, "In this situation, the patient does not know what is best for him and the doctor does." Consequently, the patient-clinician relationship is highly hierarchical and paternalistic. The functionalist perspective indicates that "it is important to maintain the medical practitioners' elitism and professional authority to allow them to be effective, and to elicit patient compliance in treatment" (Lupton, 1994 p. 106).

The Parens Patriae Power

The authority of the medical experts is further legitimised by the *Mental Health Act* (1999), which allows doctors to admit a mentally ill individual to a hospital for treatment against his or her will, for the protection of the person, or for the protection of others. When individuals lack reasonable judgement and insight to make rational decisions about their lives, it is believed that the state has to intervene. Supporters of state intervention refer to the *parens patriae* power of the state to care for people who are unable to care for themselves (McLeod & Milstein, 1993; Strong, 1983).

On the other hand, there are opposing claims-makers constructing the image of individuals with mental illness as adaptive actors. This will be detailed in the following section.

Social Construction of Mental Illness

Social constructionism situates mental illness within the discursive practice of intrapsychic, medical, social, and political realms. It allows us to "direct our gaze not at

the madness, but at the culture, institutions, and language which makes madness matter so much” (Parker, cited in Fee, 2000).

The breakdown of traditional values has led to an existential intrapsychic crisis in individuals. Oppressive social conditions further aggravate the individual’s difficulty in coping with life stresses due to limitations and inequality in the distribution of resources. The medical institution, as an agent of social control, maintains the power to define mental illness and what is to be done about individuals suffering from mental illness.

Fluidity of Self

Indebted to the anti-psychiatry movements of the 1960s and 70s, new approaches in social constructionism take the understanding of mental illness to a different level. The re-working, or re-definition, of many modern institutions (e.g., gender, family, sexuality, work, and relationships) has led to new reality dilemmas, existential anguish, and accordant methods of coping (Fee, 2000). Constantly bombarded by institutional fragmentation and cultural technological acceleration, individuals are confronted with chronic uncertainty and radical choices for life-style and identity construction. The perception of “self” is now more simulated and original, and it becomes increasingly elusive as a result of multiple and discordant voices (Gergen, cited in Fee, 2000). When meanings are no longer grounded in shared structures, “sanity” consequently becomes a relative term.

Loseke (1995) describes two related cultural themes that inform the construction of mental illness, namely, the social order as a cause of mentally disordered behaviours, and the medical institution as an agent of social control.

Reaction to Oppression

Mental hospitals historically housed a disproportionate number of working class or unemployed individuals (Brown, 1981). The medical model puts forward the theory of the *downward drift* of mentally ill individuals, whereby their poor socio-economic conditions are believed to be a result of their mental illness. In contrast, oppressed groups start to make claims about the unfairness of applying White middle-class expectations across people of different culture, race, ethnicity, class, and sexual orientation. People with mental illness who require hospitalisation are seen as the social victims of the industrial capitalist order. For example, in the United States, higher-status individuals are more likely to receive less intrusive psychotherapies, while lower-status people receive the more invasive organic therapies such as medications and surgeries (Tausig et al., 1999). R. D. Laing (as cited in Kenny, 1996), a very outspoken psychiatrist, believes that mental illness is an attempt by the individual to cure himself/herself of the maddening situation they have found themselves in. Mental illness is described as a normal reaction to oppressive social conditions (Brown, 1981). The social order is seen as the cause of the individual's problems.

Institutions as Agents of Social Control

Thomas Szasz (1983) has been perhaps the most outspoken opponent of the disease model of mental illness. He claims that mental illness is a myth and a strategy. It has primarily a prescriptive, rather than a descriptive, function that justifies the various interventions imposed on the individual by society, including involuntary commitment.

In a society infiltrated with oppressive influences, the medical institution is perceived as a mechanism of social control through the construction of the physical body

as a medicalised body. Foucault (1980, p. 59) states, "It was on the basis of power over the body that a physiological, organic knowledge of it became possible." The "truth" of mental illness is accorded truth status by the medical institution, which is charged with the power to say what counts as true (Faubion & Foucault, 2000). Epidemiological studies have supported the claim that the medical institution serves a punitive function of social control (Tausig et al., 1999). The medical institution applies interventions that regulate certain forms of behavioural deviance, especially those of lower-class culture, in order to minimise disruption to the social life and the status of dominant groups. This social control process is also internalised as a self-control mechanism, whereby individuals manage their disciplined body, and perpetuate the role of the medical institution as an agent of social control. This is further explained in the following paragraphs.

Redefining the body - the medicalised body. Lupton (1992, p. 22) states, "In the wake of poststructuralism, the human body can no longer be considered as a given reality, but as the product of certain kinds of knowledge which are subject to change." Foucault (cited in Lupton, 1994) uses the term *anatomical atlas* to refer to the human body inscribed by the medic-scientific gaze. Individuals with mental illness are subject to examination and interviews by doctors, psychiatrists, social workers, and nurses, just to name a few. Patients must confess and acquiesce, and they are to be punished by restrictions on their bodies if they are non-compliant. Lupton (1994, p. 24) states, "In mental illness, the body is the apparatus by which the brain is kept restrained, often against the owner's will." For Foucault and his followers (as cited in Lupton, 1994, p. 23), "the body is the ultimate site of political and ideological control, surveillance, and

regulation.... The state apparatuses such as...psychiatry and the law define the limits of behaviour and record activities, punishing those bodies which violate the established boundaries.”

Furthermore, discipline is created, not only through punishment, but also through “gratification with rewards and privileges for good conduct” (Lupton, 1994, p. 111-112). For example, patients confined in mental hospitals are expected to demonstrate responsible and settled behaviours, and such behaviours are then rewarded by staff compliments, privileges for going on passes off the ward or hospital grounds, and privileges for participating in rehabilitation programs.

Power as “Productive” in Social Organisation. Smart (cited in Lupton, 1994, p. 23) asserts that, “(In) examinations, individuals are located within a field of visibility, subjected to a mechanism of objectification, and thereby to the exercise of power.” “Power is not an institution, a structure, or a certain force with which certain people are endowed; it is the name given to a complex strategic relation in a given society” (Faubion & Foucault, 2000, p. 236). When patients are incited to talk about their illnesses, they are placed under the medical gaze, which, in turn, leads to greater surveillance and control. Yet, this power is diffuse, pervasive, invisible, and subtle. “Power is not necessarily a subjugating force aimed at domination which is vulnerable to resistance, but rather is closer to the idea of a form of social organisation by which social order and conformity are maintained by voluntary means” (Lupton, 1994, p. 23). Power is, therefore, not only repressive, but also productive, producing knowledge and subjectivity. The “self” is created in the process of confession, examination, and diagnosis.

Refining the body - the disciplined body. The concept of the *disciplined body* explains how bodies are controlled by the self and by the state (Lupton, 1994). Body illness is seen as rendering the body out of control, thereby requiring societal intervention to preserve order by policing behaviours such as the use of quarantines, asylums, and records-keeping. In the late twentieth century, the focus of public health moved from using external interventions to contain and control illnesses, to exhorting people to take responsibility for their health. Mental health is deemed a fundamental good. As a result, the individual unconsciously exerts disciplinary power over himself/herself through self-regulation. Such disciplinary power becomes highly effective as it relies not upon coercion, but on the willingness and even desire of people to submit to it (Burr & Butt, 2000). Grosz (cited in Lupton, 1994) states:

In this process, power relations are rendered invisible, and are dispersed, being voluntarily perpetuated by subjects upon themselves as well as upon others: subjects thus produced are not simply the imposed results of alien, coercive forces; the body is internally lived, experienced, and acted upon by the subject and the social collectivity. (p. 32)

In the psychiatric setting, individuals are described clinically as “developing insight and improved judgement.” Individuals learn to modify or self-regulate their behaviours so that they become “settled and well-behaved” before they can be released from hospitals.

To summarise, in the discourse on mental illness and power, knowledge is not a neutral objective reality out there. Instead, the medical institution retains the power to define what is knowledge, that is, what is mental illness. What is done about this knowledge then perpetuates the power of the institution. “Knowledge is controlled by,

and serves, dominant interests in the society” (Witkin, 1999, p. 5). Mental illness is, therefore, seen as “the other” in contrast to dominant standards of reason. The language of psychiatry, as a monologue of reasons about madness, becomes a hermeneutic dead-end that rests on the silencing of individuals with mental illness (Foucault, cited in Fee, 2000).

The Revolt against Social Control - Mentally Ill Individuals as Adaptive Actors

Viewed through the lens of social constructionism, the involuntary commitment of individuals suffering from mental illness can be perceived as an extreme means of social control. Coercive hospitalisation is believed to perpetuate the control and the power of the medical institution and other “helping” professions. Such power is rendered diffusive and subtle, and the voice of the individual is silenced through social and legal policies that put people in hospitals against their will.

From this perspective, the mentally ill individual who refuses hospitalisation is constructed as an adaptive individual acting against such oppression. Under such a constructed image, the behaviours of the mentally ill are perceived as the expression of individual choice and freedom. Individuals with mental illness would rather live in less desirable conditions (according to White middle class standards) than in mental institutions with “insane” people. As one mental health consumer puts it, “eating from garbage cans and sleeping in abandoned buildings feels like the only way to gain control and reclaim a little dignity” (Mitchell, 1994, p. 15).

The construction of individuals with mental illness as adaptive actors is fuelled by the belief in the individual’s right to self-determination. The concept of self-

determination is rooted in the upholding of democratic values and ideological beliefs in the broadening of individual freedom and self-direction (Freedberg, 1989). Self-determination is the "clients' right to make their own choices and to define their own destiny" (Hartman, 1993, p. 365). Self-determination has been heralded as one of the most important values in social work practice (British Columbia Association of Social Workers, 1999; Freedberg, 1989). Some people may prefer a deprived but "free" life in the community to being coerced to stay in a "safe" hospital, no matter how well-intentioned the care-providers are. Wasow (1993) asked in her interviews with mental patients whether anything was worse than living on the streets. She stated, "Their answer was, yes, there was something worse; a whole lifetime in a hospital. Many of the patients I saw in the hospital were broken shadows of people, even though the hospitals were reasonably good ones" (Wasow, 1993, p. 208).

The constructed image of people with mental illness as "adaptive actors" raises doubts about the appropriateness of involuntary hospitalisation. The next section will describe a historical trend that fuels this image and supports deinstitutionalisation of people with mental illness. However, there are mixed blessings from deinstitutionalisation, and the professional dilemma of protecting people with mental illness versus respecting their right to self-determination remains.

The Pendulum - Involuntary Hospitalisation or Deinstitutionalisation?

In addition to the mental patients' movement, whereby they strive to assert their right to self-determination, Loseke (1995) mentions a growing scepticism and a loss in

confidence in hospital care and treatment, as a historical cause of the plight of the mentally ill.

Loss of Faith in Hospital Treatment

There was evidence in the past that some people were not receiving treatment but were just being contained in hospitals (Davison & Neale, 1986; Tausig et al., 1999). Although hospital policies and review procedures are now often in place to ensure that reasonable attempts are made to provide a range of services for the patients, no effective treatment has been found for some refractory mental disorders. In other words, the traditional medical approach may be self-defeating. It may bring itself to a dead-end by focusing its search on the problematic "parts," only to realise that there may be no cure for the psychiatric disorders. Treatment abates the symptoms of mental illness, but does not cure.

As Morris points out (1995), not only are hospitals expensive, their characteristics as an institutional environment are potentially damaging. Some examples of this are: congregate living arrangements, inflexible schedules for meals and interactions with families, constraints on activities involving members of the opposite sex, and bureaucratic procedures for even the simplest activities of daily living. Involuntary hospitalisation is described as harmful and stigmatising for people (Aviram & Smoyak, 1994; Durham & Fond, 1996; Pringle & Thompson 1986). There are side effects to hospitalisation, including learned dependency, institutionalisation, regression, and stigmatisation, which "may leave the patient worse off than s/he was before hospitalised" (Halleck, 1983, p. 114). Involuntary hospitalisation can be counter-

productive because it erodes a patient's sense of self-esteem and autonomy (Freckelton, 1998).

Deinstitutionalisation

As part of the larger civil rights movement of the 1960s, many reformers began to advocate for the deinstitutionalisation of mental patients (Halleck, 1983; Miller, 1985). Acting on the constructed image of mentally ill individuals as adaptive actors, claim-makers started to challenge the oppressive effects of involuntary hospitalisation and to advocate for alternatives. Mental health consumers began to challenge the domination of the medical institution and its failure to understand their particular life circumstances (Brown, 1981). There was a shift towards a distrust in institutionalisation as a panacea, along with which came the promotion of minimal intervention and a prevailing belief that community care was more humane and therapeutic, and less stigmatising (McDonnell & Batholomew, 1997). Advances in pharmacotherapy and economic considerations also accelerated the movement towards community care (Cockerham, 1996; Durham & Fond, 1996). Many studies concluded that services for the mentally ill could be provided equally effectively at the same, if not less, cost in community settings (Durham & Fond, 1996). However, as Halleck (1983) pointed out, the political climate of the 1970s had catalysed a move towards expanding the freedom of mental patients but with little commitment to public funding. The patients' rights movement was co-opted by legislators and administrators who were attracted by the prospect of financial savings from the closing of hospitals (Brown, 1981; Miller, 1985). Social policies were changed in Canada and in the United States to close down large mental hospitals and to have

mental patients housed in the community, with little funding available to develop appropriate resources for them.

Mixed Blessings

Unfortunately, when institutions were closed or downsized, the positive and supportive elements of hospitals were gone as well, resulting in mixed blessings from deinstitutionalisation (Mitchell, 1994). Although mentally ill individuals are construed by some as competent beings asserting their right to self-determination, there are other claims-makers holding opposing constructs of the mentally ill.

Chronic patients discharged from hospitals, in some cases, do not voluntarily attend mental health centres, and their condition may rapidly deteriorate. As a result, opponents of the community care approach have voiced their support for state intervention, based on a humanitarian concern, to help the mentally ill. In addition, there are other reasons to call for involuntary hospitalisation. These include the lack of funding for developing community resources, concern for a safe neighbourhood, and various political agendas. The expected financial savings have not materialised, as it turns out that the cost of providing a range of comprehensive services to mentally ill individuals is far greater than predicted (Miller, 1985). Community residents, in some cases, take on a "NIMBY" (i.e., "Not In My Backyard") attitude, and resist efforts to relocate patients in their neighbourhood. Media reports of individuals with mental illness who have displayed violent, disruptive or self-harming behaviours often spark a flurry of debate on health care, concerning the principle of the need for treatment. Once again, psychiatric hospitals are depicted as a place of safe asylum, not incarceration, especially when clients are faced with a rejecting community (Sullivan, 1992; Wasow, 1993).

A Professional Dilemma - Client Self-determination versus Protection

The debate on client self-determination still prevails among the mental health professionals working with the mentally ill. The *British Columbia Mental Health Act* is described as unconstitutional (Paredes, 1998). The *Ontario Mental Health Act* is seen as a violation of the Charter of Rights and Freedom (Howse, 1988). The *British Columbia Mental Health Act* has also been criticised as infringing on the rights of the mentally ill, and mental health workers are described as being asked to act very much like parole officers (Skelton, 1999). There is significant tension between the professional value in fostering individual autonomy and the paternalistic belief in involuntary hospitalisation in the "best" interests of the patients and the community (Freckelton, 1998).

On the one hand, health practitioners work under the professional ethic of respecting individual rights and autonomy. Independence is a highly cherished value in North American society. Clients are encouraged to make their own choices and decisions. Many people with mental illness abhor the idea of living in hospitals or clean and furnished boarding homes, where there is structure and routine, and the staff provides supervision and support to ensure their daily living needs are met. Instead, they would rather live in substandard housing or on the streets, where they are free to come and go, and eat whatever they want, and there are no rules to follow. Some of them may use illicit drugs and alcohol. While other "sane" addicts may be roaming the streets in the middle of the night, people with mental illness are sent to hospitals against their will.

On the other hand, mental health professionals, as helping professionals, carry the responsibility for safeguarding the well-being of the clients by providing services to meet their physical, social, and emotional needs. Mental health professionals are facing a

dilemma as to where to draw the limit on respecting individual choices. Does a person who eats from garbage cans requires hospitalisation for the protection of the person? Is the person sleeping and urinating on the street, and swearing at other pedestrians, an insane person or a nuisance? Many patients refuse treatment due to their lack of insight or distorted thought processes about their illness. Forced treatment involves an infringement of the person's rights and freedom. Nevertheless, it is also believed that involuntary treatment will lead to the hope of improvement and stabilisation of the person's thoughts, emotions, and behaviours, and subsequently a return to a quality life. In some cases, involuntary hospitalisation may prevent further harm being done to the person or others due to malnourishment, poor self-care, risky money management, or aggressive behaviours. It appears that the result of ensuring a client's well-being and safety justifies the means of taking away his/her right to self-determination, at least temporarily.

While mental health patients and their advocates argue against involuntary hospitalisation as an infringement of personal rights, supporters of involuntary hospitalisation assert that it is immoral not to make efforts to hospitalise mentally ill individuals when they need protection of themselves or protection of others. The "right to self-determination" as an individual freedom is denounced as slavery, or "freedom to be left enslaved to their madness" (Loseke, 1995, p. 276). When individuals with mental illness are allowed to refuse treatment based on a disordered mind, they are deprived of the opportunity to improve their condition, and left to struggle with a haunting illness. Supporters of involuntary hospitalisation criticise those people arguing for self-determination as the ones who are the "truly insane", and accuse them of turning their

backs on the needy. Stemming from a need to protect individuals who are making seemingly irrational decisions to refuse treatment, involuntary commitment is seen as a rescue that puts people back in some form of structure, so that they will get better and regain rationality.

Abundant literature (Abramson, 1985; Freedberg, 1989; Murdach, 1996; Proctor, Morrow-Howell & Lott, 1993; Rothman, Smith, Nakashima, Paterson & Mustin, 1996) has repeatedly pointed to the conflict, and dilemma, in balancing client self-determination (autonomy or empowerment) versus beneficence (clients' best interest or protection). As the professional knowledge base grows, practitioners are better equipped to adopt a competency-based practice to take initiatives to protect the well-being of the clients, while applying the principle of client self-determination scrupulously (Rothman et al., 1996). Involuntary hospitalisation may be an inevitable last resort, taken with extreme caution under certain circumstances. Practice directiveness, or beneficent protection, has been found to be necessary and ethical in working with a vulnerable clientele including the mentally ill (Abramson, 1985; Murdach, 1996; Rothman et al., 1996).

A Renewed Emphasis on the Need for Treatment

The case of *McCorkell v. Riverview* (1993) reflects a renewed emphasis on the need to treat people with mental illness. The court came to the following conclusion:

The standards for committal strike a reasonable balance between the rights of the individual to be free from restraint by the state and society's obligation to help and protect the mentally ill. The courts have not determined that "dangerousness" is the only permissible criterion for involuntary committal....The operative word in

the *British Columbia Act* is “protection” which necessarily involves the notion of harm. (p. 273)

With the advent of the new *British Columbia Mental Health Act* in November 1999, increased attention has been given to the use of extended leave to enforce coerced treatment of mentally ill individuals in the community, if necessary, to prevent a relapse of their psychiatric conditions. More emphasis is now placed on the preventive, as opposed to the remedial, function of involuntary hospitalisation.

Reconciling Medical Model and Social Constructionist Model:

A Self-Reflective and Person-centred Practice

There will be no end to the debate between involuntary hospitalisation and community care. No particular claim can offer the true solution to the predicament of people with mental illness. The medical model has unequivocally demonstrated its value in identifying some physiological and genetic causes of mental illness. This author has witnessed the miraculous improvements in some patients with the introduction of new antipsychotic and mood-stabilising agents. Yet, the presenting picture of mental illness varies from one person to another. It depends, not only on the physical and chemical imbalances, but also on other intrapsychic, social, and environmental factors. Mental illness is essentially a socially constructed phenomenon. Social constructionism disputes the absolute truth status of the medical model, and offers alternative claims about mental illness, thereby providing multiple points of entry for intervention. Treatment should incorporate, but not be limited to, the medical perspective.

A patient's reality can be understood or interpreted in a multitude of ways. The essence of *interpreting interpretations* is to take a curious stance and to enter a patient's subjective world of reality through a self-reflective practice (Pardeck, Murphy & Chung, 1994). While one person might be relieved to learn that it is not his/her personal fault to be depressed, and that the depression is caused by neurotransmitter imbalance, another person might be more inclined to look at societal factors that are oppressive. Each person is unique. The challenge for the social worker is to resurrect the subjugated knowledges, to help the clients rediscover their hidden strengths and potential, and to mobilise community resources to provide opportunities for growth. A decision to hospitalise a person on an involuntary basis should be made only when less restrictive alternatives have been exhausted. Involuntary hospitalisation should be guided by a process of ethical decision-making, taking into consideration and balancing an individual's rights to self-determination and safety of the person and others. The inherent struggle of social workers with conflicting values thus becomes social work's essential characteristic and strength (Parton, 1994).

Treatment should be person-centred, whether it is provided at hospitals, or in the community. In addition, there will be little improvement in the patients' quality of life, either in hospital or in the community, until government funding is committed to develop appropriate resources in both settings. To make a person-centred practice a reality, a range of comprehensive services, including in-patient hospitalisation, supported housing, community care facilities, home support services, day-programs, vocational services, and recreational programs, is needed. Only when adequate resources are in place will

individuals with mental illness have the opportunity to be fully integrated into the community, in all social and occupational areas of functioning.

In summary, mental illness is not an objective reality out there (Fee, 2000). A social constructionist perspective disputes the truth status of the dominant medical model of mental illness and acknowledges alternative claims. Mental illness is understood as a socially constructed phenomenon that informs the social and legal policies governing how individuals with mental illness should be treated.

Under the medical model, mental patients are perceived as incompetent decision-makers. This justifies involuntary hospitalisation on grounds of protection and, in turn, perpetuates the power of medical professionals. Conversely, in social constructionism, the constructed image of individuals with mental illness as rational or adaptive actors questions the oppressive power of the medical institution as an agent of social control. In addition, the undesirable effects of institutionalisation, the debate on self-determination versus beneficent protection, and the lack of funding for appropriate resources all lead to mixed feelings about involuntary hospitalisation.

Involuntary hospitalisation is unequivocally the most intrusive and restrictive form of treatment. The next chapter will consider the relationship between critical social constructionism and the empowerment model of social work practice, an approach that allows mental health clients to restore a sense of control over their lives. The empowerment model also enables clients to develop the knowledge and the skills necessary to manage, and to advocate for, less restrictive types of treatment.

CHAPTER 4

AN EMPOWERMENT MODEL OF SOCIAL WORK PRACTICE

As discussed in earlier chapters, involuntary hospitalisation is seen by some claims-makers as a coerced and intrusive form of treatment that violates the client's right to self-determination. Client self-determination is upheld as an important professional practice value that shapes the goals of social work intervention. Hospital social workers working with individuals who are appealing their detention in psychiatric facilities are, therefore, put in a position that conflicts with their professional values. Segal, Silverman, and Temkin (1993, p. 707) state that individuals with mental illness are relegated to the role of passive patients in the medical model of treatment, and involuntary hospitalisation is "the most extreme form of personal disempowerment." In this chapter, the concept of empowerment, and the empowerment model of social work practice is delineated. It illuminates the key components of a social work practice that helps individuals with mental illness to assert their rights and to access other forms of treatment that are less restrictive than involuntary hospitalisation.

Empowerment is based on a non-medical conceptualisation of disturbing behaviours (Zinman, 1986, cited in Segal et al, 1993). Systemic issues, including economic, social, and cultural factors, are identified as areas that need to be changed to alleviate the suffering of people. Empowerment is an encompassing term that can be seen as a reflection of values, a goal or an outcome of intervention, a process, a perspective of social work practice, and an aim in social work research (Ackerson & Harrison, 2000). The key concepts of this approach are detailed in the following paragraphs.

Empowerment as a Value

Closely tied to the concept of empowerment is the concept of self-determination. In their study of social work practitioners, Ackerson and Harrison (2000, p. 239) state, "Most of their subjects used the terms 'self-determination' and 'empowerment' interchangeably, blending processes of motivation, cognition, and action." As one of his participants said, "They are two sides of the same coin.... I think they work hand-in-hand, and you can't have one without the other" (Ackerson & Harrison, 2000, p. 239). Empowerment is a broad concept that incorporates the social work value of self-determination.

Empowerment as a Goal

The concept of empowerment goes beyond describing a social work value to direct the goal of intervention. Segal et al. (1993) define empowerment as the goal of efforts directed to address the social, cultural, and economic issues underlying individuals' problems. Browne (1995) identifies that "one of social work's most important functions is the empowerment of oppressed people to participate in the decisions that affect their lives." Empowerment is the ultimate aim and desired outcome of social work intervention that reflects the value of self-determination.

Empowerment as a Process

Solomon (cited in Sheafor, Horejsi & Horejsi, 1988) defines empowerment as: A process whereby the social worker engages in a set of activities with the client or client system that aims to reduce the powerlessness that has been created by negative valuations based on membership in a stigmatised group. It involves identification of the power blocks that contribute to the

problem as well as the development and implementation of specific strategies aimed at either the reduction of the effects from indirect power blocks or the reduction of the operation of direct power blocks. (p. 62)

In this definition, empowerment is defined, in a “negative” way, as the absence of a concept, that is, the effort to reduce the lack of power and to reduce the oppressive effects of power. On the other hand, empowerment can be defined, in a positive way, as the process of helping individuals, families, groups, and communities to increase personal, interpersonal, socio-economic, and political strength and influence, so that they can take action to improve their life circumstances (Barker, 1999; Gutiérrez, 1990). Empowerment is perceived, not as just a reflection of the value of self-determination, but also, as the action process that, in the end, achieves the goal of self-determination (Ackerson & Harrison, 2000). Empowerment is an end, as well as a means to an end.

Two important concepts are evident in the above definitions of empowerment. First, empowerment is the goal and the process of removing power blocks, and increasing clients’ influences over their lives. The relationship between empowerment and shared power or influences will be further discussed in the next section, to illuminate the meaning of empowerment. Second, empowerment is the process of helping individuals, groups, and communities. It can occur at multiple levels of intervention, which will be detailed in a later section.

Empowerment and Shared Power

Empowerment occurs when individuals have direct control over their lives. Such a sense of control enhances a person’s quality of life (Wilson, 1996). Historical models

of social work practice had a tendency to focus on assisting individuals to change themselves to cope with, and to accept, difficult situations (Gutiérrez, 1990). As a result, the impact of objective powerlessness in relation to oppressive environmental conditions has been neglected. In contrast, a key characteristic of empowerment is shared power. Cox and Parsons (1994) posit that individuals are empowered when they are strong enough to participate in, to share in the control of, and to influence their own lives. Breton (1994) asserts that empowerment goes beyond promoting self-determination and involves the sharing of power between the clients and the service system. To illustrate the connection between the individual and the environment, three motivational elements in the personal sphere, namely, hope, self-respect, and control over one's destiny, are linked to the environmental factors of opportunity, respect for others, and power. "Opportunity justifies hope just as respect by others justifies respect of self, and power guarantees access to opportunity and gives people a sense of control over their destinies" (Breton, 1994, p. 33). To achieve this end, strategies aimed at mobilising group resources and collective action are called for.

Power exists in social relationships in our day-to-day lives. As Labonté (1990, p. 65) says, "Power is an asymmetrical pattern of dependency whereby one person . . . becomes dependent on another in an unbalanced way, [and it is] . . . the ability to define the reality of others in ways that lead them to perceive and enact relations that one desires." In the medical model of treatment, mental health practitioner and clients are placed on unequal grounds. Mental health practitioners derive their power from the agency resources and their individual professional expertise. An inherent inequality of power exists between the professionals and the clients due to the differences in their

access to information, expertise, and skills. This is manifested in how problems are identified, and how decisions are made, in the delivery of services in the formal structure of the organisations. As a result, the professionals are confronted with a paradox of empowerment, in which the inherent inequality of power between the professionals and their clients prevents the former from empowering the latter (Gruber & Trickett, 1987). The institutional structure that puts one group in a position to empower others also works to undermine the act of empowerment. People with mental illness, therefore, can assume control over decision-making in their lives only when mental health practitioners are willing to share their power (Breton, 1994).

Challenging Dominant Knowledges

Power is not merely the control over the provision of services and treatment. As delineated in Chapter 3, power/knowledge is an inseparable concept according to Foucaultian analysis (cited in White & Epston, 1990). Power is constitutive, as the person is defined by the dominant knowledge of mental illness as an individual disease. Similarly, Kondrat (1995) asserts that academic knowledge is a social construction, and formal knowledge is defined and sanctioned by those in privileged positions. In other words, the medical model of mental illness, as exalted by the psychiatric institution, defines the patient's identity and determines what is to be done about the patients. Alternative knowledges about mental illness, for example, the impact of socio-economic factors, become subjugated. Those who possess knowledge decide how resources are utilised and what types of services are being delivered. For example, pharmaceutical companies invest millions and millions of dollars in developing new medications, while many other kinds of services like housing and vocational programs are chronically

underfunded. Power, therefore, becomes inseparable from knowledge and the control of resources. Sharing power means sharing control of resources, and involves, in essence, a fundamental change in ideology, which challenges the dominant discourse on mental illness.

Redefining patients as persons. To shift the inequality of power between practitioners and clients, the dominant discourse of mental illness needs to be challenged, and subjugated knowledges need to be resurrected. Clients need support to redefine themselves as "persons" rather than "patients," despite a diagnosis of mental illness. As Labonté (1990) states:

A resource is something that is used by a subject; a service is something that is delivered to an object. An empowering practice requires that we begin viewing "clients" as fellow community members, as subjects capable of, and responsible for, their own empowerment. (p. 67)

Breton (1994) describes the distorting effect of labelling as an internalised negative valuation of self that comes from other people, and acts as a cognitive and emotional barrier to an individual's self-perception as a worthy and capable human being. Counteract this labelling effect is an important element of an empowerment practice. Clients should be valued as contributors of knowledge regarding their experiences with mental illness. The false dichotomy of mental health expertise versus client experiences needs to be re-examined. Over-emphasising the value of professional knowledge, as being superior to client experiences, may result in services that are met with strong client resistance, as the services fail to address clients' needs as persons, and to stimulate their

motivation to embark on a course of positive changes. Instead, professional knowledge and client experiences can be seen as interacting concepts that feed back into each other to form a system of knowledges. Both professional and client experiences should be given equal importance in developing services. Resources need to be allocated so that mental health clients can build on their strengths, instead of being seen in terms of deficiencies and impairment (Gutiérrez, 1990). As Pape (1989) states, the experiential knowledge of the clients represents a rich resource for professionals from an insider's perspective, and can help to develop services that are more humane, sensitive, and effective.

A shift from domination to connectedness. Traditional models of empowerment have been criticised for focusing on domination and control, and they do not necessarily fit with the characteristics of certain oppressed groups due to their reduced access to economic resources (Browne, 1995). The social conditions of oppressed groups are constrained by gender, race, socio-economic conditions, and health conditions. Without devaluing the importance of changing oppressive social conditions, a feminist model of empowerment also highlights the importance of connectedness, relatedness, and interdependence, rather than control and independence, as the desirable goal of intervention. In other words, the traditional emphasis on control and independence as symbols of success and power, especially in North American society, needs to be challenged. Interventions should be developed along the continuum of social support, to resurrect the value of interdependence and relatedness. This includes supportive friendship, family support, peer counselling, and self-help groups.

A Guiding Vision: The Concept of Recovery

Incorporating the rehabilitation model of mental illness, the concept of recovery emerged in 1990s as a guiding principle in the development of mental health services. The concept of recovery is an exciting vision of service delivery that challenges the dominant discourse of symptom reduction, provides a holistic view of treatment, and is consistent with the concept of empowerment.

The psychiatric rehabilitation model posits that the impact of mental illness is more than a collection of symptoms or mental impairment. Mental illness also leads to other significant functional consequences that can be configured as dysfunction, disability, and disadvantage. *Impairment* refers to any loss or abnormality of psychological, physiological, or anatomical structure or functions, such as hallucinations, delusions, or depressive symptoms. *Dysfunction* describes the restriction, or lack of ability, to perform an activity or task in a normal manner, such as the lack of work skills, social skills, or skills of daily living. Furthermore, *disability* is defined as any restriction, or lack of ability to perform a role in the manner, or within the range, considered normal for a human being (e.g., unemployment and homelessness). In relation to the societal context, "*disadvantage* is the lack of opportunity for an individual that limits or prevents the performance of an activity or the fulfilment of a role that is normal (depending on age, sex, social, [and] cultural factors) for that individual, such as discrimination and poverty" (Anthony, 1993, p. 14).

Based on the rehabilitation model, the recovery of an individual is possible without "curing" his/her mental illness. Recovery is:

A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993, p. 15)

All human beings, mental health clients and professionals alike, have had some experiences of trauma. In the same way as a car accident survivor recovers from the injuries, or a wife recovers from the bereavement of her husband's death, a mental health client can recover from the mental illness, without changing the fact that the illness or the injuries exist. Successful recovery means that the meaning of the illness has changed, and the individual is able to move on to pursue other life goals, without focusing on his/her impairment (Anthony, 1993).

Guided by this vision of recovery, mental health interventions should introduce new meanings, purposes, successes, and satisfaction in one's life, instead of mere symptom management (Anthony, 1993). Recovery can include, but is not limited to, the reduction in the frequency and duration of symptoms. It involves improvements but also setbacks, successes, and failures. Recovery can occur when the person is still symptomatic. Conversely, recovery can be hindered even when the person is asymptomatic, for example, when the environment fails to provide opportunities for one's growth and actualisation of potential.

Anthony (1993) also points out that recovery can occur without professional intervention. The informal support network in the individual's life, such as friends, neighbours, families, churches, and self-help groups, all play a significant role in the

person's recovery. Central to recovery is the existence of trusting personal support and choices. Bachrach (1993) concludes, from her literature review of patients' writings, that a therapeutic relationship instils hope, provides validation of self, and encourages patient involvement through mutual help and advocacy. A therapeutic relationship should be an essential component of service program planning to meet the patients' needs.

Chamberlin and Rogers (1990, p. 1242) state simply, "Mental patients need what everyone else needs: a place to live, a job, and friends." Consumer involvement and advocacy is essential in devising programs to meet these needs.

In short, empowerment is a multifaceted concept that incorporates the value of self-determination. It is used to describe the process, as well as the goal of intervention. The existing power relationship between professionals and mental health clients is unbalanced. To shift this inequality of power, the dominant discourse on mental illness should be challenged. Clients should be viewed as a resource, and as individuals with strengths, rather than impairment. The value of interdependence and connectedness also needs to be resurrected. The concept of recovery, as a guiding vision of service development, focuses on ameliorating the patients' impairment, dysfunction, disability, and disadvantage. In practice, such conceptual shifts necessitate the involvement of clients in different ways.

Types of Client Involvement

Client involvement is a key element in the empowerment process (Labonté, 1990; Lord, 1991; Lord & Hutchison, 1993; Pape, 1989). Church and Reville (1989) distinguish between three types of client involvement: (a) client participation, (b)

relationships of mutual acceptance and reciprocity. Economically, equity is possible with real jobs and/or fair incomes. (p. 32)

There are a variety of means by which clients are provided with opportunities to influence decisions and actions that affect them. Clients are recruited as members of task forces, action committees, and residents' councils to give them input in the development of services, so that the programs are tailored to meet the clients' needs. Client involvement helps to make decision-makers more accountable (Pape, 1989). Clients may also participate in research studies to help evaluate services, and to make recommendations about improving services. They may also help design research studies by, for example, taking part in focus groups to develop survey instruments.

Partnership and Coalition

At the level of partnership, clients are not just sitting on committees to give input. There is a fundamental shift in the professionals' attitude towards client participation, and the clients are seen as experts who possess knowledge about the impact of their illness on their lives. Their experiences are not, in any way, less important than the professionals' experiences. As Wilson (1996, p. 78) puts it, "meaningful participation must be based on respect for different points of view, a willingness to listen, and equality among partners." According to Church (1992, p. 4), "the differences between clients and professionals with regards to their life circumstances and experiences must be first acknowledged, and conscious efforts must be made to work together across differences."

Clients can also become involved in services, by forming coalitions, to work with others to address common concerns. These coalitions may include mental health clients, family members, health care professionals, and advocates (Wilson, 1996). Labonté

(1990) points out an important distinction between community organising and coalition. Coalition involves the collective initiation of lobbying and advocacy activities by several small community groups, to identify one or more overarching community issues shared by the groups. Therefore, member groups have to learn to set aside their different priorities to work on common goals.

Client-Controlled Activities

Client-controlled activities include: the development of self-help groups, clubhouses, housing projects, vocational or business projects, public education, advocacy efforts, and the development of resource materials (Pape, 1992). Self-help groups are distinct from other types of client involvement by the nature of membership. In self-help groups, individuals in similar circumstances offer each other emotional support and practical assistance. These groups may also be involved in advocating for changes in the wider mental health system, including public attitudes towards people with mental illness. Consumers are also involved in running skills development workshops, educational activities, and community businesses, which provide employment opportunities for consumers (Wilson, 1996).

Empowerment at Multiple Levels

Empowerment can occur at the individual, group, or community level (Hasenfield, 1987; Lord, 1989). Multiple levels of an empowerment practice have been identified: personal empowerment, group development, community critical analysis, and political action (Cox & Parsons, 1994; Labonté, 1990).

Individual Level: Sense of Self-Worth

According to Rappaport (1985):

Empowerment suggests a sense of control over one's life in personality, cognition, and motivation. It expresses itself at the level of feelings, at the level of ideas about self-worth, [and] at the level of being able to make a difference in the world around us . . . We all have it as a potential. It does not need to be purchased, nor is it a scarce commodity. (p. 17)

At the individual level, clients are supported in mobilising their internal resources. It includes several dimensions: individual-psychological, organisational, political, sociological, economic, and spiritual (Lord & Hutchison, 1993; Rappaport, 1987). Individuals develop a sense of self-worth, a sense of self-efficacy, and an internal locus of control (Gruber & Trickett, 1987; Labonté, 1990). At a micro level, the practitioner works as an enabler to facilitate clients in regaining personal control over their lives.

Group Development: Collective Experiences

Breton (1994) notes that the traditional over-emphasis on personal competency development does not necessarily lead to empowerment. Instead, the concept of *ecological competency* is proposed. This comprises all relevant personal dimensions of the person's skills, qualities, expectations, and their interaction with environmental stimuli (Breton, 1994). Empowerment, therefore, involves the mobilisation of external resources like social support networks (Lord & Hutchison, 1993).

Lord and Hutchison (1993) find that clients' participation in groups contributes to empowerment in three ways. First, participation increases the opportunities for social interaction and the development of various social roles. Therefore, it reduces social

isolation and increases feelings of self-worth. Second, participation increases individuals' confidence in their ability to participate in various activities. Such participatory competence deepens their sense of control. Third, belonging to a group, and being able to contribute to the community, allows them to feel empowered.

At the group level, clients come to realise that their experiences are not just unique, but also shared. In other words, the empowerment process validates their collective experiences to overcome isolation and its corollary of self-blame, and normalises people's experiences of powerlessness (Labonté, 1990). Examples are self-help groups, therapy groups, educational groups, and informal social support networks (Labonté, 1990; Wilson, 1996). Experiences are shared, and solutions to common problems are discussed.

Community Level: Critical Analysis

Linked to the concept of valuing patients as persons, an empowerment practice aims at shifting the focus of intervention away from personal deficits and disabilities, and turns the focus to environmental forces (Gutiérrez, 1990). In an empowerment model of service delivery, clients develop the knowledge and the skills for critical thinking about the internal and the external aspects of their shared problem. By identifying the socio-political context in which their problem is situated, individuals learn to understand how their beliefs in themselves and their experiences with mental illness are being shaped by macro-societal forces. Rapp, Shera, and Kisthardt (1993, p. 729) assert that "the empowerment perspective is not concerned with simply identifying individual differences and deficits, and [with] testing interventions designed to remedy these, but rather is focused on understanding behaviours as a function, not only of individual characteristics

(whether deficits or strengths), but also of the interaction of individuals and environments.” This reduces self-blame and allows clients to work collectively to battle with the system.

Community Level - Collective Action

A distinction among the different levels of empowerment is important, because empowerment at one level does not necessarily translate into empowerment at the other levels. As Wilson (1996, p. 75) points out, “an increase in an individual’s sense of personal control is not always accompanied by an actual increase in power.” Clients are empowered when power is shared between the clients and the system. An increase in the collective consciousness of societal forces enables individuals to develop action strategies, and to acquire the knowledge and the skills to access and develop resources (Cox & Parsons, 1994; Labonté, 1990; Lord & Hutchison, 1993, Rissel, 1994). By promoting systemic changes at a macro level, clients can achieve their common goal of reducing oppression.

While small-group development organises people around issues that are common to group members, community organisation refers to the rallying of people around issues that are larger than the group members’ own immediate concerns. An important element of community organisation is the identification of issues by the community, rather than by the agencies or the professionals, although sometimes community issues may be consistent with agency goals (Labonté, 1990).

An empowerment professional practice strives towards the following ultimate goals (Labonté, 1990, p. 73):

1. Equitable access to the means of production and physical livelihood.

2. Enhanced acquisition and application of productive personal and social skills.
3. Support for creative, educational, and caring activities.
4. A supportive and well-defined matrix of social relationship, allowing cohesive social identities to be formed.
5. Decentralised economic and political decision-making that enhances communal values.

To summarise, empowerment can be implemented through different forms of client involvement. It can occur at multiple levels of intervention, including the individual, group, and community level (Figure 2). The directionality of the level of intervention represents an increase in the scale of participation only. Clients can participate, at different levels, in different activities at the same time, or they can move between different levels of intervention as the circumstances vary.

Figure 2. Empowerment as a multifaceted concept

Empowerment and Responsibility

Lord and Hutchison (1993) find that some mental health clients associate a sense of personal responsibility with empowerment. A sense of responsibility refers to recognition of their limitations of competencies. Such limitations may be caused by the client's mental illness at the personal level, or inadequate resources at the agency and societal levels. Acknowledging such limitations is not equivalent to accepting limitations. On the contrary, acknowledgement of limitations allows clients to challenge the existing system to develop ways that can serve people with mental illness more effectively.

Breton (1994) emphasises a different notion of responsibility in her discussion of empowerment, specifically, the respect for others. She points out that one's personal empowerment may, unfortunately, be achieved at the expense of the disempowerment of others, if knowledge and skills are misused to justify one's abusive behaviours. Viewing competency as an interpersonal and intersystem transaction, empowerment should, therefore, involve the responsibility to respect others' rights. In a similar vein, Labonté (1990) refers to self-discipline and the ability to work with others as one of the criteria for empowerment.

Limitations to Empowerment

Empowerment may be met with contradictions, both within the individual and without. As a result of limitations at the individual and the community level, mental health practitioners are likely to experience a dilemma between encouraging clients to assume more control over their lives, and their well-meaning attempt to control client's

lives (Ackerson & Harrison, 2000). At the individual level, empowerment is limited by the varying degrees of people's competencies and capabilities as a result of their mental illness. At the community level, there are limitations to the availability of agency and societal resources in terms of funding, staffing, and policies. In discussing such limitations, Murdach (1996) refers to the notion of protective beneficence as a modified form of paternalism. Coercive treatment is a necessary approach of protective beneficence in working with individuals with mental illness under certain circumstances, and at certain times, for the well-being of themselves and others.

Empowerment as a Continuum

Protective beneficence and self-determination are not necessarily seen as dichotomous. Cohen (1998) proposes the concept of empowerment as a continuum between mentoring at one end, and partnership at the other end, taking into consideration and challenging individual and societal constraints. A distinguishing feature of this concept is the mutually agreed upon roles in which clients and workers share power. It is a fluid continuum of power-sharing between clients and practitioners, which varies over time and across circumstances.

It is an extremely disempowering experience for a person to be hospitalised involuntarily. Yet, it is important to keep in mind that empowerment is a multifaceted and fluid concept. Disempowerment at one level does not preclude empowerment at a different level. Even though involuntary hospitalisation sometimes becomes necessary to ensure individual safety on the basis of protective beneficence, power-sharing between mental health professionals and patients should still occur at other levels. This can be

done by involving patients in decision-making in as many activities as possible, such as diet choices, dressing, participation in rehabilitation programs, treatment, and discharge planning. When empowerment cannot occur in the form of client-controlled activities, it is still possible to allow patients to feel empowered through a different type of involvement, such as participation. For example, when a patient seems to be unable to make decision in one area of their lives, such as the use of medications, s/he should still be given the opportunity to participate in a meeting with the treatment team so that the purpose of treatment can be explained and the patient's concerns can be acknowledged.

Summary of Theoretical Background and Implications for Practice

Mental illness needs to be understood as a socially constructed phenomenon. Involuntary hospitalisations infringe upon the freedom and civil rights of mental health clients. It is an intervention inherently ridden with conflicts due to different images of mental health clients, constructed by different claims-makers in the society. It contradicts the value of self-determination, upheld by social work professionals, and it can be an extremely disempowering form of treatment for individuals with mental illness. To reconcile this dilemma, the empowerment model is useful in guiding social work practice.

Consistent with social constructionism and the Foucaultian analysis of power and knowledge (White & Epston, 1990), an empowerment model of social work practice with mental patients challenges the grand theory of the medicalisation of mental illness. It involves a paradigm shift to view mental health clients as experts about their experiences with mental illness, and underscores the value of interdependence and connectedness. It

aims to facilitate clients' development of knowledge and skills, to acquire more control over their lives. It also mobilises resources at the individual, group, and community level by raising collective consciousness. In a similar vein, the concept of recovery, as a guiding vision of mental health practice, shifts the focus of intervention away from the pathology of mental illness. The recovery model emphasises building on the strengths of the clients and minimising impairment, dysfunction, disability, and disadvantage.

Informed by social constructionism and the empowerment model, recommendations are made for mental health professionals to adopt a self-reflective, socially and culturally sensitive, strengths-focused, and advocacy-oriented practice.

A Self-reflective Practice

Social constructionism challenges the ultimate truth claim of the dominant medical ideology. There is no absolute truth about the understanding of mental illness. Truth claims are simply claims that are accorded truth status (White & Epston, 1990). Yet, social constructionism is not equivalent to relativism or nihilism whereby all claims are equally valid, and therefore our world simply disintegrates into chaos and nothingness. It does not necessarily imply that a man suffering from paranoid schizophrenia, who is stabbing himself to "get rid of a dragon that has crawled into his stomach," has an equally valid claim to his right to self-determination as anybody else, and that he should, therefore, be free from interference by mental health professionals. Instead, social constructionists should ask a very basic question (Lupton, 1994): "Whose interests are being served in the intervention?" Mental health professionals need to be cognisant of their own implicit values and assumptions in each situation where involuntary hospitalisation is deemed necessary. A self-reflective practice challenges us

to be aware of, and to question, the taken-for-granted, power differences between the clients, workers, and the wider societal system. "We must be clear about what legitimate power is, and what its limits are, and we must not extend our professional influences to support dominant cultural values and norms beyond these limits" (Hartman, 1993, p. 504).

A Socially and Culturally Sensitive Practice

Involuntary hospitalisation unequivocally deprives a person of his/her civil liberty. The loss of a job, a home, and the freedom to choose has significant impact on the person. The various claims-makers, including families, relatives, nurses, social workers, and physicians, all play a unique role in shaping the patients' experiences with involuntary hospitalisations. The clients' unique and subjective constructs of their experiences of mental illness should be the entry points for initiating interventions. Patients easily lose their individuality when they are simply given diagnostic labels. Social workers need to be sensitive to an individual's subjective experience of involuntary hospitalisation, as well as the continuation of the loss of freedom by review panel detention. In addition, patients with different cultural and racial backgrounds have different understanding of mental illness and different interpretations of involuntary hospitalisation. Family involvement also varies among different cultural groups. Social workers need to recognise the cultural diversity among mental patients and their families. Social workers should also alert themselves against negative stereotyping of different cultural practices. Services should be delivered in a manner that respects cultural differences. This author has seen a remarkable improvement in the professionals' awareness of cultural diversity among patients in recent years. A variety of services is

now provided at Riverview Hospital, including, the institution of a multicultural ward in 1994, an improvement in patients' diet choices, and a list of interpreters available to assist patients who have language difficulties. Nevertheless, services can be further improved to address the needs of patients from different cultural groups in a timely manner. Social workers should also help to raise the awareness of cultural issues concerning diagnosis and treatment in interdisciplinary case conferences.

To truly share power with the clients, mental health professionals do not need to discard their "expert knowledge," but they must cease to see it as their unique privilege. Instead, professional knowledge, being recognised as one of many truths, must be applied with caution and humility (Hartman, 1993). Pardeck, Murphy, and Chung (1994) assert that intervention should be guided by a practice of communicative competence, which is used to enter the clients' life-world of experiences. Professionals need to take a position of uncertainty and curiosity, and to respect indigenous knowledge (Hartman, 1993). Interventions can then become socially and culturally sensitive.

A Strengths Perspective

A self-reflective practice also involves challenging the values and assumptions behind mental health interventions. It helps to resurrect the subjugated knowledges, that is, the alternate story-lines of individuals (White & Epston, 1990). The strengths of the clients, instead of their pathologies, become the focus of intervention. Assessments should include information about clients' unique attributes, interests, and past accomplishments. Consistent with a recovery model of practice, treatment planning should not focus on reduction of psychiatric symptoms. Instead, treatment should be devised to encourage positive growth in making incremental steps towards the ultimate

goals of improved functioning in daily living, social, and occupational domains (Sullivan 1992).

Social Work Advocacy

The congruence between social work and social constructionism places social workers in a better position to expose multiple voices in a given society, and to challenge the oppressive construction of madness and disability (Witkin, 1999). The oppressive influences of the dominant knowledges, for example, the negative stereotyping of psychiatric illness and the scarcity of community resources, need to be exposed and counteracted through social work advocacy for appropriate resources.

The four practice orientations discussed above (i.e., a self-reflective, socially and culturally sensitive, strengths-focused, and advocacy-oriented practice) as informed by social constructionism, are consistent with an empowerment model of social work practice at the individual, group, and society level. At the individual level, treatment plans should be client-centred, instead of agency-centred. Interventions should be devised to discover power within individuals. Challenging the oppressive influences of the dominant medical model of mental illness and mental health services, involves recognising the experiences of the clients, raising collective consciousness, and giving clients more control over the distribution of resources. Treatment should focus not only on strengthening individual functioning, but also on reinforcing the support of the family, peer group, community, and other societal systems (Pinderhughes, 1983). The use of social work advocacy and a self-reflective, socially sensitive, and strengths-focused practice make the sharing of power feasible between mental health clients and practitioners. Such shared power is the cornerstone of an empowerment practice.

The medical model and the social constructionist model of mental illness have been described to inform our understanding of involuntary hospitalisation from a theoretical perspective. In the next chapter, a second area of debate regarding the legal aspect of involuntary hospitalisation, is presented.

CHAPTER 5

LEGISLATION REGARDING INVOLUNTARY HOSPITALISATION

Some proponents of involuntary hospitalisation are concerned that the law has made it too difficult to hospitalise the mentally ill. Conversely, the opponents of involuntary hospitalisation have argued that the law is a violation of individual liberty, and is not precise enough to protect individuals from unnecessary hospitalisation. Both arguments look at legislation as a flawed device that leads to problems in providing treatment for people with mental illness. Legislation is seen as the cause of a failure to treat people with mental illness, or a deprivation of their civil rights. On the other hand, Loseke (1995, p. 279) states, "While law typically is seen as a cause of social change, a constructionist perspective can examine the law as a reflection of change." Previous chapters have raised questions about involuntary hospitalisation within the medical and social domain. In this chapter, the debate will focus on the legal aspect of involuntary hospitalisation, namely the difficulties in the interpretation of committal criteria.

Difficulties with the Interpretation of Committal Criteria

Critics have never ceased to question the validity and reliability of making a psychiatric diagnosis. Political dissidents in some countries are confined to mental hospitals for purposes of social control in the guise of psychiatric care. Although in North America the evidence for making a diagnosis of mental illness is subject to strict scrutiny, there is much disagreement, even among psychiatrists, in defining mental illness (Halleck, 1983). For example, when there are comorbid problems, such as drug and alcohol abuse, it becomes more difficult to decide whether a person's problematic

behaviours and social adjustment are a result of mental illness or substance abuse.

Definitions of mental illness are tautological. The concept of the need for protection of the person or others is unclear. Furthermore, a wider interpretation of the committal criteria is reflected in recent changes in the *Mental Health Act* (1999).

Circular Definitions

To hospitalise a person against his/her will, a physician is required to demonstrate that the person has a mental disorder. In the *Mental Health Act* (1999, p. 2-3), a "person with a mental disorder" is defined as a person "who has a disorder of the mind that requires treatment," and "treatment" is defined as "safe and effective psychiatric treatment." Such a definition of mental disorder is tautological and circular in its arguments (Lund, 1980; Paredes, 1998).

Inconsistent Interpretation of the Concept of "Need for Protection"

By declaring a person as one who "requires care, supervision, and control in or through a designated facility...for the protection of the person or patient or the protection of others" (*Mental Health Act*, 1999, p. 9), the legislation recognises that there are individuals who are not able to take care of themselves, and who, therefore, require the intervention of the state. This is referred to as the *parens patriae* power of the state. The state is also delegated with the police power to protect public health, safety, welfare, and morals by hospitalising individuals with mental illness against their will, particularly when they are seen as dangers to others (Davison & Neale, 1986; Strong, 1983).

In deciding whether a person requires protection of self or others, mental health professionals have traditionally used the concept of *dangerousness*. The definition of dangerousness as a central concept in committing an individual is unclear, elusive, and

disturbingly imprecise (Halleck, 1983). It is extremely difficult, if not impossible, to identify individuals who are dangerous, and therefore, the appropriateness of using the dangerousness criteria to hospitalise individuals against their will has been challenged (Stone, cited in Monahan, 1977). There is no clear guideline about the types of dangerousness, the targets to whom or which the dangerousness is posed, the gravity of dangerousness, and the time frame used in predicting dangerousness. The prediction of dangerousness is also unreliable (Arboleda-Florez & Holly, 1984; Davison & Neale, 1986; Lund, 1980; Miller, 1985).

In British Columbia, committal is based on a criterion of "modified need for treatment" (British Columbia Law Report, 1993, p. 298), which extends beyond the concept of dangerousness. In the case of *McCorkell v. Riverview* (1993), the judge stated:

I agree with [the]...argument that the Manitoba criteria bear a close similarity to the British Columbia standard. In the Manitoba legislation, "serious harm" is not qualified; it can include harms that relate to the social, family, vocational, or financial life of the patient as well as the patient's physical condition. The operative word in the *British Columbia Act* is "protection" which necessarily involves the notion of harm. (p. 298-299)

Although the court has interpreted the concept of protection, it is debatable whether all mental health practitioners, particularly physicians, have the same interpretation or not. The descriptive language used in the *Mental Health Act* (1999) to describe the criteria regarding the need for protection, fails to provide further guidance. Terminology such as

reasonably available evidence, significant risks, or to minimise the possibility that the person will again be committed, remains open to interpretation.

In review panels, treatment teams have to prove that individuals continue to meet the committal criteria. Mental health professionals are burdened with the legal liability of committing an individual according to criteria that are subject to debate and interpretation. Different interpretations of the criteria may result in discrepancies in professional practices.

Broadening of Committal Criteria

In the highly publicised *McCorkell v. Riverview* (1993) ruling, the court ruled that the plaintiff could be detained against his will to prevent deterioration of his psychiatric condition. The *British Columbia Mental Health Act*, which came into effect in 1999, incorporates the ruling from *McCorkell v. Riverview* (1993) and reflects a wider interpretation of the need for protection of the person or others. It states specifically that a person can be hospitalised involuntarily to prevent the person's substantial mental or physical deterioration. Commitment can be maintained on a predictive basis before substantial deterioration occurs. Deterioration is understood as the worsening of an individual's psychiatric condition relative to the current state of functioning. In other words, protection of the person or others can be interpreted as a broader concept than dangerousness, including, but not limited, to the prediction of dangerousness.

The *Mental Health Act* (1999) also makes it easier to detain a person for treatment with one certificate initially, instead of two. In addition, the *Mental Health Act* (1999) has gone beyond the concept of dangerousness to incorporate the concept of social harm. It refers to mental disorder as "the person's inability to react appropriately to the

environment and to associate with others" (*Mental Health Act*, 1999, p. 164-165).

However, such a concept of social harm remains a poorly defined social construct. It has varied meanings among different cultures, subcultures, and ethnic groups. It changes across time and places. This further compromises consistency and reliability in professional practice, regarding civil commitment.

With respect to review panels, the *Mental Health Act* (1999, p. 173) specifies that the review panel hearing must include an assessment of "whether there is a significant risk that the patient, if discharged, will as a result of a mental disorder, fail to follow the treatment plan [sic]." It also dictates that when individuals apply for review panels to challenge their detentions, their near relatives must be notified in writing. The near relatives must be notified again when the patients are released by review panels. The near relatives may also present evidence for continued hospitalisation. In addition, there is a stronger emphasis on the provision of extended leaves, which allows individuals to be committed and treated in the community. The conditions of the extended leave are not specified under the *Mental Health Act* (1999) but, in practice, often include the location of residence or treatment, treatment compliance, and the monitoring of dangerous or inappropriate behaviours. All of these changes in the committal criteria and the procedures related to involuntary treatment and review panels, appear to reflect greater social surveillance at the expense of individual freedom.

In short, the power difference between mental health professionals and patients is most vividly exemplified by involuntary hospitalisation. The professionals' power is legitimised by the *Mental Health Act* (1999) to initiate involuntary detention, which can

be subsequently challenged by the review panels. The debate on the legality of the *Mental Health Act* (1999) further complicates the conflict-riddled nature of involuntary hospitalisation and review panels. Although the *Mental Health Act* (1999) has been criticised as being vague and open to interpretation (Paredes, 1998), it reflects the difficulties involved in defining mental illness and justifying involuntary hospitalisation. It elucidates the fact that mental illness is essentially a social construct.

Recent changes in the *Mental Health Act* have made it easier to commit a person to a mental hospital, and to enforce treatment compliance in the community. Its impact on the lives of mental patients and on the delivery of mental health services has yet to be examined. On the other hand, legislation not only affects, but is also affected by, social changes. The broadening of committal criteria, as reflected in the *Mental Health Act* (1999), is consistent with a greater extent of protection and control in current social climate. It states the need to look at an individual's interaction with the environment when the need for involuntary hospitalisation is considered. The need for protection of the person or others cannot be determined by a narrow definition of presenting clinical symptoms. Instead, the concept of harm in relation to the social, familial, vocational, financial, and physical functioning of individuals, needs to be considered.

The theoretical and legal debates on involuntary hospitalisation have been described in Chapter 1 - 5 of this thesis, to illuminate the conflict inherent in review panels. Both social workers and physicians play a significant role in review panels, providing assessments of the patients' psychiatric and/or social conditions, and making recommendations for release or detention. Therefore, to better understand the mental health professional's experiences with review panels, a study was conducted by this

author on the experiences of social workers and physicians at Riverview Hospital in British Columbia. A literature review of review panels in Canada and the United States will be presented in the chapter 6, followed by a description of the study itself in Chapter 7.

Chapter 6

Literature Review on Review Panels

As the involuntary commitment of individuals represents a deprivation of their civil liberty, *the Mental Health Act* (1999) provides a process called the review panel for committed individuals to repeal their committal status. While underscoring the value of the *parens patriae* power in involuntary hospitalisation, Strong (1983) recognises the need, and the obligation, to secure the patients' entitlement to speedy reviews of their involuntary status to protect their civil rights. Similarly, Arboleda-Florez and Holly (1984) acknowledge the importance of providing legal safeguards in the committal process, including the right to appeal, and the need to protect the patients and psychiatrists. Nevertheless, balancing the rights of individuals against their need for treatment in review board hearings is often a subtle and difficult process (Freckleton, 1998).

Preceding chapters of this thesis, on the theoretical conflict and the legal debate about involuntary hospitalisation, demonstrate how treatment teams are thrown into an adversarial position against the patients and their advocates in this appeal process. Treatment teams are required to defend themselves in three areas. First, they are required to argue for a diagnosis of mental illness that requires treatment. Second, they have to demonstrate the potential deterioration of the individuals without treatment. Third, they need to prove that the treatment can only be suitably provided by involuntary hospitalisation, or by extended leave through a psychiatric facility. Such an adversarial position is awkward for the health professionals, who are providing treatment and care

for “the patient’s best interests.” It is not surprising that they might have mixed feelings and opinions about the review panel process.

The number of studies on the review panel process in Canada is quite limited. All of the available studies in Canada known to this author are summarised in the following paragraphs. This is followed by a review of a number of studies in Australia and in the United States about some alternatives to review panels.

Review Panels in Canada

Adams, Pitre, and Cieszkowski (1997) undertook a project in North Bay Psychiatric Hospital in Ontario to find out the profile of patients who applied to review panels, and their outcomes. The age and gender distribution of review panel applicants was generally similar to the hospital population. However, there were more patients with mania and schizophrenia among the review panel applicants. There was no significant difference between patients who were released by review panels and those who were discharged by hospital treatment teams, in the percentage of re-admissions within a year. Yet, there was a significant positive association between multiple applications to the review panels and subsequent dangerous behaviours.

O’Reilly, Komer, and Dunbar (1999) conducted a study regarding the reasons for release by review panels in two psychiatric hospitals in Ontario. One-third of the review panel applicants suffered from schizophrenia. Thirty percent of the review panel applicants had a personality disorder as a primary or secondary diagnosis. The most frequently cited reasons for revoking certification were:

1. The review board felt that the evidence was insufficient.

2. The patient has clearly improved by the time of the review panel hearing.
3. A significant other stated at review panel that s/he would assist the patient in the community.
4. The physician agreed that the patient did not meet the criteria for certification.
5. The review panel noted a lack of past history of violence.
6. The patient's privileges were incompatible with identified risk.
7. Intractability of symptoms appeared to have been considered.
8. The assessment of harm, under "imminent physical impairment," was deemed insufficient or inappropriate.

A study was done to investigate the review panel outcomes in several psychiatric hospitals in Ontario (Komer, O'Reilly, Cernovsky & Dunbar, 1999). About one-third of the review panel applicants withdrew their applications prior to the scheduled hearings. In 25.4% of the review panel applications, the physicians changed the patients' status to *voluntary*. Only 9.4% of the certificates were rescinded, indicating a disagreement between the review panel and the treatment team decisions to keep the individual certified.

Three studies were conducted on the review panel process at Riverview Hospital in British Columbia between 1984 and 1986. The researchers Gray, Clark, Higenbottam, Ledwidge, and Paredes (1985) looked at the predictor variables for applying to review panels. Applicants were more likely to be male, single, unemployed, and under the age of 30. They were rated as "normal" on orientation and "intact" on memory, and they had experienced problems at work or school, problems with parents, or alcohol abuse, as

precipitating factors for hospitalisation. In addition, they did not have a secondary diagnosis of mental retardation or epilepsy.

It was suggested that the predictor variables could be used to formulate a management plan to reduce the likelihood that patients would apply to the review panel, because “review panel discharges precluded the possibility of a smooth transition from hospital to community and the formulation of a plan for follow-up” (Gray et al., 1985, p. 575). However, the researchers did not elaborate on the potential problems of the lack of a smooth transition from the hospital to the community.

The researchers Higenbottam, Ledwidge, Paredes, Hansen, Kogan, and Lambert (1985) conducted a study on the decision-making process of review panels in British Columbia. Some of the factors found to be predictive of discharges were: (a) being represented by a lawyer, (b) having more than two years of community living prior to admission, (c) being on boarding home waiting list, and (d) having a positive history of drug abuse. An understanding of these predictive variables could help treatment teams formulate treatment plans and prepare information for review panel presentations.

It was also found that those patients who were deemed *incapable* were more likely to be detained. This was a group of patients whose capability to manage legal and financial affairs had been formally assessed, and who had been declared incapable under the *Patients Property Act* (2001). Yet, it was not known how many other applicants were cognitively impaired, but did not have formal assessments of their capability. If patients with severe cognitive impairment were likely to be detained, it raised a question whether they would benefit from applying to review panels or not, especially when the cost of convening a review panel was considered.

A follow-up study on patients released by review panels was done by Ledwidge, Glackman, Paredes, Chen, Dhami, Hansen, and Higenbottam (1987). It was found that the patients who were released by review panels were no more likely to be readmitted to hospitals than patients who were discharged by physicians. In addition, there were significant differences between the patients released by review panels and the physician-discharged patients, in only two areas of functioning. The physician-discharged patients were rated as better adjusted, in home adjustment and work adjustment, than those patients released by review panels. The results, therefore, challenged a previous assumption that patients discharged by review panels might not fare well due to the lack of follow-up services. It was speculated that participation in post-discharge treatment might not be dependent on making those aftercare arrangements prior to discharge. It appeared that patients discharged by review panels did receive some form of services following the unexpected discharge, and such follow-up was imperative to the patients' survival.

It seems likely that the treatment team members, such as the social workers, who are involved in assisting the patients in accessing follow-up services, may experience role-conflict in providing such "emergency" response services to review panel discharges. Further discussion regarding such role conflict will be made in the following chapter on the study undertaken by this author.

In a summary of the findings from the three aforementioned studies, Paredes et al. (1987, p. 446) noted, "Hospital staff should be educated that, for some patients, a review panel discharge may have beneficial therapeutic aspects...and application by a patient to appear before the review panel should not be discouraged by ward staff." Yet, it was not

indicated in this study what the beneficial aspects were, or whether this education process for staff was being undertaken or not. In addition, it was recommended that a structure be developed for the clinical notes completed by social workers and physicians, so that all information relevant to the panel's decision would be consistently provided. Other recommendations included, providing unambiguous criteria for releasing a patient, and appointing a fixed appointee to the review panel to represent the patient.

Persad and Kazarian (1998) conducted a study to explore physician satisfaction with review boards in nine provincial psychiatric hospitals in Ontario. Ninety out of 200 questionnaires were returned. The respondents were asked to estimate the amount of time they spent on preparing review board reports and the number of times the review board had ruled against the physician. The participants also indicated their overall satisfaction with the review board meetings. In addition, they were asked to rate their overall level of comfort in certifying patients in civil commitments, on a Likert scale ranging from 1 (*very comfortable*) to 5 (*very uncomfortable*). It was found that institutional affiliation (i.e., the length of employment at the hospital) and the level of comfort in certifying patients (as reported by physicians) were the best predictors of positive satisfaction scores about review boards. Although some physicians expressed a general level of satisfaction with review boards, a majority of the respondents viewed review boards as "overly legalistic, adversarial, at times intimidating, and [an] expensive means of determining a patient's certifiability" (Persad & Kazarian, 1998, p. 907).

Some Alternatives to Review Panels and Involuntary Hospitalisation

A few American and Australian studies regarding some alternatives to safeguard individuals' civil rights, in place of a review panel or involuntary hospitalisation, are

available. These include:

1. The treatment review panel as a peer review of involuntary treatment.
2. The use of an intermediate status between a detention and a release.
3. The use of community treatment orders (as an alternative to involuntary hospitalisation).

In some jurisdictions in the United States and Canada, involuntary hospitalisation and involuntary psychiatric treatment are two separate processes. For example, the regional review boards in Ontario have the authority to overturn certificates of commitment, certificates of incompetence (about giving consent to treatment), and treatment orders (Persad & Kazarian, 1998). In British Columbia, involuntary hospitalisation also implies involuntary treatment. The need for involuntary treatment can be determined by a clinical peer review panel that is comprised of medical and psychiatric professionals, instead of a legal review. A study was conducted in Minnesota on a process called the treatment review panel, which involved the use of a clinical peer review (by a group of physicians) to consider the enforcement of pharmacological intervention on involuntarily committed patients (Zito, Lentz, Routt & Olson, 1984). The treatment review panel was subsequently changed to a judicial review process in 1988, when the Minnesota Supreme Court released its opinion on *Jarvis v. Levine* (Farnsworth 1991). The Minnesota court concluded that the Minnesota constitution guaranteed the right to privacy. The court cited the potential side-effect of tardive dyskinesia as a prominent reason to conclude that the use of neuroleptic treatment on involuntary patients was intrusive. It established the use of pre-treatment judicial review procedures prior to the introduction of all intrusive forms of treatment. The study found that 18 patients,

who were waiting for judicial reviews, stayed for an additional 80 days before treatment was commenced. It was estimated that an additional amount of \$355,000 was involved in their treatment, when the cost of extended hospital stays and the fees for the court, transportation, and expert witnesses were taken into consideration. It was concluded that "the courts offered no real advantage over the treatment review panel" (Farnsworth, 1991, p. 42).

A process called the Clinical Review Panel (CRP) statute, which was similar to the treatment review panel, was also in place in Maryland (Storch 1993). It was found that while the statute provided appropriate formal procedural protection, it also added the possibility of unnecessary legal proceedings. Storch (1993, p. 277) concluded, "Clinical decisions about medications should be made by psychiatrists and not by lawyers or judges."

Aviram and Smoyak (1994) analysed the use of a status called DPP ("discharged pending placement") or CEPP ("conditional extension pending placement") in the state of New Jersey in the United States. It was devised to handle situations where patients do not meet the criteria for continued commitment any more, but for whom no appropriate placements were available. Specific procedures were established to ensure that individual rights were protected, and continual efforts were made to locate appropriate placement for the individual. A placement review hearing must be held within 60 days of the initial DPP designation. The purpose of the review hearing was stated as follows:

The court shall inquire into the needs of the individual for custodial and supportive care, the desires of the individual regarding placement, the type of facility that would provide the needed level of care in the least restrictive manner,

the availability of such placement, the efforts of the State to locate such placement, and any other matters it deems necessary. (Aviram & Smoyak, 1994, p. 147-148)

It was hoped that the DPP status would help to monitor and hasten state attempts to find suitable placement for patients. However, no further studies were available regarding the benefits and disadvantages of DPP status.

The option of a community treatment order may also help to enforce treatment compliance in the community, as an alternative to involuntary hospitalisation. In the state of Victoria in Australia, the provision for community treatment orders allow mental health professionals to treat patients in the community, against their will if necessary, instead of forcing them to be hospitalised. Patients are required to comply with certain conditions specified in their community treatment orders. Non-compliance with community treatment orders may lead to forced hospitalisation again. Community treatment orders also exist in Ontario and Saskatchewan.

Similar to community treatment orders, patients can be placed on extended leave status in British Columbia. The extended leave status specifies that an individual be released from the hospital only under certain conditions, such as compliance with treatment, absence of aggressive behaviours, or residence in a certain community facility. Violation of such conditions may lead to rehospitalisation via police intervention. Although the community treatment order is perceived by some as being consistent with the principle of treatment in the least restrictive environment, others have debated whether it is in fact less restrictive than involuntary hospitalisation or not (McDonnell & Bartholomew, 1997).

To summarise, a literature review of review panels indicates that review panels may have some potential benefits. Nevertheless, there are problems with unexpected releases by review panels. The review panels in Ontario have been described as “being overly legalistic and adversarial” (Persad & Kazarian, 1998). There is no existing study on health professionals’ experiences with review panels in British Columbia. Therefore, a descriptive study was designed to obtain a better understanding of social workers’ and physicians’ experiences with review panels in British Columbia. The study and its findings will be described in the next chapter.

CHAPTER 7

A QUANTITATIVE STUDY OF SOCIAL WORKERS' AND PHYSICIANS' EXPERIENCES WITH REVIEW PANELS

The review panel is an inherently conflict-ridden process due to the debate about the social construction of mental illness and the legality of the *Mental Health Act* (1999). To complement the current literature on review panels, a descriptive study was designed to look at the social workers' and physicians' experiences with review panels in British Columbia, as little scientific data regarding this issue was available. The objectives of the study were to explore whether social workers and physicians had adequate knowledge of review panels, and what their attitudes towards review panels were. A descriptive approach using a written questionnaire was chosen to collect quantifiable data that could provide a measurable representation of social workers' and physicians' knowledge of review panels and their attitudes as a group (Anastas & MacDonald, 1994). It also allowed comparison between different sub-groups within the sample to find out if there was any difference or association. It was hoped that this study would help to inform the understanding of mental health professionals' experiences with review panels and the *Mental Health Act* (1999). This study was conducted at Riverview Hospital, which is an 808-bed psychiatric facility located in the city of Port Coquitlam in British Columbia. It is the only provincial hospital in British Columbia that provides a tertiary level of care and treatment for individuals with mental illness.

Levels of Mental Health Care Services

There are three levels of care services for people with mental illness in British Columbia. Individuals who have relatively mild symptoms receive treatment from their general practitioners, community psychiatrists, or community mental health centres, while residing at home or in community facilities. This is called the primary level of care. When individuals suffer from a temporary relapse of their illness, they may require brief in-patient treatments on psychiatric wards in local acute care hospitals, such as the Vancouver General Hospital, St. Paul's Hospital, or Surrey Memorial Hospital. This is called the secondary level of care. Sometimes such brief hospitalisations may fail to stabilise the patients, and they require a longer period of in-patient treatment. Such individuals may be referred to Riverview Hospital, the only tertiary care hospital in British Columbia that specialises in providing treatment and care for people with severe mental illness.

Riverview Hospital provides "in-patient treatment and care to severely psychotic or cognitively disordered persons, with primary diagnoses falling within AXIS I [sic] in the Diagnostic and Statistical Manual of Mental Disorders IV, and a high level of aberrant behaviours, who are unable to be managed in the community with currently available resources" (Riverview Hospital, 1994, p. 32). At the time of this study, there were three treatment programs at Riverview Hospital (although the organisation structured has changed since then.) The Adult Tertiary Redevelopment Program (ATRP) provided assessment, treatment, and rehabilitative services for most of the acutely mentally ill patients between the age of 19 and 65. The Adult Residential Transfer Program (ARTP) provided longer-term treatment and rehabilitative services (over three

months) for individuals with a severe mental illness, who were between the age of 19 and 65. The Geriatrics Program provided acute and longer-term assessment, treatment, and rehabilitative services for individuals with a severe mental illness who were 65 or older.

Method

The following subsections will describe the participants in this study, the exclusion criteria, development of a questionnaire, development of Likert scales, development of hypotheses, and data analysis.

Participants

Although review panels were held province-wide, a purposive sample of the social workers and physicians at Riverview Hospital was used for the following three reasons:

Time Limitation

This study was carried out for a course assignment, as part of the requirements of the Master of Social Work program at the University of British Columbia. The short time-frame of the course made it necessary to locate a sample that was readily accessible.

Expert Opinions

Riverview Hospital was the only place where social work assessments were consistently completed, as per hospital policy, making their expert opinions valuable. Social workers had to complete a clinical note on the patient's history of illness, current level of functioning, and discharge plan. Social workers also needed to make recommendations about whether the patient should be released or not. It was felt that a more comprehensive picture of review panels could be gathered by collecting data from two types of informants, namely the social workers and the physicians, who were both

closely involved in the review panel process.

High Percentage of Applications

Approximately 86% of the patients at Riverview Hospital were involuntary (Clinical Record Services, personal communication, February 5, 2002). A significant number of review panels took place at Riverview Hospital. According to the *Mental Health Act* Review Panel Statistical Report in 1999, 202 out of a total of 462 panels (44%) were convened at Riverview Hospital. Therefore, the physicians and social workers at Riverview had more experience with review panels on an ongoing basis.

Exclusion Criteria

1. Although many people with mental illness might have impaired insight or judgement, they were considered capable of making personal decisions, unless they had been declared otherwise under the *Patients Property Act* (2001). It was important to note the difference between *incapability of person* and *incapability of finances*. Some individuals might be declared incapable of making financial decisions, but they might still be capable of making personal decisions about their lives. In contrast, some individuals with mental illness suffered from such severe impairment in their cognitive functioning and judgement that they had been declared incapable in making personal decisions under the *Patients Property Act* (2001). Legal representatives were appointed to act on their behalf to make appropriate decisions about personal, legal, and financial matters. From a legal point of view, those review panel applications signed by incapable individuals were invalid. Respondents were reminded that such applications involving incapable patients were not the focus of this study.

2. Some psychiatrists at Riverview Hospital also sat on review panel hearings as decision-making members. Their role as decision-making panel members was totally independent of the hospital, and it was distinct from their roles on the treatment teams. Physicians were asked specifically to respond to the questionnaires from their experience as hospital presenters, if applicable. Their experience as panel members was not the focus of this study.

Development of Questionnaire

A self-report questionnaire was developed for this study, to look at the knowledge and attitudes of social workers and physicians about review panels (see Appendix B). The questionnaire was developed based on a literature review on the conflicting theoretical and legal aspects of involuntary hospitalisation, available studies on review panels in Canada, and this author's personal experience as a social worker at Riverview Hospital. The development of the questionnaire was also informed by this author's discussions with patients, families, and staff of various disciplines, including nurses, physicians, and other social workers.

A self-report questionnaire ensured subjects' confidentiality and it was the least intrusive method to use with the subjects. It was an appropriate tool, as negative ratings of the respondents' attitudes towards review panels could be quite sensitive. An open question was included at the end to solicit general comments about the respondents' experiences with review panels.

Part I of the questionnaire requested background data on the gender, occupational position, training, work experience of the subjects, and the various ways they had been involved in the review panel process (such as preparing reports and educating patients

about the review panels.) These contextual factors were used in data analysis. In Part II, the subjects were asked to report on their level of knowledge about various aspects of the review panels, including review panel composition, the roles of the members, and the decision-making process. In Part III, a Likert-type scale was used, asking subjects to rate their agreement with 22 statements that describe their attitudes towards the review panels. Subjects were asked (in the covering letter) to respond to the questionnaire according to their current experiences with review panels, following the changes in the new *Mental Health Act* (1999).

Development of Likert Scales

The following section (from p. 79 to p. 88) explains the rationale for developing the Likert scale items in the questionnaire. It describes a broad range of issues about review panels that have emerged from this author's personal experience and communication with other staff at Riverview Hospital. Whenever appropriate, current literature is cited to support or illustrate such concerns. To investigate respondents' attitudes towards review panels, these concerns were organised into 22 attitude statements in the questionnaire. The respondents were asked to rate their agreement with each statement on a Likert scale ranging from 1 (*totally disagree*) to 5 (*totally agree*). The statements were categorised into four themes: (a) patient-related issues, (b) effects on treatment teams, (c) role conflict, and (d) operational issues. There were several issues in each category, which are illustrated as follows.

Patient-related Issues

Several patient-related issues were identified. These included positive benefits of review panels, patient's deterioration following a review panel release, patients with

cognitive impairment, confidentiality, patients with substance abuse problems, patients with criminal histories, and patients with personality disorders.

Positive benefits. It could be logically argued that review panels gave the patients an opportunity to regain a sense of control over decision-making about their lives, as the patients could challenge the treatment teams' decisions to keep them in hospital against their will. Such a sense of hope might help to encourage them to understand the reasons for their hospitalisation, and to improve their behaviours in order to obtain a release. If they were detained, which meant that the review panel members concurred with the treatment teams' decisions for hospitalisation, this might convey a message to the patients on the importance of treatment compliance and collaboration with the treatment teams to work on discharge goals.

Patient's deterioration. In the clinical experience of Riverview social workers and physicians, there were many patients who suffer almost immediate relapse after review panel releases and require rehospitalisation. It raised doubts among hospital staff about the appropriateness of a review panel release in those situations, when it appeared that the patients might have done better had they been detained. This was similar to a statement made by Hoffman and Bay (1993) that some patients might have benefited from treatment, but unfortunately, fell through the cracks created by the legislation.

Patients with cognitive impairment. Another common concern raised by some hospital staff was the patient's cognitive ability to comprehend the implications of a review panel. Individuals who suffered from dementia, amnesic disorders, or brain injuries might show significant cognitive impairment affecting judgement and

information processing. It was debatable whether they had the ability to make appropriate decisions to apply for release from the hospital or not.

Confidentiality. Until November 1999, a patient's decision to apply to a review panel was considered a confidential decision that could not be disclosed to others, except with the patient's permission, or if deemed necessary by professional judgement arising from safety concerns. In the event of a release, patients were likely to go back to their near relatives or family members for support, if there were any. In the past, the near relatives or family members might have no knowledge about the review panels, and they might be totally unprepared for such release. This left a grey area that led to confusion, misunderstanding, and possibly inconsistent practice. A new clause has been added to the new *Mental Health Act* (1999), which states that patients' near relatives should be notified of their applications to review panels. The near relatives might also present evidence for or against release. It has sparked some debate among Riverview social workers about whether this violates the patients' right to choose who will be involved in their treatment, and to whom information will be released, or not.

Patients with substance abuse problems. Higenbottam et al. (1985) found that a positive history of drug abuse is predictive of review panel discharges. They speculated that such patients responded quickly to hospital treatment, particularly if their psychotic symptoms were drug-induced, thereby making it more likely for them to be discharged by review panels. On the other hand, some hospital staff felt that patients' drug-induced psychotic symptoms might have subsided by the time they were transferred to Riverview Hospital, following their treatment at the acute care hospital.

Some physicians questioned whether individuals with substance abuse problems would benefit from prolonged psychiatric hospital treatment or not. Such patients appeared to stabilise fairly quickly in a structured and restricted setting, and might not need active assessment and treatment for long durations. Some staff felt that such individuals would benefit from alcohol and drug treatment, counselling, and residential services in the community, rather than psychiatric treatment in a hospital. It was argued that hospitalising individuals with substance abuse problems was, not only inappropriate, but also limiting their access to more suitable services.

Patients with criminal histories. There were also a number of individuals who were held at Riverview Hospital for a prolonged period of time, as their criminal histories made it extremely difficult to find appropriate community placements for them. Many social workers felt that even though the clients' symptoms were well under control, and that there were no current criminal charges, attempts to refer them for community placements often failed due to the public's concern about their history of criminal charges, such as sexual assaults, fire-setting, and aggravated assaults. This author has worked with a patient who has been clinically stable with no behavioural or psychiatric problems for two years. Unfortunately, his application for placement was repeatedly rejected by all facilities due to sexual offences and murder charges that occurred 30 years ago. It was doubtful that such individuals would benefit from prolonged detention in a mental hospital. It might not be the best utilisation of tertiary care hospital resources.

Patients with personality disorders. O'Reilly et al (1999, p. 260) noted that a significant portion (30%) of review panel applicants had a diagnosis of personality disorder (e.g., antisocial personality disorder, dependent personality disorder, and

borderline personality disorder), as a primary or secondary diagnosis, in addition to an Axis I diagnosis (e.g., schizophrenia, bipolar affective disorder), according to the Diagnostic and Statistic Manual of Mental Disorders IV. These individuals often stabilised quickly in a confined and structured setting like Riverview Hospital. Although they might have displayed behaviours that presented a potential risk to self or others in the past, it was dubious whether there was any clinical benefit in hospitalising this group of individuals for prolonged periods or not (O'Reilly et al., 1999). Many Riverview staff have worked with such individuals, who they felt were well enough to be discharged, and their treatment teams might even concur with them from a purely clinical perspective. Yet, their personality disorders might present as an impaired ability to sustain supportive interpersonal relationships, a failure to take responsibility for their behaviours, or repeated self-harm. Their release from hospitals would depend not only on their clinical readiness, but also on a variety of factors like availability of resources, their potential to become a risk again, and their likelihood to suffer from a relapse.

Effects on Treatment Teams

Despite social workers' and physicians' concerns and frustrations, review panels might have positive or therapeutic value in treatment and discharge planning, which might have been overlooked and under-recognised. Review panels might act as a buffer when there was disagreement between the patients and the treatment teams, and they might serve to reduce the tension in the patients' relationships with the teams. An application to review panels might also help to make sure that attempts for discharge planning were made, and if not, the reasons for continuation of involuntary hospitalisation must be shown to be justified. Factors like episodic remission of

psychotic symptoms, concerns from family and community care-givers, past criminal involvement, and lack of appropriate community support services might influence a physician's decision about the need to keep a person committed. Yet, prolonged hospitalisation might not necessarily lead to effective treatment. Review panels might be useful in making legal decisions when the treatment team faced dissenting opinions concerning detention.

On the other hand, it was not an uncommon experience among Riverview social workers to find families or community service-providers very frustrated, even irate, about review panel releases, and questioning the appropriateness of such releases. Perhaps due to some confusion, lack of information, or misunderstanding about the role of review panels, treatment teams might be blamed by community caregivers when patients released by review panels started to deteriorate in the community.

Role Conflicts Experienced by Social Workers and Physicians

"Health professionals were faced with the continuing need to redefine and realign their roles" as a result of the ever-expanding knowledge in health care and the continually changing care delivery systems (Conway, 1988, p. 69). Harrison, Drolen, and Atherton (1989, p. 622) stated, "Social workers were especially vulnerable to role problems as they worked in agencies with diverse missions, functions, and methods." Riverview social workers and physicians might experience conflicts in their multiple roles as educators, therapists, and advocates, as a result of differences in their professional values, ideologies, training, and experience. Several areas related to role conflict, including professional paternalism, adverse effect on client-worker relationship, and "band-aid" services, are described in the following paragraphs.

Professional beneficence. Adams et al. (1997) posited that a swing towards individual rights and liberty had changed the paternalistic approach towards patient care considerably. Yet, mental health professionals were still placed in a position to provide treatment in the clients' best interests, and to help to improve or maintain their well-being, under the principle of beneficence. While the clients' right to the appeal process was recognised as their fundamental right to self-determination, Riverview staff might feel compromised by their conflicting values of beneficence. This conflict might also have adverse effects on the trusting relationship between the physicians and the patients.

Social workers at Riverview might experience multiple conflicts in their roles, having to work with clients on discharge planning issues on the one hand, while providing clients with emotional support during the appeal process on the other hand. Similarly, Prior (1992) commented on the inherent contradiction in the roles of the British social workers in applying for certification of an individual, while remaining as the care-provider looking for "less restrictive" types of services for the individual. Another contradiction was the expectation on the social worker to protect the public's interests while the social worker was also an advocate for the individual.

Adverse effect on client-worker relationship. A release by review panels might also affect therapist-patient relationships in a negative manner by giving an impression that the staff might be excessively restrictive, or that they might have made a clinical or legal error (O'Reilly et al, 1999). Social workers and physicians at Riverview might find themselves in a dilemma attempting to establish therapeutic rapport with the patients, while being perceived as authority figures controlling the patients' lives and keeping them in the hospital against their wishes. In particular, the social worker's success in

developing a consensual and feasible discharge plan with the patient might be jeopardised by such conflicting roles.

“Band-aid” Services. Social workers were often involved in providing “emergency” band-aid services in the event of a release by review panels. When patients were released by review panels, they were essentially deemed “capable of living in the community without formal supervision.” Nevertheless, social workers often had to come to their rescue by providing transportation, financial support, and referral services to community support services. Such services included income assistance, housing, follow-up mental health services, drug and alcohol counselling, and social and recreational programs. Client refusal of such services was not uncommon. Unfortunately, the social workers’ hands were tied, as their responsibilities and authority became limited when de-certified patients could not be forced to accept treatment and services.

Operational Issues Concerning Review Panels

There were structural issues, such as the interpretation of legislation and agency policy requirements, which might increase social workers and physicians’ frustration with the review panel process. These included committal criteria, social work assessments, and alternatives to review panels.

Committal criteria. The vagueness of the language used in committal criteria might lead to unclear expectations about the content of review panel presentations and inconsistency in review panel decisions. To demonstrate how fallible clinical decisions were, Adams et al (1997, p. 75) concluded in their study that “review panels might be

more influenced by the appearance and conduct of the hearing than the evidence presented.”

Social work assessments. It was mandatory for social workers and psychiatrists at Riverview to submit assessment reports on their patients. These reports would be presented and reviewed at the review panel hearings. Social work assessments were not compulsory for review panels in other hospitals in British Columbia.

Some Riverview social workers had raised concerns regarding their workload and the pressure in completing assessments to comply with hospital protocol. While the value of social work assessments was recognised, some staff questioned whether it was the best use of professional time and resources to make social work assessments mandatory for all hearings or not. In some situations, there might be strongly compelling evidence to indicate a detention, such as florid psychotic symptoms, recent assaultive behaviour, or severe cognitive impairment. Some hospital staff felt that in such situations, the potential benefits of social work assessments became less apparent, while they became extra work to the social workers. Therefore, it was argued that social work assessments should be made optional in those situations.

Alternatives to review panels. Under current legislation in British Columbia, review panels are authorised to give only an “all-or-nothing” decision with respect to the committal status of the patient (i.e., either a detention or a release), with no options for intermediate recommendations. A review of some studies about possible alternatives to review panels was reported on p. 66-68. It was not clear whether there was a need for more flexibility and options regarding the outcomes of review panels, or not.

Other Statements

Bay and Hoffman (1993) found that 20 - 40% of involuntary patients had their status changed to voluntary by their physicians prior to the hearing. Adams et al's study (1997) revealed that the physicians changed the patients' status to voluntary in 39% of the cases, probably because they were reluctant to expend the large amount of time to prepare for, and to attend, review board hearings, and then subject their decisions to scrutiny and reversal. Some Riverview staff suggested social workers and physicians would be more likely to discharge a patient, if s/he had applied for a review panel. In addition, the participants in this author's study were asked if they felt that the patients or their families had adequate knowledge of the review panel process.

Development of Tests of Association or Difference

The following paragraphs describe why a number of tests of association or difference were developed regarding the participants' training, experience, attitudes, and their professions (i.e., social workers versus physicians.)

Hypotheses regarding training, experience, and attitudes. Available literature indicates that role conflict is mediated by one's knowledge and experience. In the structural-functional perspective, roles are conceived as fixed positions in the social structure with associated expectations (Conway, 1988). Conversely, the concept of roles can be described in the symbolic interactionists' perspective, as the process whereby the individual responds to the meaning given to the activity, or the object, in the interaction. Multiple roles can be overloading or beneficial, and various role problems (including role ambiguity, role conflict, and role overload) may result from problems in the social structure (Hardy & Hardy, 1988). Regardless of differences in the conceptualisation of

roles in these paradigms, both the structuralists and the symbolic interactionists agree that “competence is necessary for adequate role performance” (Hardy, 1988, p. 235).

Competence, in turn, is related to the knowledge and the skills of the role occupants, among other factors. In other words, the more knowledgeable and skilful the workers are, the more competent they will be in performing their roles, and the less likely they will experience role conflict and ambiguity. It follows that adequate knowledge may help to foster a more positive attitude towards role performance.

Since one’s knowledge might have a positive effect on attitudes, it was hypothesised that the more the social workers and physicians knew about review panels, the more positive they would be about the review panels process. To investigate this relationship between knowledge and attitudes, participants were asked to report the training they have received regarding the *Mental Health Act* (1999) and review panels. Their self-reported training was used as a proxy to reflect their knowledge about review panels. On the basis of their self-reported training, participants were grouped into three categories: (a) participants who had never received training, (b) participants who had received training more than six months ago, and (c) participants who had received training within the last six months. The differences in the participants’ attitudes towards review panels among these three groups, which had different levels of training about the *Mental Health Act* (1999) and about the review panels, were examined by Hypothesis 1.1 and Hypothesis 1.2 respectively.

Hypothesis 1.1: Social workers and physicians who receive more training on *Mental Health Act* will have more positive attitudes towards review panels.

Hypothesis 1.2: Social workers and physicians who receive more training on review panels will have more positive attitudes towards review panels.

One study in the state of Illinois in the United States described the attitude of social workers who acted as qualified examiners making decisions as to whether, or not, an individual should be certified (Dworkin, 1989). It was found that more experienced workers tended to have a more positive attitude towards their roles as qualified examiners. In other words, the longer they had been employed in their positions as qualified examiners, the more positive they felt about their role in certifying an individual. If social workers and physicians had more experience with review panels, they might also have more positive attitudes towards review panels. To investigate the relationship between work experiences and attitudes towards review panels, demographic variables including the length of employment, work experiences within and outside British Columbia, and the frequency of participants' involvement with review panels, were included in this study. The relationships between work experiences and attitudes were examined by Hypothesis 2 and Hypothesis 3.

Hypothesis 2: There will be a significant positive association between the social workers' and physicians' work experiences and their attitudes towards review panels.

Hypothesis 3: There will be a significant difference in their attitudes towards review panels between social workers and physicians who are more frequently involved in review panels, and those who are infrequently involved.

Hypotheses of differences between social workers and physicians. The physicians were procedurally responsible, and ultimately legally liable, for certifying patients and hospitalising them against their will. While social workers might make recommendations about certifying a patient, they did not shoulder such legal responsibility of signing the certificates. As a result, physicians might have more training and knowledge about *Mental Health Act* (1999) and review panels. This was examined by Hypotheses 4.1 and 4.2.

Hypothesis 4.1: Physicians will have more training about the *Mental Health Act* than social workers.

Hypothesis 4.2: Physicians will have more training about review panels than social workers.

Participants were also asked to rate their level of knowledge regarding six aspects of the review panel process: (a) composition (membership), (b) roles of different members of review panels, (c) roles of legal advocates, (d) eligibility criteria for applying to review panels, (e) decision-making of review panels, and (e) guidelines for writing reports for review panels. The difference between social workers and physicians in their reported knowledge about review panels was examined by Hypothesis 5.

Hypothesis 5: Physicians will have more knowledge about review panels than social workers.

It was not clear whether social workers and physicians might have different attitudes towards review panels or not. On the one hand, social workers and physicians

might differ in their ideological conceptualisation of mental illness and involuntary hospitalisation as a result of the nature of differences in their professional training. It seemed logical to assume that physicians might adopt a more medical perspective because of their training, while the social workers might be more likely to assume a socio-psychological perspective about mental illness and involuntary hospitalisation. The social workers might be more likely to believe in clients' right to self-determination. As a result, social workers might be more positive towards review panels.

On the other hand, more training and knowledge might lead to the implication that the physicians had more positive attitudes towards review panels. The physicians might tend to err on the safe side, and became over-cautious in certifying patients due to their legal liability in protecting the patients and the public. Therefore, they might be relieved to leave the issue of continual certification to review panels for a legal decision. Moreover, physicians had some options about whether they wanted to be involved in review panels or not, but it was mandatory for social workers to be responsible for discharge planning and additional social work assignments in unanticipated release from review panels. Therefore, social workers might have more negative attitudes towards the panels than physicians. The next hypothesis was made regarding the difference between social workers and physicians in their attitudes towards review panels.

Hypothesis 6: There will be a significant difference between social workers and physicians in their attitudes towards review panels.

Use of Pilot in Refining the Questionnaire

As a pilot, the questionnaire was sent to four social workers and two physicians

who were former employees of Riverview Hospital, and who were assumed to have some experience with review panels in the past. All four social workers completed and returned the questionnaires. This author was informed that one physician had no involvement with review panels, although he had worked at Riverview Hospital for over twenty years. The other physician was successfully contacted in a follow-up phone call to solicit her feedback about the questionnaire. The questionnaire was then modified based on the feedback from this pilot.

Reliability of Measuring Instrument

There was no concern about inter-rater reliability as a self-report measuring instrument was used. The issue of test-retest reliability is not pertinent to this study at a descriptive level of design.

Validity of Measuring Instrument

The manifest content of the questionnaire appeared to have face validity. It also seemed to have content validity as attempts had been made, in developing the questionnaire, to include various perceived issues pertaining to the knowledge and attitudes of social workers and physicians about review panels. This was done through discussions with the staff from many disciplines, the observation of their reactions in the review panel process, and gathering feedback from a small pilot.

At a descriptive level of design, the issues of criterion validity and construct validity did not constitute significant concerns in this study.

Procedures

The subjects were recruited through e-mails to individual social workers, and the physicians were contacted via their medical secretaries because not all physicians were

on the e-mail system. This author also attended the social work staff meeting and the medical staff meeting of the Adult Residential Transfer Program to encourage the return of the questionnaires. Plans to attend the medical staff meetings of the Adult Tertiary Redevelopment Program and the Geriatrics Program, unfortunately, did not materialise due to conflicting schedules.

The questionnaires were distributed with self-addressed return envelopes to all social workers and physicians working on patient service units (wards) at Riverview Hospital via house-mail in the first week of March, 2000. Subjects completed the questionnaires and returned them by house-mail to this author within about a month. All data collected remained anonymous to encourage staff to provide their honest opinions of the review panel process. A covering letter (see Appendix A) accompanied the questionnaires to explain the purpose of the study. It was emphasised that participation in the study was entirely voluntary, and would not affect their working relationship with the investigator, the hospital, or the review panel office. Completion of the questionnaire implied subjects' consent to being surveyed as per the covering letter. The staff meetings provided a formal arena where the purpose of the research was briefly explained to promote the subjects' interest in the research. No coercion and no individual tracking of subjects was used.

Data Analysis

SPSS was used in analysing the data. Frequency tables and measures of central tendency were obtained on the background demographic characteristics, the training and knowledge of participants, and their ratings on the 22 Likert-type items on attitudes. Due

to the small sample size, the general practitioners and the psychiatrist/others were reclassified into one group, the physicians, for analysis.

Eighteen out of the total of 22 Likert-type items used in the questionnaire were grouped under four categories. These include: (a) patient-related issues (items 1, 4, 6, 11, and 14 on part III of the questionnaire); (b) effects on treatment teams (items 3, 7, 15, and 19); (c) role Conflict (items 2, 9, 13, and 18); and (d) operational issues (items 5, 10, 12, 16, and 17).

For the purpose of analysis, the median of six panels was chosen as a cut-off point to differentiate how frequently social workers and physicians were involved in review panels. Those social workers and physicians who were involved in more than six panels in three months were defined as “frequently involved,” and those who were involved in six panels or less in the past three months were referred to as the “infrequently involved” group.

Participants were categorised in three subgroups on the basis of their self-reported level of training. The first group had never received any formal training. The second group had received some training within the last six months, and the third group had received some training more than six months ago. ANOVA (One Way Analysis of Variance) was performed to investigate if there were significant differences between these three subgroups of social workers and physicians, in their self-reported training and their attitudes towards review panels (Hypothesis 1.1 and 1.2).

Pearson's r tests were performed to test if there was a significant association between the social workers' and physicians' work experiences versus their attitudes towards review panels (Hypothesis 2). A t -test was done to find out if there was a

difference in the attitudes between the staff who were frequently involved in review panels, and the staff who were infrequently involved in review panels (Hypothesis 3). T-tests were also performed to address Hypothesis 4.1, Hypothesis 4.2, Hypothesis 5, and Hypothesis 6 regarding the differences between social workers and physicians, in their training about the *Mental Health Act*, their training about review panels, their knowledge of review panels, and their attitudes about review panels. An alpha level of 0.05 was used for all statistical tests.

Results

In 1999, 202 review panels were convened at Riverview Hospital. Patients were released. The number of review panels held while this study was underway was not available from the Mental Health Review Panel Office. All of the 25 social workers and 45 physicians working at Riverview Hospital carrying clinical case-loads on the patient service units at Riverview Hospital, were included as the population group for this study. Physicians who were not assigned to the wards, for example, research physicians, anaestheticians, and duty doctors, were excluded from the study, as they were not involved in the review panel process at all. Thirty-nine social workers and physicians participated in the actual study, giving an overall response rate of 55.7% (comprising a response rate of 76 % for social workers and 44% for doctors).

Major Demographic Characteristics

In the respondent group, there were 19 social workers and 20 doctors. Seven out of the 20 doctors were general physicians, and 13 were psychiatrist or others. Twenty-one respondents were men, and 18 were women. Thirteen (68%) of the social workers were women, while 15 (74%) of the physicians were men. Among the social workers, 8

of them had a Bachelor's Degree in Social Work, while 11 had a Master's Degree in Social Work.

In the following sections, the results on the demographic characteristics and attitudes of social workers and physicians are reported as a group, namely, the "respondents", except for the two sections on "Differences between Social Workers and Physicians" on p.111. In the latter sections, results were reported on social workers and physicians as two separate groups.

Not surprisingly, the largest group of respondents (42.1%) worked in the Adult Tertiary Redevelopment Program (ATRP), which was the acute assessment and treatment area. The patients in that program were more likely to apply for review panels than the patients in the long-stay program or the patients in the geriatrics program. Therefore, the staff in the Adult Tertiary Redevelopment Program probably had more experience with the review panel process. Eight respondents were from the Adult Residential Transfer Program (ARTP). Eight respondents were from the Adult Residential Transfer Program (ARTP). Ten respondents were working in the Geriatrics Program, while the other four worked in more than one area (Figure 3).

Figure 3. Number of respondents by programs and occupation.

Sixty percent of the respondents had worked for more than five years at Riverview Hospital (with a median of 6.75 years). Data on the length of work experience of the sample are summarised in figure 4.

Figure 4. Respondents' length of employment by occupation.

Involvement in Review Panels

Twenty-six respondents (70.3 %) had been involved in six or less review panels in the last three months, at the time of the survey. Figure 5 shows the frequency distribution of social workers and physicians in terms of how often they were involved in the review panels process. With respect to the types of involvement in the review panel process, only 39.5% of respondents had advised the patients of their rights to apply for review panels. Less than half (46.2 %) of the respondents were involved in educating the patients about the purpose and process of the review panels. Similarly, 41 % of the

respondents were involved in educating the families about the review panels. Slightly less than half of social workers and physicians (48.7 %) provided supportive counselling to the patients about their decisions to apply for review panels or not. On the other hand, two-thirds of the respondents were involved in preparing reports for review panels (66.7 %). Only 23.1 % had acted as hospital presenters to state the evidence for detention from the treatment team's point of view. Just over 20% of respondents had participated as one of the three panel members at review panels, making decisions about whether patients should be detained or not, based on the presentations from the treatment team, the patients, and their advocates. Liaising with the legal advocates did not appear to be a regular part of the process, as only 6 social workers and physicians had been involved in this manner during this three-month period (15.4%).

Figure 5. Number of panels involved in last 3 months by occupation.

Training on Mental Health Act and Review Panels

Interestingly, as many as nine social workers and physicians (23.7%) had never received any training on the *Mental Health Act*. Another seven received some training more than 6 months ago, while a slight majority (57.9%) had some training in the past six months. This contrasted sharply with the training the social workers and physicians had received on review panels. Eighteen respondents (50 %) never received any training on review panels while 13 (36.1%) received some training more than 6 months ago. Therefore, only 13.9% had some training on review panels in the past 6 months.

Figure 6. Respondents' training on *Mental Health Act* by occupation.

Knowledge of the Review Panel Process

A slight majority felt they had adequate knowledge of the membership (69.2 %), the roles of the various members (61.5%), eligibility criteria of review panels (61.5%),

and the guidelines in preparing review panel reports (61.5%). Only a bare majority of social workers and physicians reported an adequate level of knowledge of the roles of the legal advocates (53.8%) and the decision-making process of the review panels (56.4%).

Attitudes towards the Review Panel

The mean ratings of 18 Likert-type items are displayed in tables 1 - 4. The other 4 items are discussed in a separate paragraph under "Other Statements". Higher ratings indicate a more positive attitude. "Negative" statements are marked with an asterisk (*). For negative statements, higher ratings denote disagreement with the statements. The attitude statements are categorised under four themes: (a) patient-related issues, (b) effects on treatment team, (c) role conflict, and (d) operational issues. Frequency distribution of respondents' mean ratings on each attitude statement is presented following the tables.

Table 1

Mean Attitude Ratings for Patient-related Issues

Item	Attitude Statement	Mean Rating
1	Review panels give patients a sense of control over their hospitalisation	4.4444
4	Review panels give patients an incentive to improve their behaviours	3.3684
6	Some patients released by review panels would have been better protected if they had remained hospitalised*	1.9487
11	Review panels encourage patients to work collaboratively with their treatment teams for release in future	3.3846
14	Patients should be discouraged from applying to review panels when they lack cognitive abilities to comprehend the purpose of review panels*	3.0000

Table 2

Mean Attitude Ratings for Effects on Treatment Teams

Item	Attitude Statement	Mean Rating
3	Review panels hold treatment teams accountable for effective treatment and discharge planning	2.7143
7	Review panels act as a buffer when there is disagreement between patients and the treatment teams	3.5789
15	Review panels are useful in making legal decisions when the treatment team faces dissenting opinions in detention	3.7568
19	Treatment teams get blamed by community care-givers when patients released by review panels start to deteriorate in the community	2.4324

Table 3

Mean Attitude Ratings for Role Conflict

Item	Attitude Statement	Mean Rating
2	I feel my discussions with patients about their review panels affect our working relationship in a negative way*	4.2973
9	I feel uncomfortable providing “quick-response” follow-up services for patients released by review panels*	2.4857
13	I am working against my team when I discuss with patients their right to apply to review panels*	4.9474
18	It is a violation of patients’ rights to inform their near relatives of their applications to review panels*	4.4848

Table 4

Mean Attitude Ratings for Operational Issues

Item	Attitude Statement	Mean Rating
5	Social work reports and psychiatrists' reports for review panels are not redundant*	5.0513
10	Review panel criteria are not difficult to interpret*	3.4444
12	Current legislation does not give panel members flexibility and options regarding outcomes of review panels*	2.3871
16	Review panels give sufficient consideration to social work assessments when making their decisions	3.9000
17	Social work assessments are not needed when other compelling evidence for detention exists*	4.2632

Patient-related issues. A majority of respondents (77.8%) agreed that review panels gave patients a sense of control over their hospitalisations. Yet, slightly less than half of the respondents (47.4%) felt that review panels gave patients an incentive to improve their behaviours. Similarly, 48.7 % of respondents believed that review panels encouraged patients to work collaboratively with their treatment team for release in future. An overwhelming majority of respondents (87.2%) agreed that some patients released by review panels would have been better protected if they had remained hospitalised. 64.1% of social workers and physicians felt that patients should be discouraged from applying to review panels when they lacked cognitive abilities to comprehend the purpose of review panels.

Effects on treatment teams. Surprisingly, most social workers and physicians (71.4%) did not feel that review panels held the treatment teams accountable for effective treatments and discharge planning. Again, 67.6% of respondents did not find review panels useful in making legal decisions when the treatment teams faced dissenting opinions in detention. A vast majority (83.8 %) of social workers and physicians felt that the treatment teams were blamed by community caregivers when those patients released by review panels started to deteriorate in the community. Nevertheless, 63.2 % agreed that review panels served as a buffer when there was disagreement between the patients and the treatment teams.

Role conflict. Only about one-third (32.4%) of social workers and physicians felt that their discussions with patients about their review panels affected their working relationship in a negative way. In addition, only a minority of respondents (13.2 %) believed that they were working against their teams when they discussed with the patients

their right to apply to review panels. Conversely, a majority (82.9%) of respondents felt uncomfortable providing “quick-response” follow-up services for those patients released by review panels. A majority of respondents (72.7%) did not believe it was a violation of patients’ rights to inform their near relatives of their applications to review panels, despite an initial concern voiced by some staff when the notification to near relatives was incorporated into the *Mental Health Act* (1999). Six respondents (15.4%) were not sure about their opinions regarding this statement.

Operational issues. Only a small percentage (15.4 %) of social workers and physicians found that social work reports and psychiatrists’ reports for review panels were redundant. However, approximately one-third of respondents (34.2%) agreed that social work assessments were not needed when other compelling evidence for detention existed, such as floridly psychotic symptoms and recent violent behaviour. A majority of social workers and physicians (70%) believed that review panels gave sufficient consideration to social work assessments when making their decisions. Interestingly, nine respondents (23.1%) were not sure whether sufficient consideration was given. Fifty-eight percent of respondents agreed that review panel criteria were difficult to interpret. Currently the review panel could only make a decision whether to detain or not to detain a patient. Most respondents (83.9%) felt that current legislation in British Columbia did not give panel members flexibility and options regarding the outcomes of review panels. It should be noted that eight respondents (20.5%) gave a “Not Sure” response to this statement.

Other statements. Most respondents (73 %) felt that patients did not have adequate knowledge of the purpose and the process of review panel hearings. An even

higher percentage (88.2%) of respondents agreed that families did not have adequate knowledge of the purpose and the process of review panel hearings.

Only 34.4% of social workers and physicians agreed that review panels diverted patients with substance abuse and/or legal issues to other services instead of psychiatric commitment, when they were clinically stabilised. Seven respondents (17.9%) gave a "Not Sure" response to this statement. About two-thirds (66.6%) of social workers and physicians would support de-certification of patients if they were likely to be released by review panels.

Relationships between Training and Attitudes

Hypothesis 1.1: Social workers and physicians who receive more training on the *Mental Health Act* will have more positive attitudes towards review panels.

Hypothesis 1.2: Social workers and physicians who receive more training on review panels will have more positive attitudes towards review panels.

There was no significant difference between the respondents' training on *Mental Health Act* and their attitudes. Therefore, Hypothesis 1.1 was refuted. Nevertheless, Hypothesis 1.2 was supported, as the results indicated a significant difference between the respondents' training on review panels and their attitudes. Respondents who have received training on review panels within the last 6 months had a somewhat more positive attitude. They were more likely to feel that the social workers and physicians' reports were not redundant, than those who have received training more than 6 months ago ($p=0.002$). Respondents who have received training within the past 6 months were also more likely than those who have never received any training, to believe that the

current legislation gave review panels flexibility and options regarding their outcomes ($p=0.005$).

Relationships between Work Experience and Attitudes

Hypothesis 2: There will be a significant positive association between the social workers' and physicians' work experiences and their attitudes towards review panels.

Social workers' and physicians' length of employment was negatively correlated with their attitudes towards review panels in three ways. The longer their length of employment, the more likely they were to feel that the social workers' and physicians' reports were redundant (Pearson's $r = -0.319$, $p=0.048$). Interestingly, social workers and physicians who had been working at the Hospital longer were also more likely to find the review panel criteria difficult to interpret (Pearson's $r = -0.463$, $p=0.004$). It seemed more likely for them to feel that they were working against their team when they discussed with the patients about their right to apply to review panels (Pearson's $r = -0.338$, $p=0.038$). No significant difference was found between the respondents' other work experiences within or outside British Columbia and their attitudes towards review panels. Therefore, the findings did not support Hypothesis 2.

Differences between Practitioners who were "Frequently Involved" and "Infrequently Involved"

Hypothesis 3: There is a significant difference in their attitudes towards review panels between social workers and physicians who are more frequently involved in review panels, and those who are infrequently involved.

The results supported Hypothesis 3. Social workers and physicians who were involved more frequently in review panels appeared to experience a higher comfort level regarding their relationship with the patients. They tended to believe that their discussions with the patients about their review panels did not affect their working relationships in a negative way ($p=0.014$). They were more likely to feel that the social workers' and psychiatrists' reports were not redundant ($p=0.024$). They also felt more comfortable in providing "quick-response" follow-up services ($p=0.021$).

Differences between Social Workers and Physicians in their Training and Knowledge

Hypothesis 4.1: Physicians will have more training about the *Mental Health Act* than social workers.

Hypothesis 4.2: Physicians will have more training about review panels than social workers.

Hypothesis 5: Physicians will have more knowledge about review panels than social workers.

No difference was found between social workers and physicians with respect to their training on the *Mental Health Act* and review panels, or their knowledge of review panels. Therefore, Hypothesis 4.1, Hypothesis 4.2 and Hypothesis 5 were refuted.

Differences between Social Workers' and Physicians' Attitudes towards Review Panels

Hypothesis 6: There will be a significant difference between social workers and physicians in their attitudes towards review panels.

Hypothesis 6 was supported. Physicians appeared to have a somewhat more positive attitude towards review panels than social workers. Social workers were more likely than physicians to feel that review panel criteria were difficult to interpret

($p=0.041$). Social workers were also less likely to believe that review panels encouraged the patients to work collaboratively with the treatment teams ($p=0.032$). Moreover, social workers were less likely than physicians to find review panels useful in helping to make legal decisions about detention, when there were dissenting opinions within the teams ($p=0.018$).

Other Comments

Sixteen respondents (41%) provided written feedback regarding their experiences with review panels. Eleven were social workers and the other five were physicians. Several outstanding themes were identified, as follows.

Education of staff, patients and families. One social worker wrote that he was not provided with any knowledge on review panels, but he made an effort to research the topic on his own. Another social worker stated, "More education for patients and families about the review panel process was needed."

Adversarial nature of review panels. One physician commented that, neither the patients' rights, nor their need for protection was best served by an adversarial process. Instead, an alternative of seeking "a second opinion by a group of independent clinicians" was recommended. Currently, patients or their representatives can seek an independent second opinion by another physician under the Mental Health Act (1999), but there is no provision for a review by a group of clinicians. Another physician stated that patients' non-compliant attitudes towards treatment were reinforced by their repeated and regular applications to review panels.

Uniqueness of individual situation. Two social workers and one physician commented that each individual situation was unique, and had to be assessed differently.

Issues related to role conflict. One physician felt that doctors should not act as hospital presenters as it placed them in a conflict of interests. A social worker stated, "Review panel reports significantly damaged therapeutic rapport between the patients and the team when they were read at review panels." One physician also commented that there was a duty to inform families of the right to attend review panels, and to warn families of potential release, even if confidentiality was broken.

Issues related to eligibility criteria. Four social workers and one physician provided comments on the problems regarding the eligibility criteria for review panel applications. Factors affecting patients' competency to apply for review panels included: (a) acute psychiatric symptoms; (b) patients who applied while on open units, but were subsequently transferred to secure care units; (c) cognitive impairment in the geriatric population; and (d) social and placement issues in the geriatric population.

Issues related to the roles of legal advocates. One social worker and one physician raised questions about the training of legal advocates, with respect to their qualification to assess the patients' understanding of the review panel process. They were unsure how the legal advocates' performance was being monitored. One respondent also stated, "I was consulted only once by the advocate during several years of employment at the hospital."

Exclusive nature of the presentation process. Three social workers felt that other disciplines, particularly social workers, should attend review panels for a more direct impact on review panel decisions.

The decision-making process and responsibility of the review panels. One social worker stated, "There were no criteria in review panel decisions." Another social worker

suggested the review panels should take into consideration the patient's history of illness when making their decisions. Two social workers also felt that a review panel should be held legally accountable for their decision if a patient released by review panels decompensated, or became a danger to himself/herself or others.

Economic costs of review panels. Two social workers made reference to the expense of review panels, in terms of monetary and staff resources, especially when a detention was almost inevitable for those applicants who were acutely psychotic, or severely cognitively impaired.

To summarise, the results reflected social workers' and physician's lack of training on review panels and their mixed attitudes towards review panels. Various concerns about the review panel process were raised, including the roles of legal advocates, eligibility criteria, presentation format, economic costs, and the lack of education for patients and families. These findings were presented at Grand Rounds at Riverview Hospital. Feedback from the audience is discussed in the next section.

Grand Rounds Presentation of the Findings at Riverview Hospital

The results of this study were presented at Grand Rounds at Riverview Hospital on January 31, 2000 for two purposes. The Grand Rounds was open to all staff, students-in-training, patients, and families. It was a formal opportunity for respondents to learn about the findings of the study. It also helped to collect further feedback about the study from a wider audience, which included staff from all disciplines, such as nursing staff, rehabilitation therapists, mental health legal advocates, administrative staff, and patients'

advocates. The presentation was videotaped as per hospital practice. The feedback from the audience is summarised, as follows.

Concerns about the Quality of Life of Patients who were Released

Several participants from different disciplines, including physicians, social workers, and nursing staff, voiced quite strong concerns about the prognosis of patients who were released by review panels. Although these patients might not seem to differ from those patients who were released by treatment teams, in terms of their adjustment and their rate of rehospitalisation (Ledwidge et al., 1987), there was no research study about their quality of life following their release. Such concerns seemed to reflect the staff's belief in a psychosocial approach of care for mental patients, instead of the medical model that focused on symptomatic stabilisation.

Psychological Impact on Detained Patients

While a lot of attention had been devoted to the outcomes of review panels when patients were released, little was known about those patients who were detained. Patients might feel defeated, frustrated, or angry about their continual certification, especially when they were detained by repeated hearings.

Patients are "Lost" through Release by Review Panels

As review panel criteria focus on clinical stabilisation and potential deterioration of symptoms, a major benefit of hospitalisation, namely the provision of rehabilitative opportunities, might be neglected. Patients who might have potentially benefited from such rehabilitative programs to improve their life skills and quality of life were "lost" through release by review panels.

Relationship between Discharge Plans and Review Panel Releases

One physician pointed out that quite often patients who were released by review panels were those who had stabilised to some degree. Had they been detained, they would likely have been discharged by their physicians soon after the review panels. Two-thirds of the respondents in this survey indicated a willingness to decertify the patients if a review panel was coming up. This figure was higher than what was reported in literature. The relationship between pre-panel discharge planning and review panel releases was not formally studied.

Summary

In summary, the response rate of the study was quite satisfactory. Many social workers and physicians did not have adequate training on the *Mental Health Act* and the review panels. They also had mixed feelings about review panels. In the next chapter, the findings of the study will be discussed and interpreted within the context of an empowerment model of social work practice. Recommendations will be made regarding the current review panel process to address the needs of the patients, families and staff.

CHAPTER 8

DISCUSSION AND RECOMMENDATIONS

Discussion

This study indicates that there was a general lack of training regarding review panels for the social workers and physicians. Patients and families were believed to have inadequate knowledge of review panels. Various conflicts about the review panel process were also apparent, including its adversarial nature, staff frustration about review panel decisions, and questions about the role of legal advocates.

Lack of Training

The *Mental Health Act* (1999) came into effect in November 1999, and it led to a recent flood of workshops held at Riverview Hospital. As a result, one would have anticipated that more practitioners would have attended those training workshops. Yet, the percentage of social workers and physicians who had received training on the *Mental Health Act* in the past three months (57.9%) turned out to be lower than expected. In fact, 50% of the social workers and physicians had never received any training on review panels. Despite this apparent inadequate level of training, social workers and physicians generally reported having fairly adequate knowledge of the review panel process. As stated by a social worker in his written feedback, social workers and physicians had to “learn on the job.”

Such a glaring lack of formal training is far from satisfactory, and it constitutes a concern for professional practice. Social workers and physicians play a pivotal role in the patients’ continual detention, including educating patients and families about the

review panel process, providing support and counselling for patients, and preparing documentation for the panels. Therefore, training on the *Mental Health Act* and review panels should be made mandatory for social workers and physicians. This will be further discussed on p. 122-137 in the “Recommendations” section.

Queries about the Roles of Legal Advocates

Respondents' written comments further underscored their concerns about the role of the legal advocates, the social workers' and physicians' frustration with review panel decisions, and the lack of review panel members' accountability in some situations. Some respondents suggested releasing review panel annual reports and arranging annual meetings between the hospital staff and the Mental Health Law Program, to exchange information and to foster mutual understanding.

These findings echo Miller's vivid description (1985, p. 17) of legal advocates as a travelling hit squad which “makes the circuit of hospitals in an attempt to stir up business, by suggesting grievances and law suits to patients who have not sought legal counsel or expressed dissatisfaction with their treatment.” To address staff's concerns about review panel decisions and the roles of legal advocates, regular meetings and information sharing among social workers, physicians, review panel office staff, and legal advocates would be helpful. This is consistent with Myers' (1997) belief in the value of encouraging constructive dialogue between patients and their representatives, doctors, and social workers.

Factors associated with Attitudes

Those respondents who were more frequently involved with review panels had more positive attitudes towards them. Respondents' training on review panels was also

positively correlated with their attitudes towards them. Physicians had more positive attitudes towards review panels than social workers. These factors are further discussed as follows.

Frequency of involvement with review panels. Persad and Kazarian's study (1998) reveals that length of institutional affiliation is one of the best predictors of satisfaction scores about Ontario review boards. The results of this author's study somewhat contradict Persad and Kazarian's findings (1998). In this author's study, the respondents' length of employment had a negative correlation with their attitudes. Those respondents who had worked longer at Riverview Hospital were more likely to believe that they were working against their teams when they discussed with the patients about review panels. They were also more likely to believe that the psychiatrists' and social workers' reports were redundant, and that the committal criteria were difficult to interpret. There were insufficient data to explain such a correlation. Instead, positive attitudes were found in those respondents who had a higher frequency of involvement with review panels. Those respondents who were more frequently involved in review panels reported a higher comfort level in providing quick-response follow-up services. They were also less likely to find that review panels affected their relationships in a negative way, or to find social workers' and psychiatrists' reports redundant.

It appears that in this author's study, institutional affiliation, or length of employment, is a more global measure of clinical experience, but not a specific measure of experiences with review panels, due to the variation in the respondents' roles and responsibilities as social workers, general practitioners, or psychiatrists. Notably, one physician indicated, "I have worked here for many years, but I have not attended a

hearing or written a review panel report.” On the other hand, the frequency of their involvement with review panels is a more direct and specific measure of their experiences with review panels. The finding that those social workers and physicians who were more frequently involved had more positive attitudes towards review panels, is consistent with Dworkin’s claim (1989) that more experienced practitioners have a more positive attitude regarding their role in certifying patients.

Training on review panels. Respondents who had more training on review panels seemed to have more positive attitudes. This reflects the importance of providing training to social workers and physicians to reduce their frustration with review panels. In fact, O’Reilly et al (1999) suggest that the lower rate of patients discharged by review boards, compared to previous studies, might be a result of a concerted efforts by the hospitals to improve physician skills through continuing education in preparing for, and in presenting at, review boards,.

Occupation. There was no significant difference between social workers and physicians in their training and knowledge of review panels. Yet, the social workers found review panel criteria more difficult to interpret, and they did not find review panels helpful in making legal decisions.

Instead of indicating a lack of knowledge, the difference between social workers and physicians in their attitudes might have two possible explanations. First, perhaps it reflects a more psycho-social perspective adopted by social workers, rather than a medical perspective that emphasises mere symptomatic stabilisation. Social workers are likely to put a stronger emphasis on the social factors impacting on the individual’s life when they make recommendations regarding the person's continued detention. It is

difficult to define and interpret the concept of social harm in the *Mental Health Act* (1999). Therefore, social workers may be more likely than physicians to feel that there are limits in applying legal criteria to make decisions about involuntary hospitalisation. Such a difference in professional perspectives perhaps also explains why nine respondents were not sure whether review panel decisions gave sufficient consideration to social work assessments or not.

Second, physicians may find review panels more useful in making legal decisions because it is the physicians, not the social workers, who shoulder the legal liability in certifying patients (Adam, Pitre & Cieszkowski, 1997). As the underprediction of dangerousness can result in tragedy, there is apparently a propensity for physicians on the treatment teams to be over-cautious in maintaining patients on certificates and to over-predict dangerousness (Halleck, 1983). The physicians are relieved of any legal liability when it is left to the review panel to make decisions about a patient's release. This might explain why physicians had more positive attitudes toward review panels than social workers.

Limitations of the Study

Time and Resources

Due to the limitation of time and resources, the sample in this study was confined to social workers and physicians at Riverview Hospital. In general hospitals, the social workers are not routinely involved in preparation for review panels. The patients are less chronic, and their periods of hospitalisation are shorter. The training and attitudes of

social workers and physicians in general hospitals may be different and will require further study.

Hospital staff from other disciplines are also closely involved in patients' treatment and care. Nursing staff, in particular, may be involved in educating patients about their rights to apply to review panels. They may also need to deal with the aftermath of review panels, which may include managing angry and frustrated patients who are detained, or working with uncooperative patients who are released, and who no longer comply with hospital routines. An understanding of the nursing staff's perception of review panels would help to make recommendations about the current review panel process.

Last but not the least, as a result of the limits of time and resources, it was not feasible to explore the patients' and families' perception of review panels. The findings of this study identify several patient-related issues in the review panel process. A future study of their experiences with review panels would provide invaluable insight.

Limitation of a Mail-in Questionnaire

An inherent limitation of the use of a mail-in questionnaire resulted in the participants not having the opportunity to clarify their answers with the researcher, in case there was any ambiguity. The percentage of "Not Sure" responses for 33 out of the 39 attitude statements was less than 10%. Most of the statements seemed to be quite self-explanatory, yet 17.9 % of respondents gave a "Not Sure" response to the statement related to the availability of options in review panel outcomes, and 20.5 % gave a "Not Sure" response to another statement concerning whether it was a violation of patients' rights to inform their near-relatives of the applications or not. This reflected some

ambiguity or confusion about these two statements. A mail-in questionnaire precluded the possibility of clarifying these statements for more accurate responses. It also did not allow the in-depth exploration of the participants' understanding of review panels.

Limitation of a Descriptive Design

As a result of the limited time and scope of this study, no information on the cultural or racial background of social workers and physicians was collected. For the same reason, no further attempt was made to analyse the data on gender distribution among social workers and physicians.

Recommendations

The results of this study reveal that neither social workers nor physicians had adequate training on the *Mental Health Act* and review panels. The practice of legal advocates was questioned. Social workers and physicians also experienced a dilemma in working with patients who were appealing their involuntary hospitalisation. While the client's right to an appeal process through review panels is duly recognised as a reflection of the principle of self-determination, a practice dilemma arises when the patient's ability to make decisions about review panel applications is impaired by his/her illness. These findings have significant implications for practice, specifically, providing training for social workers and physicians, facilitating communication with legal advocates, and empowering patients in the review panel process.

Training for Social Workers and Physicians

Involuntary hospitalisation involves an infringement of an individual's civil rights and liberty. A review panel decision about whether to keep an individual in the hospital or not, should be exercised cautiously and ethically, involving careful consideration of an

individual's clinical conditions and social factors. Current literature has indicated the importance of knowledge in allowing a practitioner to perform his/her roles and in reducing staff frustration. The results of this study also confirm a positive correlation between a respondent's training on review panels and his/her attitudes towards them. Therefore, training on the *Mental Health Act* (1999) and review panels should be made mandatory for all social workers, physicians, and legal advocates. This would also provide a forum for social workers, physicians, and legal advocates to discuss the difficulties in interpreting the *Mental Health Act* (1999), and to develop a more consistent understanding of the concept of social and personal harm.

Quite a number of significant changes have been introduced into the *Mental Health Act* (1999). The renewed attention to extended leave status allows individuals to remain committed while they are living in community facilities. This has far-reaching impact on care and service delivery, discharge planning, and collaboration with community care-providers. Many new forms have been implemented with the *Mental Health Act* (1999), for example, forms requiring mandatory notification of a patient's near relative when an application for review panel is made. This inevitably leads to changes in the duties and responsibilities of social workers and physicians. Social workers and physicians are constantly and directly involved with patient care and services in terms of treatment and discharge planning. Therefore, they need to be well abreast of the changes in the *Mental Health Act* (1999) and its legal and clinical implications in their practice. Clearer guidelines and protocol from hospital administration are needed immediately, to make sure that social workers, physicians, and

other staff are aware of any changes in their duties and responsibilities in providing care and arranging services for patients.

This leads to a second question about the apparent discrepancy between the provision of training opportunities and the utilisation of those opportunities. The current schedule of training workshops needs to be reviewed, and the managers of patient service units (wards) will need to ensure that their staff have received training.

Balancing Patients' Rights and Need for Treatment

The findings of this study reflect the same dilemma indicated by current literature, namely, that there is no hard-and-fast answer to protecting patients' civil rights, while their needs for treatment are served and the interests of the public are protected. Patients have the right to self-determination and freedom like any citizen does, but at times, their rights need to be balanced against their need for treatment. It is a delicate balance that necessitates cautious professional judgement.

Each individual situation leading to involuntary hospitalisation is unique and involves a combination of medical, psychological, and social factors. Treatment needs to be provided in the least restrictive manner in a world with limited resources. Training for mental health professionals should include, not only interpretation of the certification criteria from a medical perspective, but also, the consideration of psychosocial factors in determining the need for protection of patients or others. Training for social workers and physicians should also help them recognise that an adversarial process may be necessary to protect patients' rights. Working with conflicting principles and ethical dilemma is an inherent part of clinical practice with people with mental illness. It is essential for mental health professionals to develop the skills to deal with such role conflict.

Furthermore, training should be provided for staff to improve their awareness of the power differences between patients and mental health professionals. The findings of this study indicate that less than half of the respondents (i.e., social workers and physicians) were involved in educating the patients and providing them with support, regarding the review panel process, although two-thirds of the respondents did not feel such discussions would affect their relationships with the patients. Guided by a self-reflective, socially sensitive, and strengths-focused practice, social workers and physicians need to be trained to provide such support and education for the patients. A self-reflective practice alerts social workers and physicians to the biases of the medical approach to mental illness and the power of the psychiatric institution. A socially and culturally sensitive practice would guide the mental health professionals in taking a curious stance in understanding patients' knowledge of their experiences with involuntary hospitalisations and review panels. Social workers and physicians should acknowledge the patients' experiences with mental illness, and recognise their sense of powerlessness about involuntary hospitalisation, while reviewing the decision to apply for review panels with the patients. It is also a good opportunity for social workers and physicians to involve the patients, as much as possible, in making decisions about their treatment and discharge planning. Although the patients' rights to apply for review panels are recognised, they need to be encouraged to work collaboratively with the treatment team for a release, by focusing on their strengths and potential.

Improved Communication with Legal Advocates

Various concerns have been raised about the training and the practice of the legal advocates in this study. It is important that social workers and physicians are provided

with opportunities for training and dialogue with the Mental Health Law Program (for which the legal advocates work). This would help to further the social workers' and physicians' understanding of the legal aspects of the review panel process. Periodic meetings would be useful to improve communication, and to develop a mutual understanding of the roles of social workers, physicians, and legal advocates. Furthermore, interdisciplinary collaboration between social workers, physicians, and legal advocates should be encouraged, to review the patients' progress, treatment, and the appropriateness of their review panel applications.

Education for Patients and Families

Neither the patients nor the families reportedly had adequate knowledge of review panels. Patients' lack of knowledge and understanding of review panels appeared to have a negative impact on social workers' and physicians' attitudes towards review panels, as indicated by the respondent's written comments. In a study by O'Reilly, Komer & Dunbar (1999), the "availability of significant others to assist patients if released by review panels" was cited as the reason for release in 13 out of 105 cases (12.4%). It was not sure if these significant others understood the review panel process and the responsibilities entailed in the release. Patients' and families' understanding of review panels might be hindered by language barriers and limited access to resources due to their cultural backgrounds. For patients and their families to truly benefit from exercising their rights to apply for a review panel, it will be important to educate patients and families concerning the review panel process. It is also imperative to be aware of how patients' and families' cultural differences affect their understanding of mental illness, their perception of legal hearings, and their relationships with mental health professionals.

Respondents also had concerns about the cost of review panels. The figures on the economic cost of review panels in British Columbia or Ontario are not available. Nevertheless, according to Persad and Kazarian (1998, p. 906), "the direct and indirect cost of mental health review tribunals in the United Kingdom was estimated at £12, 274, 380 per annum." These concerns point to a need to improve how patients are prepared for their review panel applications. While the value of a due process for patients to appeal a detention is recognised, merely being informed of their right to apply (as required by current legislation) may not be the best answer to this ethical dilemma. Instead, it is recommended that an educational component be added to the review panel process. Current legislation does not allow the mandatory inclusion of such an educational process. Nevertheless, individuals applying to review panels should be strongly encouraged to attend educational programs, so that they can make informed decisions about their applications and their discharge options. Given the queries regarding the roles of the legal advocates and their impact on the patients' decision to apply to review panels, education for the patients can best be provided in partnership with the Mental Health Law Program or patient advocacy organisations. This will be discussed further in the following section.

Empowerment Model of Social Work Practice with Involuntary Patients

Involuntary hospitalisation is a deprivation of an individual's civil liberty and sense of control. Patients easily become helpless individuals subjected to the gaze of the medical institution. Involuntary hospitalisation is an extremely disempowering experience for individuals with mental illness. As the findings of this study indicate, review panels may, in theory, help patients to reinstate a sense of control and mastery

over their lives. However, the current review panel process falls short of re-empowering individuals. On the contrary, repeated detention, and a questionable quality of life following unanticipated releases with little community supports, can induce a sense of frustration and defeat in the patients. Just being given the chance to appeal their hospitalisation through review panels does not, in practice, allow individuals to exercise their rights properly. The legal establishment supports the patients' need for appeal hearings, partly for their own vested interests. Paralegal advocates and lawyers are paid to "assist" the patients in their applications. Yet, when patients sign the applications for review panels without any understanding of the committal criteria and without any knowledge of support services available in the community, they are not able to benefit from the applications. The legal interpretation of the *Mental Health Act* is a body of knowledge that is beyond the understanding of many people, even those who are not mental patients. It may be particularly problematic for those patients who have limited English-speaking ability. This knowledge redefines mental patients as legal clients, who are led through the review panel process under a different set of rules established by the legal institution. Under the gaze of the legal institution, some patients remain powerless individuals, who are simply going through the motions of hearings without receiving any real assistance.

Chamberlin (1993) states that empowerment includes the ability to make choices, and making such choices cannot occur in a vacuum. Instead, access to information, assertiveness, positive self-esteem, learning to think critically, and learning the skills important to the patients, are all essential to assist individuals in weighing the pros and cons of each option, thereby becoming empowered in the process. In keeping with the

empowerment model of social work practice, it is recommended that an educational program be initiated to provide patients with the support and resources required to prepare for the review panels. An educational program would also help patients learn about available community resources and the skills required to live independently, so that they can achieve their goal of being released from the hospital. An educational program should incorporate several elements, including: (a) teaching individuals the skills required to access and organise their support services, (b) encouraging individuals to attend rehabilitative programs, and (c) providing peer support regarding the experiences of going through the hearings.

The educational process can complement the patients' treatment plans by encouraging them to utilise appropriate resources to make decisions about their treatment. Individuals should be seen as collaborators and partners, rather than patients (Morris, 1995). Efforts need to be made to ensure that clients are aware of their right to due process, and that they receive proper support to navigate their way through the myriad of medical and legal systems. Patients need to develop much-needed knowledge about community resources, and about the skills needed for independent living. Through exercising their rights to an appeal, and being equipped with the knowledge and skills needed, they can redevelop an internal locus of control and become empowered at an individual level.

At the group level, patients' experiences with involuntary hospitalisation are shared with, and validated by, peer support. They can be assisted in identifying the socio-political factors that shape the image of mental illness. This helps to promote collective consciousness concerning the impact of social forces on individuals.

Consistent with the recovery conceptualisation of services, the self-help component of the educational program empowers the group to reduce their disabilities and disadvantages (Anthony, 1993). Group participation allows patients to redefine their roles as helpers and leaders, rather than passive victims. They can search for new meanings of their illness and new goals of their lives. They can also work collectively to remove systemic barriers that limit their opportunities and thwart their growth.

At the societal level, patients need to develop the skills, knowledge, and action strategies that aim at promoting wider changes at a macro-societal level, such as demystifying mental illness and dangerousness, mobilising community resources, and achieving equity of access to resources. Appropriate resources for individuals with mental illness, including housing, financial assistance, employment, education opportunities, and social support, need to be provided so that treatment can be offered in the least restrictive manner possible. Such an educational initiative is consistent with Abramson's approach (1985) of existential advocacy to promote client self-determination by helping them clarify their wants, needs, and values; identifying alternatives; and providing information to facilitate decision-making. It is hoped that review panels can then become a truly empowering process.

Examining Alternatives to Review Panels and Involuntary Hospitalisation

Paredes et al. (1987, p. 446) suggest that "hospital staff should be educated that for some patients a review panel discharge might have beneficial therapeutic aspects." However, such therapeutic effects of review panels are not clear. The results of this author's study indicate that the respondents generally harboured only slightly positive attitudes towards two items, specifically, about "giving patients a sense of control," and

"buffering the disagreement between patients and their treatment teams." In fact, the findings reflect negative ratings on most of the attitude statements. Review panels seemed to lead to frustration among social workers and physicians regarding eligibility criteria and review panels decisions. Some respondents believed that it was inappropriate for patients with cognitive impairment, or with little understanding of the review panel process, to apply to review panels. Neither social workers nor physicians felt comfortable providing "quick-response" follow-up services. Treatment teams were likely to get blamed by families and community caregivers when a patient released by a review panel started to decompensate. Most respondents also felt that current legislation did not provide review panels with options in making decisions. These findings seem to echo Persad and Kazarian's (1998, p. 907) comment that "a majority of physicians view review boards as overly legalistic, adversarial, and expensive means of determining a patient's certifiability." It also confirms the belief that "while the fundamental principle of protecting the civil and legal of rights is not disputed, the clinical perspective questions the net social and economic benefits" of review panels (Chan & Conacher, 1994, p. 433).

In view of its adversarial nature, some mental health professionals argue that the review panel process may not be the best avenue to address the need to balance the patients' civil rights with their need for protection. One physician in this study recommended that efforts be made to look at a less adversarial process such as obtaining a second opinion by an independent panel of a group of clinicians (e.g., psychiatrists and general practitioners) who are accountable to the public for the release of patients. However, some legal advocates argue that the adversarial process is the only way of protecting clients' rights. Alternatively, a review of legislation, to allow some flexibility

and options in review panel outcomes, may be helpful. Current data in this study does not address specifically the advantages and disadvantages of other alternatives to review panels. Further studies comparing the experiences of patients, families, and professionals regarding review panels and other alternatives for protecting patients' rights would be needed before further recommendations can be made about a less adversarial process or other options. In view of limitation of resources, this author believes that improvements to the existing system concerning review panels should take priority over attempts to explore other alternatives. Nevertheless, a discussion on the need for changes in legislation can be included in the education and support program for hospital patients, proposed previously in this thesis, to promote collective consciousness and critical thinking. Changes in legislation would also be an appropriate issue for further examination by community advocacy groups to involve mental health clients and families. In future studies, it would be most important to listen to the patients and families, to find out what alternatives may best serve the patients' needs and protect their rights.

In British Columbia, there are a number of organisations that can probably play an important role in advocating for a study of the impact of the changes in the Mental Health Act (1999) on the provision of services, and an evaluation of review panels and other alternatives. These organizations have been very active and instrumental in advocating for the rights of individuals with mental illness, providing education and support for patients and families, developing appropriate resources, and improving public awareness and understanding of mental illness. The Mental Patients Association works to assist in the rehabilitation of mental patients, to promote the welfare of patients, and to establish

and operate social, vocational, recreational, residential, and emergency services (About the MPA, 2001). Their Mental Health Empowerment Advocates Program helps to educate mental health consumers on their rights and to share self-help skills. The Canadian Mental Health Association was founded in 1918. It supports education and research projects in relation to employment, housing, early intervention, peer support, recreation services for people with mental illness, and it runs public education campaigns for the community. Although less rights-oriented than the Mental Patients' Association, it also acts as a social advocate to encourage public action and commitment to strengthening community mental health services and legislation and policies affecting services (About CMHA, 2002). On the other hand, the British Columbia Schizophrenia Society is seen as pro-treatment. It is mandated to work at the provincial level to improve legislation that affects people with schizophrenia and other serious and persistent mental illness (British Columbia Schizophrenia Society, 2002). It brings an interesting perspective with a focus on patients' rights to access treatment and their need for services, instead of a right to self-determination. A review of possible alternatives to review panels and involuntary hospitalisation, and an examination of the impact of the changes in the *Mental Health Act* (1999) on mental patients calls for collective examination by these community advocacy organisations. Some of these proposed alternatives are described on p. 69-72 in chapter 6.

Adams et al. (1997) and O'Reilly et al. (1999) advocate for a status less restrictive than involuntary hospitalisations, called community treatment orders, which is similar to the extended leave status stipulated in the *British Columbia Mental Health Act* (1999). It is argued that such a status would allow mental patients to be treated in the community

without more intrusive, coercive hospitalisation, and it would foster continuity of care with flexibility (Gray & Clements, 1998). Yet, the question of intrusiveness remains controversial. Although patients generally prefer to live in the community rather than in the hospital, the community treatment order is not without its flaws. A new question has emerged with the implementation of the community treatment order (McDonnell & Bartholomew, 1997, p.32): "How does a patient get out of the psychiatric system as opposed to just getting out of hospital?" It is suggested that the criteria and duration of the order need to be clearly specified. It is also emphasised that a holistic approach towards care, which ensures patients' access to supportive therapies, should be provided in the community setting (McDonnell & Bartholomew, 1997). As Myers (1997) points out, the ultimate reconciliation between patients' rights and their need/right for treatment is likely to come from sources outside the review panels. More public tolerance, better care in the community, and improved conditions in psychiatric hospitals are required. True community integration aims at providing resources to maximise the growth and potential of clients, instead of mere reduction of patient recidivism (Sullivan, 1992).

There has been renewed emphasis on the provision of extended leave under the new *Mental Health Act* (1999) in British Columbia. A study on patients' experiences with the extended leave status in British Columbia, that enforces treatment of individuals in the community, would offer an interesting contrast with their experiences with review panels.

Review of Current Operational Procedures of Review Panels

It is interesting that, in this author's study, one-third of the social worker and physicians agreed that social work assessments were not needed when other compelling

evidence for certification was present. However, only a minority of respondents felt that social workers' and psychiatrists' reports were redundant. This seems to recognise the contribution of social work assessments, but perhaps reflects staff's frustration with the workload associated with review panel applications. Such staff frustration is likely to be higher when they are working with patients who are recently transferred to Riverview Hospital after they have been treated in acute care hospitals for a period of time. The mere fact of their transfers to Riverview Hospital implies a need for continued treatment, and the patients are still extremely unsettled, due to their floridly psychotic symptoms or mood lability, following unsuccessful treatment at the acute care hospitals. Despite this, they are often eligible to apply for review panels since the initial certificates for involuntary detention are only valid for a month. There is insufficient data to suggest a solution to reduce staff frustration. However, the compulsory requirement for social work assessments and social workers' workload issues need to be reviewed. The value of social work assessments should be maintained without an excessive adverse impact on the workers.

In addition, some practical suggestions have been provided, from a social work and a legal perspective, regarding what should be included in the assessment, despite the difficulties with the interpretation of committal criteria (McLeod & Milstein, 1993). It is suggested that differentiation be made between *evidence* and *hearsay*, so that specific examples are presented to explicate effectively the treatment teams' concerns about the need for protection of individuals or others. In addition, it is more convincing to provide evidence of the presence of positive symptoms rather than the presence of negative symptoms.

In this author's study, there were comments from several respondents regarding the lack of interdisciplinary input at review panel presentations. Currently, social workers very rarely attend review panels. Social work assessments are presented, usually in a summary form, by hospital appointees, who are typically psychiatrists. Since social workers have the responsibility of providing quick-response follow-up services, social workers should be offered the opportunity to attend review panel hearings. Although some social workers at Riverview have voiced concerns about the adverse impact of review panel reports, the findings indicate that less than one-third of respondents felt that review panels led to adverse effect on their relationships with the patients. Therefore, the need to review the presentation format seems justified. This author was invited by a psychiatrist to help to present the opinions of the treatment team at one review panel hearing. In this example, the patient suffered from moderate cognitive impairment, particularly in her judgement, planning, and organisation. Nevertheless, her social skills were intact, and this enabled her to present herself in a very impressive manner in interpersonal interaction. It was felt that the chance of a release for this patient was fairly high, as her common-law husband had agreed to support her. This author spent an additional hour preparing for the presentation and attending the hearing. Drawing on information from personal communication with the patient's mother and the patient's worker from the health services of another province, this author was able to present their concerns regarding the couple's relationship conflicts. This author also directed the panel members to review the details of the patient's neuropsychological testing, which included abundant evidence of her cognitive deficits. The panel concluded that the patient should be detained.

It is time consuming to prepare for the presentation and to attend the hearings. It also means extra work for the social workers, who already have heavy caseloads. However, social work assessments might have a more direct impact on the decisions of the panels if social workers are able to present at the hearing. Therefore, social workers would need to balance the pros and cons of such participation to decide whether their attendance at the hearing would be useful or not.

O'Reilly et al. (1999) also recommend the presentation of evidence by ward staff or family members who witness acts of violence or self-harm instead of relying on opinions. Moreover, given staff's role conflict in providing quick-response follow-up services, when patients are released by review panels, it would be helpful to explore the possibility of having an independent social worker at the review panel office to arrange referrals to community support services.

Proposed Areas for Further Research

As the *Mental Health Act* just came into effect in 1999, it would be interesting to repeat the study in the future, to see if there is any difference in social worker and physicians' attitudes toward review panels. Some of the statements in the questionnaire used for this author's study would need to be modified to improve clarity, if the study is to be repeated in future. In addition, future studies should take into consideration that the monthly statistics on the number of review panels convened in each year are not available from the Mental Health Review Panel office at this time. Under the new *British Columbia Mental Health Act (1999)*, patients can be committed in the community on extended leave status to ensure their compliance with treatment. It remains to be seen

how the extended leave status is being operationalised in British Columbia, and what its impact on involuntary hospitalisation will be.

To complement the findings of this study on review panels, it would be worthwhile to explore patients' experiences with review panels. Future research studies should be done on patients' views about review panels. In addition to complementing the current findings, it would also help to empower the patients by involving them as research participants. Their experiences would be invaluable in reviewing the review panel process and in exploring ways to better serve their interests and protect their rights. Patients can also be recruited as interviewers, or as assistants in collecting data, and in developing questionnaires or interview guides for future studies.

Further research studies looking into the attitudes of review panel members and legal advocates would provide more information about review panels, particularly the decision-making process. Implementing a similar survey with social workers and physicians working in general hospitals might also help to identify further concerns about the review panel process. In addition, it would be interesting to collect data on the gender and cultural characteristics of the respondents, and to use regression analysis to examine the impact of these variables on their attitudes towards review panels in future studies.

Summary of Implications for Social Work Practice

In summary, the findings of this study indicate a lack of training for social workers and physicians, concern about the roles of legal advocates, lack of education for patients and families, and frustration about operational issues. Implications for practice are outlined, as follows:

1. Sufficient and updated training should be given to social workers and physicians, especially to those who are frequently involved with review panels.
2. A self-reflective and strengths-focused practice, sensitive to the patients' cultural diversity and their subjective experiences with involuntary hospitalisation, should be adopted.
3. Education regarding the review panel process should be provided for patients and families by the Mental Health Law Program.
4. An educational component should be instituted (in partnership with Mental Health Law Program) to support patients who are planning to apply to review panels, so that patients can make informed decisions and learn the skills to prepare for review panels.
5. More collaboration between the treatment teams and legal advocates is needed to serve the patients better in terms of protecting their legal rights, while treatment is provided.
6. Further exploration of possible alternatives, including a second opinion by a group of physicians, would be useful.
7. A review of the current format of social work assessments, presentation at review panel hearings, and the responsibility for arranging follow-up support services is needed.
8. Further research on the perception of other service-providers, the experiences of patients about review panels, and the impact of cultural variables on attitudes would be invaluable, and is highly recommended.

Conclusion

When individuals with mental illness are hospitalised against their will, they are placed in a “no-win” situation, and so are the staff. Involuntary hospitalisation, and hence the appeal process of review panels, are inherently ridden with conflict from a theoretical, legal, and operational perspective. Social workers and physicians who were involved in review panels had mixed feelings about the process. Physicians seemed to have more positive attitudes towards review panels than social workers in certain respects. In addition, social workers and physicians who were more frequently involved, or those who had more updated training on review panels, tended to have somewhat more positive attitudes towards review panels. The lack of training for social workers and physicians was apparent. Neither patients nor families had adequate knowledge of review panels.

Informed by an empowerment model of social work practice, it is recommended that education be provided for patients and families regarding the review panel process. Patients could benefit from more education and support about how to make informed decisions. They could also learn to develop the skills and to access the resources necessary to prepare themselves for the review panel hearings. Moreover, such an educational process could help to raise collective consciousness among the patients, and to identify systemic forces impacting on the lives of mental patients, leading to political and societal reforms. Review panels could then become a truly empowering experience for individuals who are hospitalised against their will.

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**Riverview
Hospital**

Please do not put your name on the questionnaire. The results of the questionnaire will be anonymous and will be destroyed when the study is completed. A written report will be made available upon request at the completion of the study in April 2000. If you have any questions, please contact Dr. Carole Christensen, principal investigator, or So-han Yip, co-investigator at the above numbers.

Thank you for your anticipated participation in this study.

Social Workers= and Physicians= Experience with Review Panels

Part I

8. Have you attended/received formal training /workshops on the following topics:

- Part II

(1) composition (membership) of review panels:
 ___ no or little knowledge ___ some knowledge ___ adequate knowledge

(2) roles of different members of review panels:
 ___ no or little knowledge ___ some knowledge ___ adequate knowledge

Appendix B

(3) roles of legal advocates:

___ no or little knowledge ___ some knowledge ___ adequate knowledge

(4) eligibility criteria for applying to review panels:

___ no or little knowledge ___ some knowledge ___ adequate knowledge

(5) decision-making of review panels:

___ no or little knowledge ___ some knowledge ___ adequate knowledge

(6) guidelines for writing reports for review panels:

___ no or little knowledge ___ some knowledge ___ adequate knowledge

Part III

Please indicate how much you agree/disagree with the following statements by marking a circle on a scale of 1 - 6, with A1" indicating Astrongly disagree and A6" indicating Astrongly agree :

	Not sure 0	strongly disagree 1	2	3	4	5	strongly agree 6
(1) Review panels give patients a sense of control over their hospitalizations.	0	1	2	3	4	5	6
(2) I feel my discussions with patients about their review panels affect our working relationship in a negative way.	0	1	2	3	4	5	6
(3) Review panels hold treatment teams accountable for effective treatment and discharge planning.	0	1	2	3	4	5	6
(4) Review panels give patients an incentive to improve their behaviours.	0	1	2	3	4	5	6
(5) Social work reports and psychiatrists= reports for review panels are redundant.	0	1	2	3	4	5	6
(6) Some patients released by review panels would have been better protected if they had remained hospitalized.	0	1	2	3	4	5	6
(7) Review panels act as a buffer when there is disagreement between patients and the treatment teams.	0	1	2	3	4	5	6
(8) Review panels divert patients with substance abuse and/or legal issues to services other than psychiatric commitment when they are clinically stabilized.	0	1	2	3	4	5	6
(9) I feel uncomfortable providing Aquick-response follow-up services for patients released by review panels.	0	1	2	3	4	5	6
(10) Review panel criteria are difficult to interpret.	0	1	2	3	4	5	6
(11) Review panels encourage patients to work collaboratively with their treatment teams for release in future.	0	1	2	3	4	5	6

Appendix B

	sure	Not disagree	strongly			agree	strongly		
		0	1	2	3	4	5	6	
(12) Current legislation does not give panel members flexibility and options regarding outcomes of review panels. For example, there is a review panel outcome called Adischarge pending placement in New Jersey in the States.		0		1	2	3	4	5	6
(13) I am working against my team when I discuss with patients about their right to apply to review panels.		0		1	2	3	4	5	6
(14) Patients should be discouraged from applying to review panels when they lack cognitive abilities to comprehend the purpose of review panels.		0		1	2	3	4	5	6
(15) Review panels are useful in making legal decisions when the treatment team faces dissenting opinions in detention		0		1	2	3	4	5	6
(16) Review panels give sufficient consideration to social work assessments when making their decisions.		0		1	2	3	4	5	6
(17) Social work assessments are not needed when other compelling evidence for detention exists e.g. floridly psychotic symptoms, recent violent behaviours.		0		1	2	3	4	5	6
(18) It is a violation of patients' rights to inform their near relatives of their applications to review panels.		0		1	2	3	4	5	6
(19) Treatment teams get blamed by community care-givers e.g. families, mental health teams, etc. when patients released by review panels start to deteriorate in the community.		0		1	2	3	4	5	6
(20) Patients have adequate knowledge of the purpose and process of review panel hearings.	0		1	2	3	4	5	6	
(21) I will support Adcertification of patients if they are likely to be released by review panels.		0		1	2	3	4	5	6
(22) Families have adequate knowledge of the purpose and process of review panel hearings.	0		1	2	3	4	5	6	

Do you have other comments or suggestions about review panels?

Thank you for participating in this study.