



**Newfoundland and Labrador
Mental Health Care and Treatment Act Evaluation
Final Report**

**Prepared By
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Newfoundland and Labrador Centre for Health Information
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Executive Summary

Newfoundland and Labrador's Mental Health Care and Treatment Act (MHCTA) was proclaimed in 2006 and came into effect in October, 2007. The community treatment order (CTO) provisions were deferred until January 1, 2008. A CTO refers to a plan of involuntary treatment within the community. Before proclamation in 2006, the Act had not been updated since 1971. The need for new legislation was highlighted after the death of Thomas Hagan in 1980. Thomas Hagan was killed by a neighbor who lived with a mental illness. The Luther Inquiry (2003) also highlighted the need for new legislation. In his inquiry into the sudden deaths of Norman Reid and Darryl Power, Judge Luther stated, "Our province, to its utter shame, has by far the oldest Mental Health Act in the country" (Luther, 2003).

The new legislation was created to address the gaps identified in these Inquiries and by people in the mental health field. The legislation stipulates that a review of the Act is required to be undertaken every five years. The Newfoundland and Labrador Centre for Health Information (the Centre) was approached by the Department of Health and Community Services (DHCS) to lead an evaluation of the Act.

The core components and research questions of the evaluation were developed in consultation with key stakeholders in the Mental Health field, particularly those involved in carrying out processes and procedures outlined in the Act. The core components identified for evaluation focused on certification, Community Treatment Orders, detention, patient rights, and the Review Board.

Data were collected using a review of administrative data, patient survey, and key informant focus groups and interviews. Each Regional Health Authority (RHA) was asked to provide data related to involuntary admission since the MHCTA went into place in October 2007 to present (if available). The patient survey was distributed to patients at discharge from an involuntary admission. The survey centered around patient rights and their hospitalization experience. Focus groups and interviews were conducted with key stakeholders. Discussion was directed by a semi-structured focus groups and interview guides pertaining to the core components previously identified for the evaluation.

There were several benefits and facilitators identified as well as some challenges. One of the main facilitators of the MHCTA identified by many participants is that the MCHTA provides improved standards and structure. As one nurse stated, "*It's much more pragmatic, the steps are laid out, it's much more structured and ...there's a tendency for clinical reasons, everybody to be more attentive to it.*" The timelines and automatic review leads to more accountability and therefore, better care for patients.

The MHCTA is patient-centered and allows for better informed patients and respect for patient rights. A member of the Review Board focus group stated,

"I think it has really paid a great deal more attention to the individual rights of the person. We've had many more applications for the review than had happened previously...but certainly there has been that vigilance that an oversight that wasn't available before."

From a policing perspective, they reported now having more grounds to detain and convey an individual to a psychiatric facility. Under the old Mental Health Act, peace officers were required to observe behaviors that indicated someone was at risk of harming themselves or others; the

new Act provides the opportunity for peace officers to take the word of family or friends, a mental health professional and may detain and apprehend an individual under the Act.

Although there were some concerns expressed over the vagueness of the risk of deterioration certification criteria, many participants agreed that this criteria allows for earlier treatment so that individuals do not deteriorate to the point of harm themselves or others. This also can lead to shorter hospital stays and faster recovery. One psychiatrist stated, *“I think it is a good thing because we are picking up patients earlier and treating them and sort of preventing a further deterioration and further consequences of their mental illness.”*

There were several challenges reported. One challenge revolves around the need for education and clarification of the roles of individuals involved in certification. This includes the role of individuals from the detention through discharge and reintegration into the community. Many participants questioned the responsibilities of both their own roles and the roles of other professionals. There was also some confusion over the language used in the Act; the vagueness of the language used was thought to contribute to inconsistencies. Regular training was thought to be needed for all professionals across disciplines.

Another key challenge that is woven throughout the report involves the lack of support services, particularly in rural areas of the province. Without services and proper resources in communities, the Act cannot be used as intended. Resources and supports such as those required for CTOs, safe rooms, and health care personnel are limited or non-existent in many rural areas of the province.

Considering that only seriously mentally ill individuals are involuntarily admitted under the MHCTA, during the initial admission period, many individuals are so ill that they may not be able to comprehend their illness or understand the magnitude of what is happening to them. Currently, the Act outlines protocols for Rights Advisors in explaining patient rights within the first 24 hours of detainment or certification. Many participants thought that this occurs at a time when a patient is too unwell to understand. Another example from the Act in which a patient is asked to make a decision regarding their care is when they are asked if they would like to have a patient representative. Patients are also asked to choose a representative. As discussed in the focus groups, patients often assigned inappropriate individuals or do not assign a patient representative at all.

Emerging from the evaluation findings are 9 recommendations related to the MHTCA criteria and procedures. They are presented for consideration in an effort to improve the care and treatment of individuals who are involuntarily admitted under the MCHTA as well as improve the current processes for the various stakeholder groups.

The evaluation activities took place over a period of four years and involved many stakeholders. The commitment and interest demonstrated by the stakeholders was excellent and can provide a solid foundation which to continue development of treatment and care of those affected by mental illness.

1 Introduction

1.1 Background

Newfoundland and Labrador's Mental Health Care and Treatment Act (MHCTA) was proclaimed in 2006 and came into effect in October, 2007. The community treatment order (CTO) provisions were deferred until January 1, 2008. A CTO refers to a plan of involuntary treatment within the community. Criteria for a CTO are listed in Section 40(2) of the Act. Before proclamation in 2006, the Act had not been updated since 1971. The need for new legislation was highlighted in the Luther Inquiry (2003). In his inquiry into the sudden deaths of Norman Reid and Darryl Power, Judge Luther stated, "Our province, to its utter shame, has by far the oldest Mental Health Act in the country" (Luther, 2003). Norman Reid and Darryl Power were shot and killed by police on August 26, 2000 and October 16, 2000, respectively. The Luther Inquiry revealed that the complicated interplay of the social, health, and justice systems fell short in the lives of both men (Luther, 2003).

Prior to the Luther Inquiry (2003), it was known that the Act needed updating. New legislation was first recommended following the Judicial Inquiry into the death of Thomas Hagan in 1980. Thomas Hagan was killed by a neighbor who lived with a mental illness.

The new legislation was created to address the gaps identified in these Inquiries and by people in the mental health field. The legislation stipulates an evaluation. As stated in Section 6 of the Act, a review of the Act is required to be undertaken every five years:

The minister shall, every 5 years, conduct a review of this Act and the regulations and the principles upon which this Act is based and consider the areas in which improvements may be made and report his or her findings to the Lieutenant-Governor in Council.

The Newfoundland and Labrador Centre for Health Information (the Centre) was engaged to carry out the evaluation of province's MHCTA. The evaluation was conducted in two phases and produced an interim and final report. This report forms the final report and encompasses the development of the evaluation framework, the findings from the interim report, and the final evaluation findings.

1.2 Purpose, Objectives and Research Questions

The purpose of this final evaluation report is to report on evaluation activities, including a summary of the evaluation framework, and review the findings from the evaluation of the Mental Health Care and Treatment Act. The specific objectives of this final report are to:

1. describe the framework used for the evaluation of the MHCTA;
2. identify key issues relating to the provincial MHCTA;
3. identify facilitators and barriers to implementing the MHCTA; and
4. make recommendations for improving the MHCTA.

The core components of the evaluation focused on certification, Community Treatment Orders, detention, patient rights, and the Review Board. The following research questions were identified:

1. How is the Mental Health Care and Treatment Act being used?
2. Why are CTOs not being used?
3. Are CTOs accessible to patients who may benefit from them?
4. How and where are individuals being detained pending transfer to a psychiatric facility?
5. How has the new Act impacted the workload of peace officers?
6. What impact has the new Mental Health Care and Treatment Act had on patient rights?
7. Are the new roles of patient representative and rights advisor helping to safeguard patient rights?
8. Are there patient rights that are not addressed in the new Act?
9. Is there improved efficiency and effectiveness in the operation of the Review Board?
10. How is the Review Board functioning?

1.3 Newfoundland and Labrador Mental Health Care and Treatment Act (MHCTA)

As stated in the Mental Health Care and Treatment Act (MHCTA), SNL 2006, the purpose of the legislation is:

- a) to provide for the treatment, care and supervision of a person with a mental disorder that is likely to result in dangerous behaviour or in substantial mental or physical deterioration or serious physical impairment;
- b) to protect a person with a mental disorder from causing harm to himself or herself or another and to prevent a person with a mental disorder from suffering substantial mental or physical deterioration or serious physical impairment;
- c) to provide for the apprehension, detention, custody, restraint, observation, assessment, treatment and care and supervision of a person with a mental disorder by means that are the least restrictive and intrusive for the achievement of the purpose set out in paragraphs (a) and (b); and
- d) to provide for the rights of persons apprehended, detained, restrained, admitted, assessed, treated and cared for and supervised under this Act (the Act).

The Act takes a rights-based approach to guide involuntary admission to a health care facility and considers the patient's right to health and safety and the health care system's obligation to provide interventions and support services. Essentially, involuntary admission takes away the rights of individuals; however, safeguards have been put into place to decrease the likelihood of the violation of patient rights.

Although involuntary admission impedes on a patient's rights and freedoms, it can prevent further physical and mental deterioration and the risk of harm to self and others. It can assist in a consumer's right to health, which has been impeded by the mental illness itself. Involuntary admission and treatment is required for only a small number of consumers with the most severe mental illnesses. The type of mental illness most commonly associated with involuntary admission includes bipolar disorder (manic depression) and schizophrenia (Grey et al., 2008). Without involuntary admission and treatment, consumers would often be left untreated,

potentially leading to further mental and physical anguish and associated challenges of daily living affecting both the consumer and those around them.

Generally, mental health legislation across the country takes one of two perspectives: a human needs approach and a civil libertarian approach. Simply stated, the human needs perspective views mental illness as an illness of the brain that without treatment can cause the loss of autonomy resulting in the inability to function and cause risk of harm to self or others. Many individuals lack insight into their illness leading them incapable of making decisions around their treatment. Therefore, the purpose of involuntary admission to a mental health facility is for treatment and not to impede individual rights or to protect society. Conversely, the civil libertarian approach views mental health legislation as a way of taking away the freedom of individuals. Libertarians believe that the only exception to this is when police intervention is needed to protect the safety of the public. Both approaches are visible in mental health legislation across Canada (Grey, et al., 2008).

1.4 Mental Health Legislation across Canada

The following is a brief synopsis of a review of Mental Health Legislation across Canada conducted by Gray et al. (2008). According to Gray et al. (2008) there are three main areas of provincial comparisons: 1) committal criteria including criteria around bodily harm and deterioration; 2) treatment authorization; and 3) CTOs.

1) Among the Canadian provinces and territories Mental Health Acts, there is variation in the definition of a mental disorder. There are also some commonalities in the descriptions presented with the Acts. In many it is defined as a disorganization of thought, mood, perception, memory or orientation that will impair judgment, impact ones capacity to recognize reality or affect ones' ability to meet the normal demands of life. Psychopathic or personality disorders are not included in any Act's definition. Those provinces which include the need for treatment are Newfoundland and Labrador, Nova Scotia, Saskatchewan and British Columbia. Prince Edward Island's Act is the only Act to include the mental disorder which results from the abuse of drugs or alcohol. Ontario's Act definition is very broad compared to other provinces as it includes "any disease or disability of the mind". Quebec does not have a definition for a mental disorder listed in their Act.

Newfoundland and Labrador, British Columbia, Alberta, Saskatchewan, Manitoba, and Nova Scotia have broadened the bodily harm criteria to include other types of harm and have introduced the deterioration criteria. According to Gray et al. (2008) jurisdictions who continue to use only the bodily harm criteria limit their involuntary admissions to a certain population of patients.

2) In some jurisdictions, involuntary admitted patients can refuse treatment. Newfoundland and Labrador, British Columbia, and Saskatchewan do not allow for treatment refusal. In Manitoba and Nova Scotia a substitute decision maker must follow patient's previous wishes and best interests. Refusal of treatment can be overridden by a Review Board in Alberta and the Yukon and by a tribunal in Nova Scotia. Ontario has no such legislation; therefore, treatment refusal can go on for an undetermined amount of time.

3) The criteria around CTOs differ among provinces. There are provinces which do not have CTOs listed in their Acts such as New Brunswick, Quebec, British Columbia, The Yukon, The

Northwest Territories and Nunavut. Criteria for a CTO often include a previous stay in a psychiatric facility. It has been suggested that the committal criteria may restrict some patients from being placed on a CTO. In other countries CTOs can be used instead of an involuntary hospitalization, without the prerequisite of the individual having to be involuntarily admitted before being placed on a CTO.

2 Development of Evaluation Framework

The framework used by the Centre was informed by the previous work of Heather Heathfield and the PROBE Project in the United Kingdom (Heathfield, 1998). The Centre's framework employs a series of 7 steps, that can be used to evaluate programs, policies, and legislation.

- Step 1: Identification of Key Stakeholders in Each Jurisdiction
- Step 2: Orient Key Stakeholders to the Centre's evaluation framework and Reach Agreement on **WHY** an Evaluation is Needed
- Step 3: Agree on **When** to Evaluate
- Step 4: Agree on **What** to Evaluate
- Step 5: Agree on **How** to Evaluate
- Step 6: Analyze and Report
- Step 7: Agree on Recommendations and Forward Them to Key Stakeholders

The Centre's evaluation framework requires that the evaluation team work closely with key stakeholders impacted by the implementation of the new legislation. In this evaluation it included provincial government department (e.g., Department of Health and Community Services), administration (e.g., Regional Directors of Mental Health and Addictions), and health professionals (e.g., clinicians), family members, consumer organizations, Review Board, and peace officers. The scope of deliverables for the evaluation was defined in collaboration with all parties through a priority setting exercise.

2.1 Methods

2.1.1 Key Informant Interviews

Members of the MHCTA Stakeholder Committee were invited to participate in an interview to discuss the direction and content of the evaluation of the province's MHCTA. If interested, participants were asked to contact the investigator to schedule an interview time.

The purpose of the interviews was to gain insight into the experiences in using the MHCTA, discuss the challenges and facilitators in using the Act and provide feedback for planning of the evaluation.

A discussion guide (Appendix A) was developed and used to guide the interview. The majority of the interviews were one-on-one; however some involved two to three participants. All interviews were audio-taped and transcribed. Participants were asked to sign a consent form prior to taking part in the interviews (Appendix B).

A thematic content analysis was conducted to identify themes to influence areas for further evaluation.

Eighteen interviews took place with 22 members of the MHCTA Stakeholder Committee including representatives from health professionals directly involved with the MHCTA, peace officers, consumer and family organizations, the Department of Health and Community Services and legal professionals. Interviews took place between September and November, 2008. Interviews ranged from 15 to 70 minutes in length. The majority of participants had been involved with the Stakeholder Committee since the preparations and creation of the new MHCTA.

2.1.2 Evaluation Framework Stakeholder Workshop

The MHCTA Stakeholder Committee, as well as representatives from mental health professional groups and organizations, gathered in February 2009 to discuss the evaluation process for the Act. A total of 17 participants took part in this full-day workshop held at the Capital Hotel in St. John's. Representatives from consumer and family organizations, the Department of Health and Community Services, health care professionals, and peace officers attended. The workshop was facilitated by representatives from the Centre.

The purpose of the workshop was to discuss the research questions proposed in the key informant interviews and to gather and document any additional questions and concerns. Findings from the key informant interviews were presented to participants. In discussion groups participants were asked to provide feedback on the proposed research questions and record any concerns, comments and additional questions for the development of the evaluation framework.

2.1.3 Consultation with Psychiatrists

In September 2009, ten psychiatrists from the St. John's area participated in a dinner meeting at the Ramada Hotel to discuss the evaluation questions and direction of the evaluation of the MHCTA. The consultation was facilitated by representatives from the Centre. The meeting was approximately two hours in length and consisted of a presentation of findings from the key informant interviews and framework workshop and an open discussion. Detailed notes were taken to be included in the final evaluation framework.

The purpose of the consultation was to discuss the evaluation process and proposed questions, and to suggest any additional areas for evaluation and discuss concerns associated with the evaluation.

2.2 Results

The following evaluation questions, indicators, and data sources were developed based on findings from the stakeholder interviews, the evaluation framework stakeholder workshop, and consultation with psychiatrists.

Table 1: Proposed Core Research Questions and Methodology

Research Question	Indicator	Data Sources
<p>Certification</p> <p>How is the Mental Health Care and Treatment Act being used?</p>	<p>Number of certifications before and after the new Act</p> <p>Adherence to timelines</p> <p>Length of certifications for old and new Acts</p>	<p>Administrative data (i.e. nursing checklist, audits) at Waterford, HSC, GF & CB</p> <p>Interviews/focus groups with psychiatrists, treatment team (including case managers, nurses, etc.)</p>

Research Question	Indicator	Data Sources
<p>Community Treatment Orders</p> <p>Why are CTOs not being used?</p> <p>Are CTOs accessible to patients who may benefit from them?</p>	<p>Use of CTOs</p> <p>Facilitators and barriers to using CTOs</p>	<p>Interview/focus group with various stakeholders (i.e. psychiatrists, consumers, team leaders, regional directors, etc.)</p>
<p>Detention</p> <p>How and where are individuals being detained pending transfer to a psychiatric facility?</p> <p>How has the new Act impacted the workload of peace officers?</p>	<p>Use of safe rooms & police holding cells</p> <p>Facilitators and barriers to using safe rooms</p> <p>Workload of peace officers</p>	<p>Interviews/focus groups with RCMP, RNC, managers of mental health facilities.</p>
<p>Patient Rights</p> <p>What impact has the new Mental Health Care and Treatment Act had on patient rights?</p> <p>Are the new roles of patient representative and rights advisor helping to safeguard patient rights?</p> <p>Are there patient rights that are not addressed in the new Act?</p>	<p>Patient satisfaction</p> <p>Use of rights advisors and patient representatives</p> <p>Facilitators and barriers to meeting requirements</p>	<p>Patient survey at discharge</p> <p>Interviews/focus groups with rights advisors</p> <p>Administrative data (nursing checklist, rights advisor records)</p>
<p>Review Board</p> <p>Is there improved efficiency and effectiveness in the operation of the review board?</p> <p>How is the review board functioning?</p>	<p>Review board timelines</p> <p>Roles and functions of the review board</p> <p>Facilitators and barriers</p>	<p>Interviews/focus groups</p> <p>Administrative records</p> <p>Patient survey at discharge</p>

2.3 Evaluation Framework

Based on the key informant interviews, evaluation framework stakeholder workshop, and consultation with psychiatrists, the key elements of the MHCTA evaluation framework were finalized in September 2010 with refinements made in the fall of 2010 (Appendix C).

3 Evaluation Report

3.1 Methods for Evaluation

A combination of research methods were used to gather quantitative and qualitative data in this evaluation. Conclusions and recommendations were drawn from administrative data provided by each Regional Health Authority (RHA), patient surveys were distributed to individuals who were involuntarily admitted under the MHCTA, and focus groups and interviews were conducted with stakeholders involved in the MHCTA.

3.1.1 Administrative Data

Accessing Administrative Data

Directors and program managers in the Mental Health and Addictions Program in Eastern, Western, Central and Labrador-Grenfell Health authorities were contacted for a summary of the MHCTA administrative data. The total number of first and second certifications, type of professional signing the certificates, and month of certification was requested.

Administrative Data Analysis and Presentation

The data provided was collected by fiscal year since the implementation of the new Act. The data was not altered from its original form and was gathered together in tables to show the yearly distribution. Additionally, bar graphs were constructed to visually represent the yearly breakdown of the results. The data submitted by Central Health was a shorter time period than other RHAs. Western Health provided data from 2007 to present.

3.1.2 Patient Surveys

Survey Development

A patient survey was developed (Appendix G) in consultation with the MHCTA stakeholder group. The purpose of the survey was to provide an opportunity for patients to express their experience of involuntary admission. The survey consisted of 13 questions regarding satisfaction with patient rights, treatment, and plans for follow-up. Check boxes were provided (Yes/No/Does Not Apply). Demographic information was also collected. An open-answer question for additional comments was provided.

Survey Distribution

Survey packages were sent to Managers in Eastern and Central Health and the Director of Mental Health and Addictions in Western. Surveys were distributed by nurses to patients upon discharge from involuntary admission under the MHCTA. Patients were asked to complete a survey, once completed they were asked to place the survey in a sealed envelope. Nurses were available for support in completing the survey if required. In an effort to maximize response rate and to express appreciation for their involvement, patients were given a \$10 gift card after completing the survey. Completed surveys were couriered to the Centre. The survey was distributed between October 2011 and February 2012.

Survey Analysis and Presentation

The completed survey responses were entered into an electronic database. The Statistical Package for Social Sciences (Version 17) was used to generate descriptive statistics including frequencies, means and percentages.

Responses to the statements are presented for each statement by the total frequency and percent breakdown. The sample size was not large enough for statistically significant findings; therefore, caution should be taken when interpreting survey results.

3.1.3 Focus Groups and Interviews

Mental health professionals (including psychiatrists, general practitioners, nurses, case managers, nurse practitioners, and social workers), peace officers, members of the review board, legal aid, and rights advisors were invited to take part in semi-structured focus groups. Some professionals opted to take part in a semi-structured interview instead of the focus group. The purpose of the focus groups was to discuss the facilitators and barriers in using the Mental Health Care and Treatment Act. Informants received an invitation letter (example found in Appendix D) via email describing the purpose of the evaluation and inviting them to take part in a scheduled focus group. The date and time of the focus groups was provided. For groups taking place outside of the St. John's area (excluding the RCMP focus group), a teleconference number were provided. A semi-structured discussion guide (examples found in Appendix E) was used to guide the conversation.

Focus groups and interviews with key stakeholder groups were held between May 2011 and February 2012 and were approximately 20 to 90 minutes in length. With permission of the participants, the focus groups were audio taped and transcribed. For those participants who did not agree to have the session recorded, detailed notes were taken. A consent form was signed by participants who took part in face-to-face focus groups or interviews (example found in Appendix F). For those focus groups and interviews that took place over the telephone, the consent form was read out loud and verbal consent was provided.

Description of Participants

A total of 15 focus groups took place with stakeholder groups. Some focus groups included a combination of nurses, Assertive Community Treatment (ACT) team members, social workers, case managers, while other groups included one type of health care professional only. Below is a list of health care professionals who took part in focus groups.

Western Regional Health Authority

- Mental health providers (e.g. nurses, Assertive Community Treatment (ACT) team members) (n=10)
- Psychiatrists (n=3)

Labrador Grenfell Regional Health Authority

- Mental health providers (e.g. case managers, nurses, social workers, etc.) (n=25)
- General Practitioners (n=2)

Central Regional Health Authority

- Mental health providers (e.g. nurses, case managers, social workers, ACT team members) (n=14)
- Nurse practitioners (n=21)

Eastern Regional Health Authority

- Mental health providers (e.g. nurses, case managers, social workers) (n=11)
- Psychiatrists, psychiatry residents, and general physicians (n=21)

Other Stakeholder Focus Groups

- Review board (n=13)
- Royal Canadian Mounted Police (RCMP) (n=17)
- Royal Newfoundland Constabulary (RNC)
 - Focus Group 1 (n=23)
 - Focus Group 2 (n=2)
- Rights Advisors (n=3)
- Mental Health Care and Treatment Act Stakeholder Committee (focus group specific to Community Treatment Orders (CTOs)) (n=10)

Individual Key Informant Interviews (4)

A total of 154 participants from across the province took part in focus groups or interviews.

Data Analysis

A thematic analysis was used to analyze focus group transcripts through inductive coding based on the coding strategy used by Strauss and Corbin (1998). Nvivo 8 qualitative software (QSR International, 2008), was used to assist in the coding and analysis of the focus group transcripts. Open coding of the data involved reading through each transcript to determine the overall content of each focus group. Codes were created based on their similarities. Subcategories were developed from the open coding categories; such subcategories were used to link with other categories and subcategories, depending on context. From the subcategories, themes or commonalities that bring meaning to an experience were developed, while making note of significant statements. The codes and themes developed from the focus groups and interviews were constantly compared within each transcript as well as between each focus group and interview.

4 Findings

4.1 Administrative Data

The MHCTA requires that each RHA maintain records of certification data. The following section presents administrative data provided by each of the RHAs. Comparisons across regions are provided where possible.

4.1.1 First Certificate of Involuntary Admission

A certificate of involuntary admission requires two separate assessments and signatures from two physicians. The first signature may be provided by a GP, psychiatrist, or nurse practitioner. The number of first certificates is presented by health professional, where possible, for the regional health authorities in the following tables and figures (Tables 2-5; Figures 1-4).

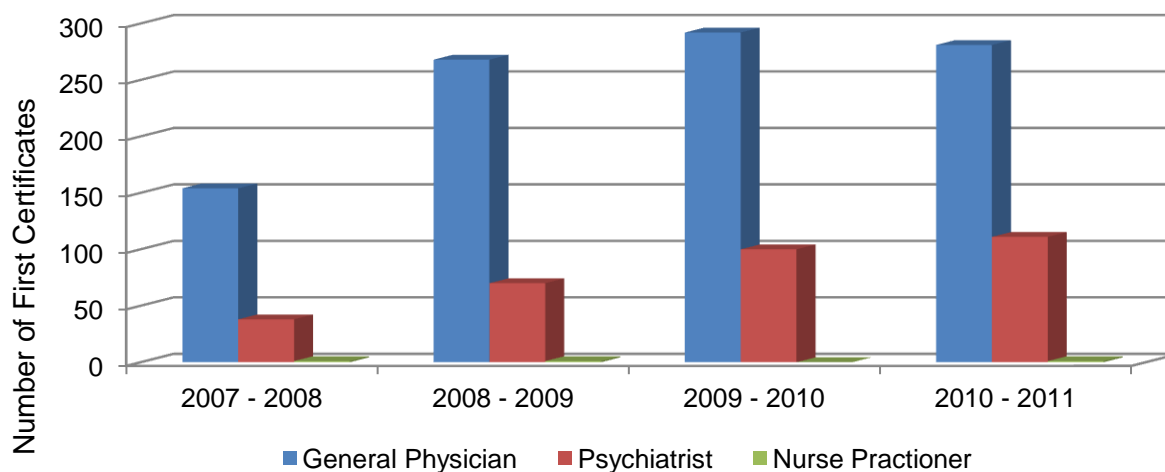
Table 2: Number of first certificates of involuntary admission by health professional, Eastern Health, 2007-2008¹ to 2010-2011

Year	General Practitioner	Psychiatrist	Nurse Practitioner	Total
2010 - 2011	281	111	1	393
2009 - 2010	292	100	0	392
2008 - 2009	268	70	1	339
2007 - 2008 ¹	154	38	1	193

Source: The Mental Health and Addictions Program, Eastern Health 2007-2008 to 2010-2011

Note: ¹ Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Figure 1: Number of first certificates of involuntary admission by health professional, Eastern Health, 2007-2008¹ to 2010-2011



Source: The Mental Health and Addictions Program, Eastern Health 2007-2008 to 2010-2011

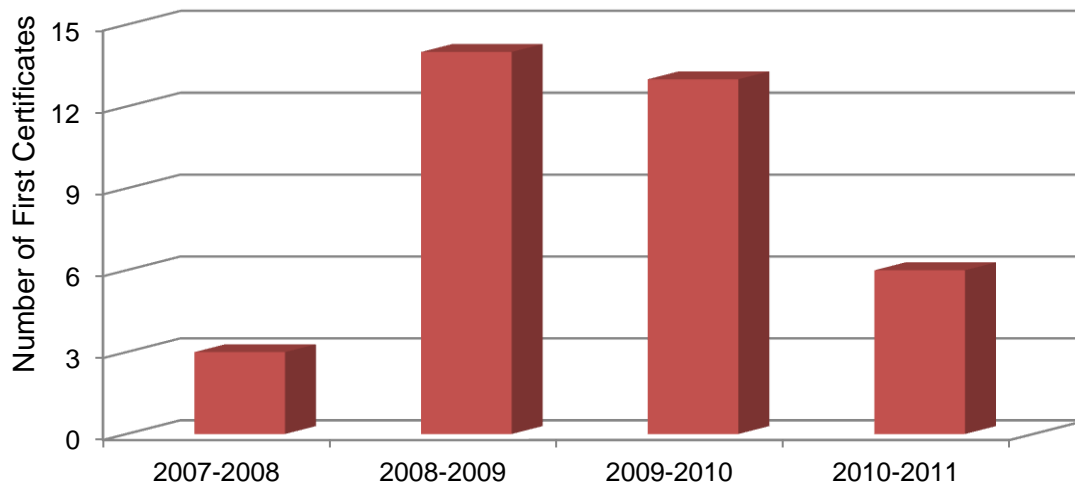
Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Table 3: Number of first certificates of involuntary admission, Labrador-Grenfell Health, 2007-2008¹ to 2010-2011

Year	Total
2010-2011	6
2009-2010	13
2008-2009	14
2007-2008	3

Source: The Mental Health and Addictions Program, Labrador-Grenfell Health 2007-2008 to 2010-2011
Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Figure 2: Number of first certificates of involuntary admission, Labrador-Grenfell Health, 2007-2008¹ to 2010-2011



Source: The Mental Health and Addictions Program, Labrador-Grenfell Health 2007-2008 to 2010-2011
Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Table 4: Number of first certificates of involuntary admission by health professional, Western Health, 2007-2008¹ to 2011-2012

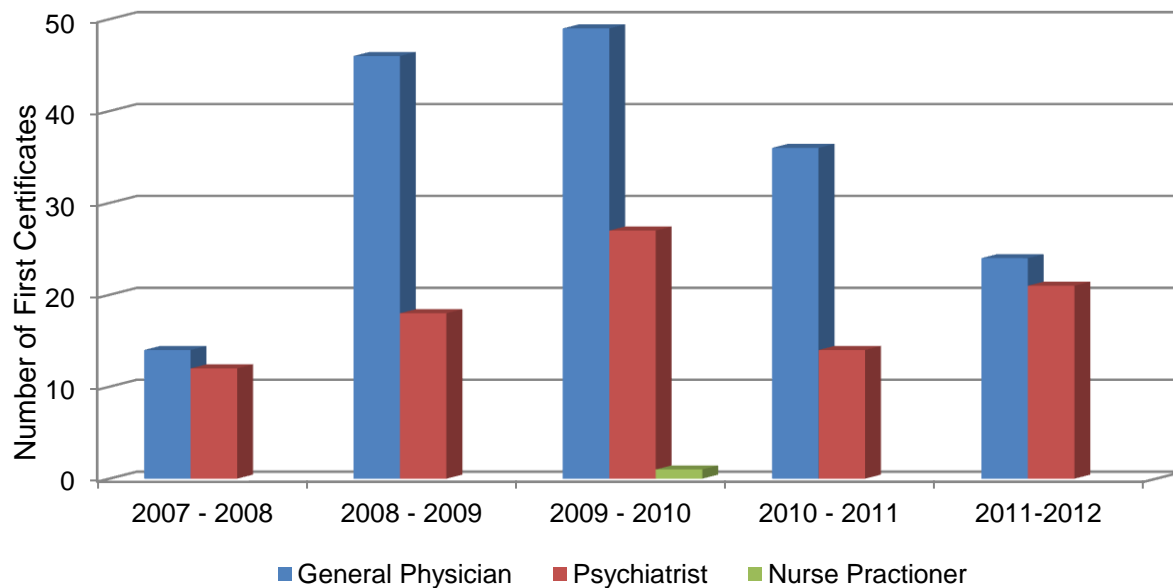
Year	General Practitioner	Psychiatrist	Nurse Practitioner	Total
2011 – 2012 ²	24	21	0	45
2010 - 2011	36	14	0	50
2009 - 2010	49	27	1	77
2008 - 2009	46	18	0	64
2007 - 2008 ¹	14	12	0	26

Source: The Mental Health and Addictions Program, Western Health 2007-2008 to 2011-2012

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Note²: Western Health was the only RHA to provide data for 2011-2012.

Figure 3: Number of first certificates of involuntary admission by health professional, Western Health, July 2007-2008¹ to 2011-2012



Source: The Mental Health and Addictions Program, Western Health 2007-2008 to 2011-2012

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Table 5: Number of first certificates of involuntary admission by health professional, Central Health¹, July 2010 to Feb 31, 2012

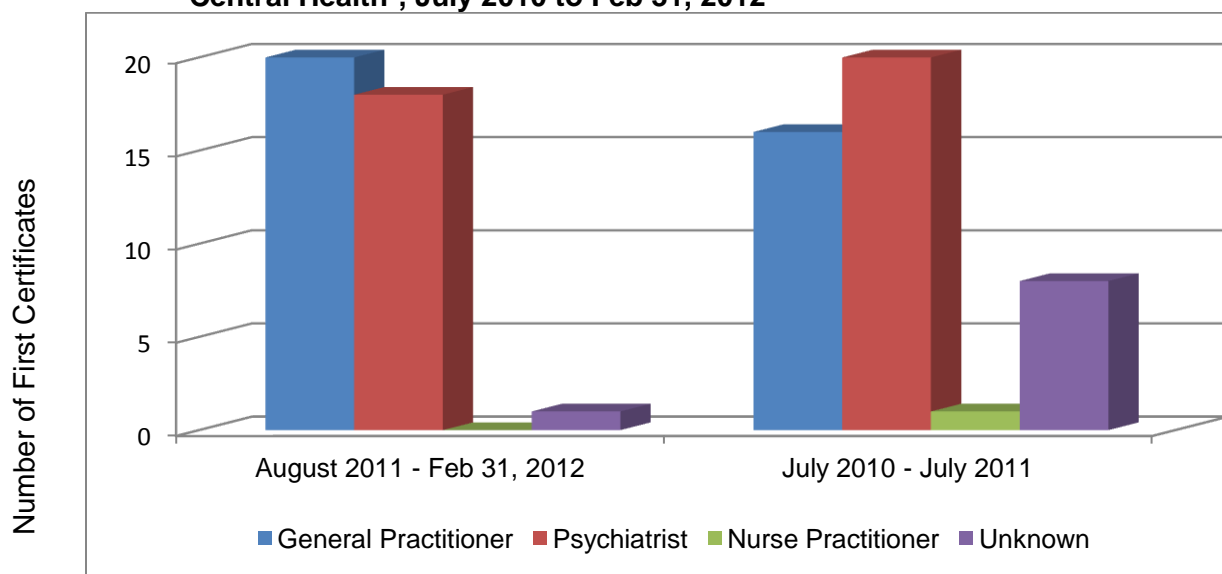
Year	General Practitioner	Psychiatrist	Nurse Practitioner	Unknown	Total
August 2011 – Feb 31, 2012	20	18	0	1	39
July 2010 – July 2011	16	20	1	8	45
March 19 2009 – July 7 2010	NA ²	NA ²	NA ²	NA ²	33
January 2008 – December 2008	NA ²	NA ²	NA ²	NA ²	63

Source: The Mental Health and Addictions Program, Central Health, July 2010 – Feb 31, 2012

Note¹: The available data for Central Health has a different time period.

Note²: Data not available.

Figure 4: Number of first certificates of involuntary admission by health professional, Central Health¹, July 2010 to Feb 31, 2012



Note¹: The available data for Central Health has a different time period.

There was a slight increase in the total number of first certificates in Eastern Health between the years 2008-2009 and 2009-2010. First certificates in Central Health between July 2010 and February 2012 remained fairly consistent; however, since 2008 the number of first certificates in Central Health has decreased from 63 to 39. The number of first certificates decreased slightly in Western Health from 2009-2010 to 2011-2012. There was also a slight decrease in Labrador-Grenfell from 14 in 2008-2009 to 6 in 2010-2011.

General practitioners (GPs) signed the majority of first certificates in Eastern Health; the number of first certificates signed by GPs and psychiatrists in Central and Western Health Authorities were similar. In all regions nurse practitioners rarely signed first certificates. Nurse practitioners (as described in the Focus Group and Interview findings section of this report) may collaborate regularly with GPs; therefore there is often no need for them to sign the first certificates when a

GP is available. The higher number of GP signatures in Eastern Health may be due to the overall higher number of GPs in this Health Authority.

4.1.2 Consideration of First Certificates of Involuntary Admission Versus Number of Unique Patients

The number of first certificates, the number of unique patients per year and the range of certificates per patient is presented for Eastern Health and Western Health in the following tables and figures (Tables 6-7; Figures 5-6). A patient may have more than one first certificate issued in any given year, which is why the number of first certificates is greater than the number of patients experiencing a first certificate per year. The range of first certificates refers to the number of first certificates a patient may experience in one given year. For example, throughout the year 2010-2011 in Eastern Health, a range of 1-11 first certificates is noted in Table 6. This means that patients experienced from 1 to, at most, 11 first certificates in that year.

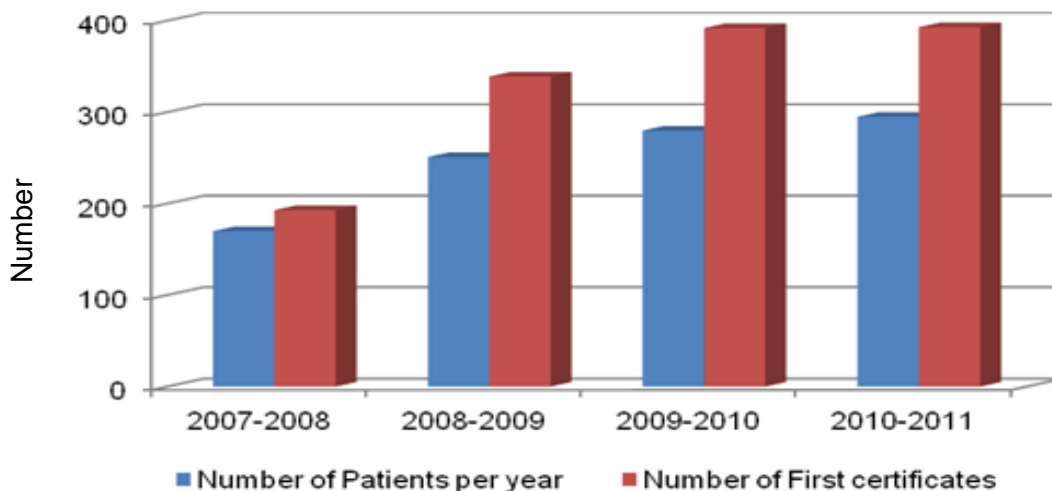
Table 6: Number of first certificates of involuntary admission, number of unique patients and range of first certificates, Eastern Health, 2007-2008¹ to 2010-2011

Year	Number of First Certificates	Number of Unique Patients per Year	Range of First Certificates Per Patient
2010-2011	393	295	1-11
2009-2010	392	280	1-21
2008-2009	339	251	1-15
2007-2008	193	170	1-3

Source: The Mental Health and Addictions Program, Eastern Health 2007-2008 to 2010-2011

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Figure 5: A comparison of unique patients versus number of first certificates of involuntary admission issued, Eastern Health, 2007-2008¹ to 2010-2011



Source: The Mental Health and Addictions Program, Eastern Health 2007-2008 to 2010-2011

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Table 7: Number of first certificates of involuntary admission, number of unique patients and range of first certificates, Western Health, 2007-2008¹ to 2011-2012

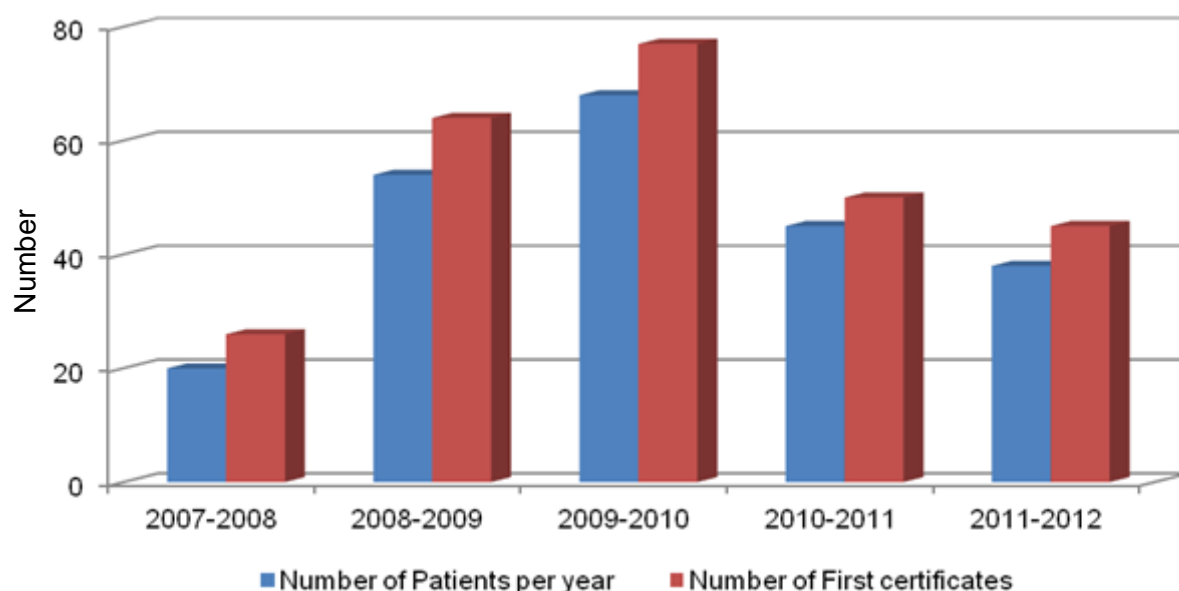
Year	Number of First Certificates	Number of Patients per year	Range of First Certificates per Patient
2011-2012	45	38	1-4
2010-2011	50	45	1-3
2009-2010	77	68	1-3
2008-2009	64	54	1-4
2007-2008	26	20	1-3

Source: The Mental Health and Addictions Program, Western Health 2007-2008 to 2011-2012

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Note²: Western Health was the only RHA to provide data for 2011-2012.

Figure 6: A comparison of unique patients versus number of first certificates of involuntary admission issued, Western Health, 2007-2008¹ to 2011-2012



Source: The Mental Health and Addictions Program, Western Health 2007-2008 to 2011-2012

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

As noted, in Eastern Health, between 2008-2009, the range of certificates per patient varied from 1 to 21. For example, a patient was involuntarily admitted under a first certificate 21 times throughout that year. This may highlight the need for resources in the community to protect against the “revolving door.”

4.1.3 Second Certificate of Involuntary Admission

The second signature and assessment for a certificate of involuntary admission may be provided by a GP or psychiatrist (the individual must be someone other than the individual who provided the assessment and signed the first certificate). The number of second certificates is presented by health professional, where possible, for the regional health authorities in the following tables and figures (Tables 8-11; Figures 7-10).

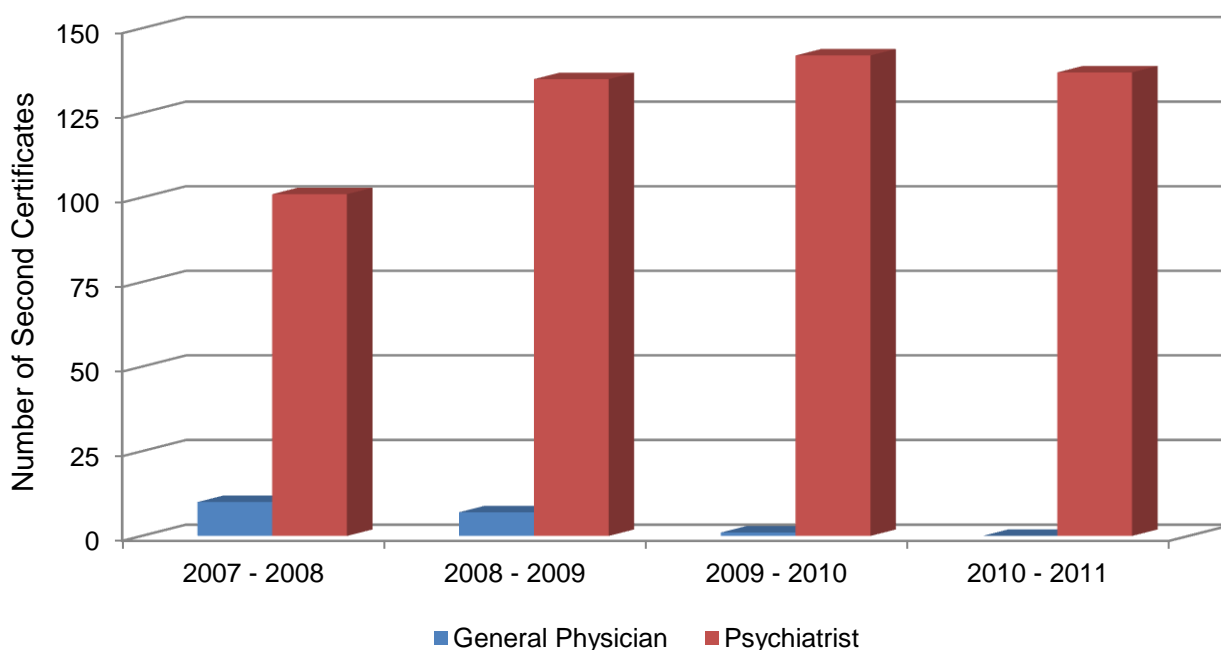
Table 8: Number of second certificates of involuntary admission by health professional, Eastern Health, 2007-2008¹ to 2010-2011

Year	General Practitioner	Psychiatrist	Total
2010 - 2011	0	137	137
2009 - 2010	1	142	143
2008 - 2009	7	135	142
2007 - 2008 ¹	10	101	111

Source: The Mental Health and Addictions Program, Eastern Health 2007-2008 to 2010-2011

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Figure 7: Number of second certificates of involuntary admission by health professional, Eastern Health, 2007-2008¹ to 2010-2011



Source: The Mental Health and Addictions Program, Eastern Health 2007-2008 to 2010-2011

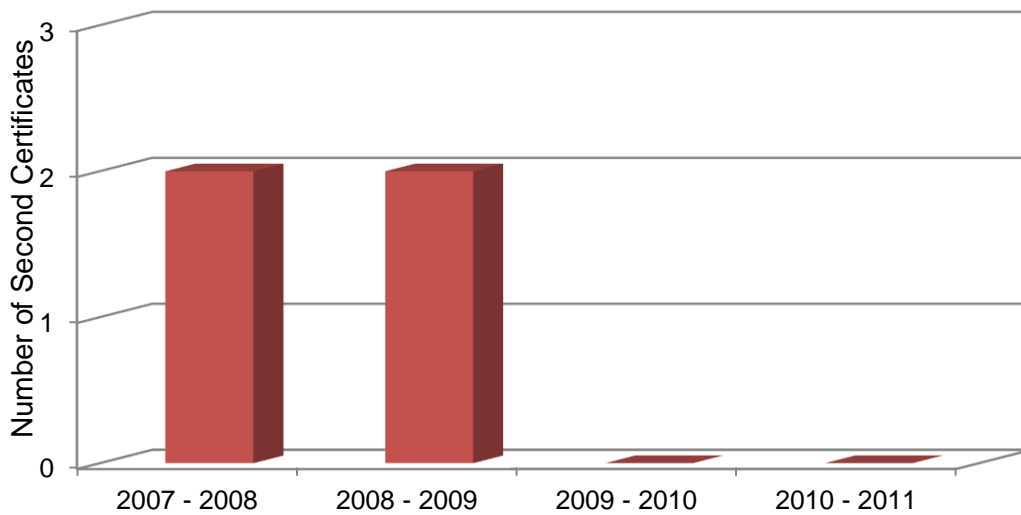
Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Table 9: Number of second certificates of involuntary admission, Labrador-Grenfell Health, 2007-2008¹ to 2010-2011

Year	Total
2010 - 2011	0
2009 - 2010	0
2008 - 2009	2
2007 - 2008 ¹	2

Source: The Mental Health and Addictions Program, Labrador-Grenfell Health 2007-2008 to 2010-2011
 Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Figure 8: Number of second certificates of involuntary admission, Labrador-Grenfell Health, 2007-2008 to 2010-2011



Source: The Mental Health and Addictions Program, Labrador-Grenfell Health 2007-2008 to 2010-2011
 Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Table 10: Number of second certificates of involuntary admission by health professional, Western Health, 2007-2008¹ to 2011-2012

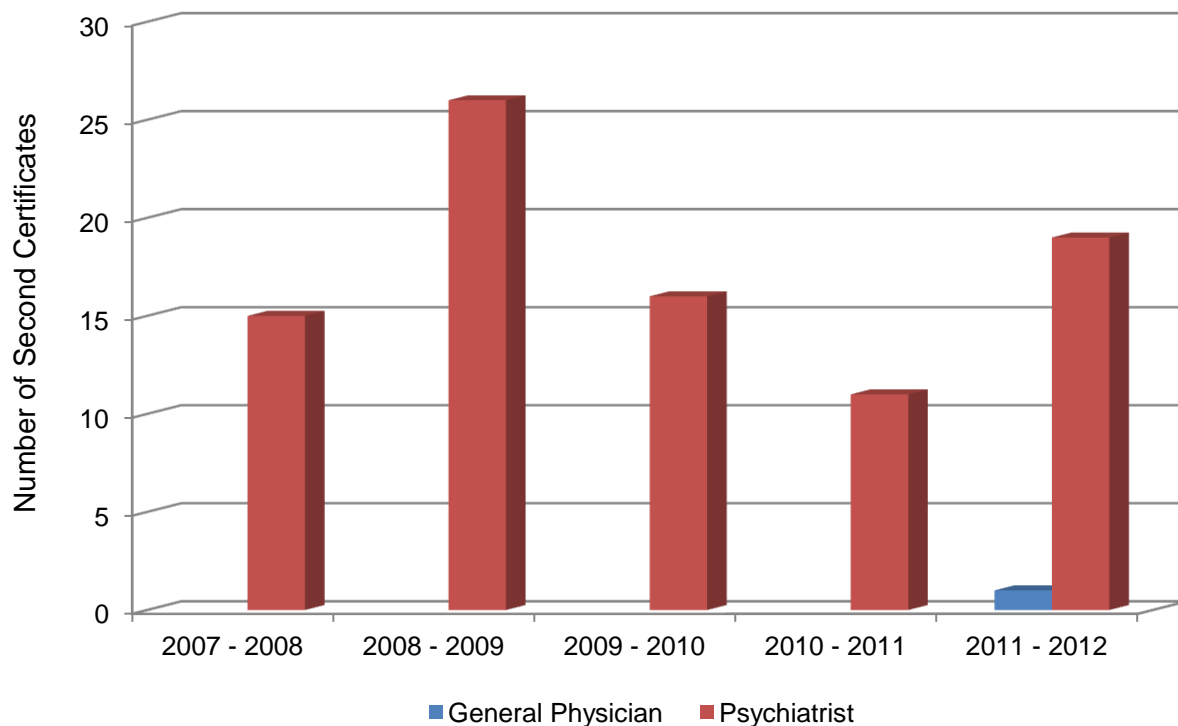
Year	General Practitioner	Psychiatrist	Total
2011 - 2012 ²	1	19	20
2010 - 2011	0	11	11
2009 - 2010	0	16	16
2008 - 2009	0	26	26
2007 - 2008 ¹	0	15	15

Source: The Mental Health and Addictions Program, Western Health 2007-2008 to 2010-2011

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Note²: Western Health was the only RHA to provide data for 2011-2012.

Figure 9: Number of second certificates of involuntary admission by health professional, Western Health, 2007-2008¹ to 2011-2012



Source: The Mental Health and Addictions Program, Western Health 2007-2008 to 2011-2012

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

Table 11: Number of second certificates of involuntary admission by health professional, Central Health¹, July 2010 to Feb 31, 2012

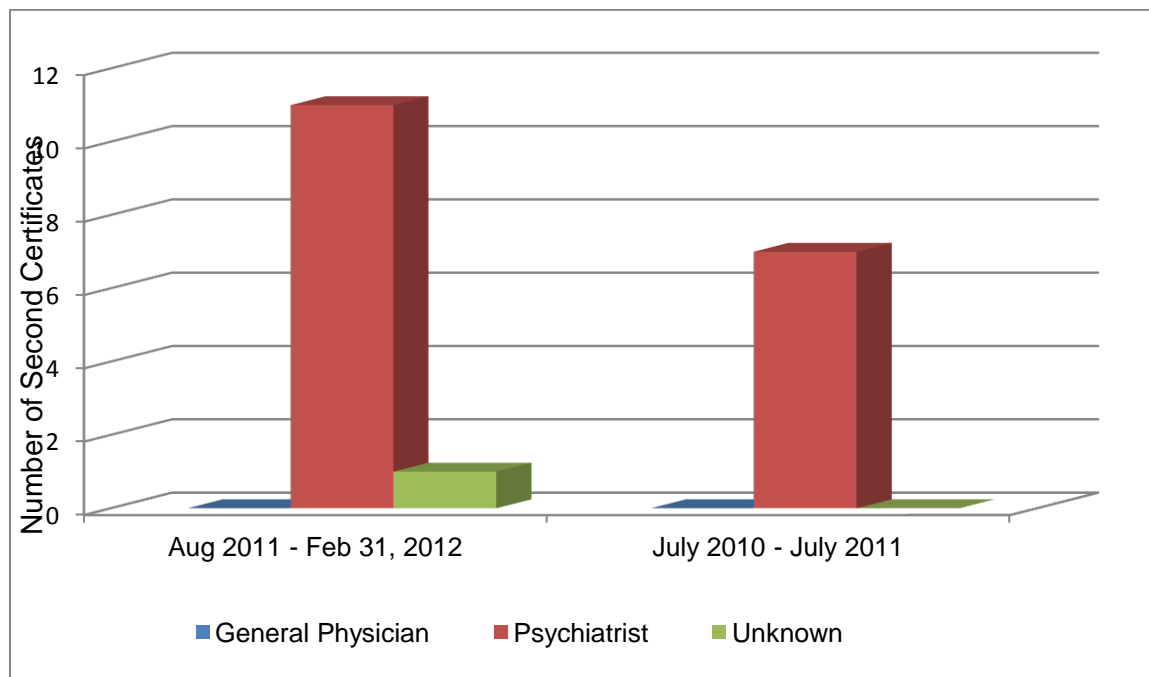
Year	General Practitioner	Psychiatrist	Unknown	Total
August 2011 – Feb 31, 2012	0	11	1	12
July 2010 – July 2011	0	7	0	7
March 19 2009 – July 7 2010	NA ²	NA ²	NA ²	36
January 2008-December 2008	NA ²	NA ²	NA ²	32

Source: The Mental Health and Addictions Program, Central Health, July 2010 – Feb 31, 2012

Note¹: The available data for Central Health has a different time period.

Note²: Data not available.

Figure 10: Number of second certificates of involuntary admission by health professional, Central Health¹, July 2010 to Feb 31, 2012



Source: The Mental Health and Addictions Program, Central Health, July 2010 – Feb 31, 2012

Note¹: The available data for Central Health has a different time period.

The number of second certificates in each RHA remained fairly stable throughout the years of data available for each, with the exception of Central Health. There was a decrease from 36 second certificates in 2009 - 2010 to only 7 certificates in July 2010 - July 2011. In all RHAs psychiatrists signed the second certificate in the majority of cases. Although the Labrador-Grenfell Region does not have a practicing psychiatrist there were a total of 4 second certificates between 2007-2009. Locum or visiting psychiatrists occasionally visit the Labrador-Grenfell Region.

4.1.4 Community Treatment Orders (CTOs)

A Community Treatment Order (CTO) refers to a plan of involuntary treatment within the community as ordered by a psychiatrist. The criteria for implementing a CTO are listed in Section 40(2) of the Act. The first Community Treatment Order (CTO) was implemented in 2008-2009 in Eastern Health. During the most recent year (2010-2011) there have been 3 CTOs that were each implemented in Eastern Health. Community treatment order data was not available for Western Health, Central Health or Labrador-Grenfell Health. The number of CTOs issued has been low (as discussed in focus groups and interviews). Barriers to the implementation of CTOs are discussed in the focus group and interview findings of this report.

Table 12: Number of Community Treatment Orders, Eastern Health, 2007-2008¹ to 2010-2011

Year	Community Treatment Order (CTO)
2010 - 2011	3
2009 - 2010	1
2008 - 2009	1
2007 - 2008 ¹	0

Source: The Mental Health and Addictions Program, Eastern Health 2007-2008 to 2010-2011

Note¹: Act was proclaimed October 2007 therefore data gathered prior to October 2007 was not included.

4.1.5 Patient Passes

Section 37(1) of the Act outlines procedures for the attending physician to designate an authorized pass permitting “ the patient to be absent from a ward or a psychiatric unit for a specified period of time, subject to the conditions specified in the pass and in the regulations.” Passes can be permitted for a variety of reasons, including patients going outside to smoke a cigarette. During the data collection for this evaluation, it was suggested by participants in a mental health professional focus group that it may be interesting to investigate the number of patient passes given to involuntary patients. While patient passes were not identified as one of the indicators in the evaluation framework, the data was collected. A brief summary of this administrative data will be forwarded to the Department of Health and Community Services for their information.

4.2 Patient Surveys

There were a total of 16 respondents to a patient survey of involuntary patients at the point of discharge from October 2011 to February 2012. Given the low response it is difficult to determine any significance in the numbers presented below; therefore, caution is needed when interpreting the results.

4.2.1 Demographics (Tables 13-16)

There were 6 patients that responded from the Waterford Hospital in St. John's, 1 from the Newfoundland Regional Health Centre in Grand Falls-Windsor and 9 patients from Western Memorial Regional Health Centre in Corner Brook (see Table 13). Out of the 16 respondents, 5 stated that Eastern Health was their home region; 8 cited Western Health; 1 cited Central health and 2 were unsure of their home region (see Table 14). The majority of responses were from male patients (62.5%, n=10); females made up 31.3% (n=5) (see Table 15). The education status among respondents varied with 33.3% (n=5) having less than high school; 33.3% (n=5) completed high school; 20.0% (n=3) having some college or university; and 13.3% (n=2) having completed college or university (see Table 16).

Table 13: Percentage of Respondents by Facility Location

	Frequency	Percent ¹ (%)
St. John's	6	37.5
Grand Falls-Windsor	1	6.3
Corner Brook	9	56.3
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

Table 14: Percentage of Respondents by Home region

	Frequency	Percent ¹ (%)
Eastern Health	5	31.3
Western Health	8	50.0
Central Health	1	6.3
Out of Province	0	0
Out of Country	0	0
Not sure	2	12.5
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

Table 15: Percentage of Respondents by Sex

	Frequency	Percent ¹ (%)
Male	10	62.5
Female	5	31.3
Other	1	6.3
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

Table 16: Percentage of Respondents by Education Level

	Frequency	Percent ¹ (%)
Less than high school	5	33.3
Completed high school	5	33.3
Some college/ university	3	20.0
College/ university completed	2	13.3
Total	15	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

4.2.2 Procedural Rights (Tables 17-21)

The majority of respondents recalled that they were told they were certified and the reasoning for their hospitalization. Most respondents reported that they were told about their rights and felt they were treated with respect. Interestingly, a number of respondents reported that they were unsure if they were told of their certification (25%). Twenty-five percent (25%) were also unsure if they were told about their rights as a patient. This may be due to difficulty in recalling a traumatizing period of their life when the symptoms of severe mental illness may have contributed to their understanding at that time. Only 56% of respondents were aware that they were able to contact a lawyer. The remaining 44% did not know, were unsure or thought that this right did not apply to them.

Table 17: Percentage of respondents who were told that they were certified

	Frequency	Percent (%)
Yes	10	62.5
No	2	12.5
Not Sure	4	25.0
Does Not Apply to Me	0	0
Total	16	100.0

Table 18: Percentage of respondents who were told why they were hospitalized

	Frequency	Percent ¹ (%)
Yes	11	68.8
No	3	18.8
Not Sure	2	12.5
Does Not Apply to Me	0	0
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

Table 19: Percentage of respondents who were told about their rights as a patient

	Frequency	Percent (%)
Yes	10	62.5
No	2	12.5
Not Sure	4	25.0
Does Not Apply to Me	0	0
Total	16	100.0

Table 20: Percentage of respondents who were treated with respect during their hospital stay

	Frequency	Percent ¹ (%)
Yes	13	81.3
No	2	12.5
Not Sure	1	6.3
Does Not Apply to Me	0	0
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

Table 21: Percentage of respondents who knew they could contact a lawyer

	Frequency	Percent ¹ (%)
Yes	9	56.3
No	2	12.5
Not Sure	3	18.8
Does not apply to me	2	12.5
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

4.2.3 Rights Advisor (Tables 22-23)

The majority of respondents stated that they were contacted by a rights advisor and felt that the rights advisor helped them understand their rights; 18.8% and 37.5% respectively stated they were unsure if a rights advisor visited them and they were unsure if the advisor helped them to understand their rights. This may highlight the need for more than one visit from a rights advisor and the need for repeating patient rights.

Table 22: Percentage of respondents who spoke with rights advisors when hospitalized

	Frequency	Percent (%)
Yes	10	62.5
No	3	18.8
Does not apply to me	0	0
Not Sure	3	18.8
Total	16	100.0

Table 23: Percentage of Respondents who had assistance from the rights advisor to help them understand their patient rights

	Frequency	Percent ¹ (%)
Yes	9	56.3
No	1	6.3
Does not apply to me	0	0
Not Sure	6	37.5
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

4.2.4 Patient Representative (Tables 24-25)

Respondents were asked if they would like to assign a patient representative. Forty percent (40%; n=6) said they did assign a representative, 33.3% (n=5) said they did not and 26.7% (n=4) stated they were not sure (see Table 24). The high percentage of respondents who indicated that they did not assign a patient representative or were unsure if they assigned a representative is fairly high (33.3% and 26.7% respectively). Again, this may be because the patient did not understand the significance of assigning a representative due to their lack of understanding or their mental illness symptoms at the time.

Table 24: Percentage of respondents who had a patient representative

	Frequency	Percent (%)
Yes	6	40
No	5	33.3
Not Sure	4	26.7
Does not apply to me	0	0
Total	15	100.0

Table 25: Percentage of respondents who agreed that the patient representative and treatment team worked well together

	Frequency	Percent ¹ (%)
Yes	5	31.3
No	1	6.3
Not Sure	7	43.8
Does not apply to me	3	18.8
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

4.2.5 Treatment Plan and Discharge (Tables 26-30)

Respondents were asked if they were told about their treatment plan. Forty percent of respondents stated that they understood their treatment plan. A majority of respondents (68.8%) reported that they had a follow-up appointment with their psychiatrist and 75% stated that they have access to help if needed. Twenty-five (25%) stated they did not have access or were unsure if they had access to help. This may highlight the need for accessible supports in the community and the need for support in navigating the health care system. Although the majority of respondents reported living with family or friends (42.9%), a large number reported living alone (35.7%).

Table 26: Percentage of respondents who were told about their treatment plan

	Frequency	Percent (%)
Yes	6	40
No	6	40
Not Sure	3	20
Does not apply to me	0	0
Total	15	100.0

Table 27: Percentage of respondents who thought they needed to stay in the hospital longer

	Frequency	Percent ¹ (%)
Yes	3	18.8
No	11	68.8
Not Sure	1	6.3
Does not apply to me	1	6.3
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding

Table 28: Percentage of respondents who had living arrangements

	Frequency	Percent (%)
Alone	5	35.7
With friends of family	6	42.9
Supportive housing	2	14.3
Other	1	7.1
Total	14	100

Table 29: Percentage of respondents who had an appointment for follow up with a mental health care provider

	Frequency	Percent ¹ (%)
Yes	11	68.8
No	2	12.5
Not Sure	2	12.5
Does not apply to me	1	6.3
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

Table 30: Percent of respondents who indicated they will have access to help if needed

	Frequency	Percent ¹ (%)
Yes	12	75.0
No	1	6.3
Not Sure	3	18.8
Does not apply to me	0	0
Total	16	100.0

Note¹: Sum of percentages for survey responses may not equal 100% due to rounding.

4.2.6 Survey Comments

Respondents were given the opportunity to provide other comments. There were 10 comments from the 16 respondents. Comments can be broken down into positive and negative categories. Negative comments included feeling like they were disrespected by staff, not understanding why they were certified or unsure if they were certified, and not remembering talking to a rights advisor. The positive comments included feeling more focused on their health since the involuntary admission and wanting to move forward in their life.

4.3 Patient Interview

Patients were given an opportunity to contact the evaluation team if they wished to share their experience in person. Only one patient contacted a member of the team to share her story of having been involuntarily admitted under the MHCTA three times. Due to the confidential nature of the patient interview, there was no process for the evaluation team to hear the perspectives of the police, health care professionals, and/or family involved in this situation.

She said she felt “*victimized from the experiences*” and “*was treated violently*”; she said the police came to her home, handcuffed her, took her to a medical facility, and did not give any explanation as to why she was detained or where she was going.

The information she shared was mostly related to the care she received in hospital. She recalled that she was assessed very briefly by two separate doctors and was told that she was certified; however, she said the doctors did not explain why she was certified. She recalled being visited by a rights advisor, who she described as being helpful and sympathetic. She said that she was forced to take medication on some occasions and then allowed to refuse on others. She stated that she was never told what the medication was or why she was given the medication. She said her family was contacted by the mental health professionals without her consent and, as a result, she said she felt her privacy had been violated.

The woman described an incident in which she was placed in a “*solitary confinement room*” for approximately 24 hours, without food, water or access to a bathroom. Overall, she described her care as “*horrible*.” She suggested that there should be an avenue in which patients can express their grievances and mistreatment. A member of the evaluation team recommended that she contact the Client Relationships Consultant in the Regional Health Authority and provided her with the contact information so that she could report her experience. She was also given the information for the Citizen’s Representative Office.

4.4 Focus Group and Interview Findings

The following themes emerged from focus group and interview discussions. The themes are divided into the following categories: Certification Process, Community Treatment Orders, the Role of Peace Officer in Detainment and Apprehension, Patient Rights, Rights Advisors, Patient Representatives, and the Review Board. Themes are presented in no particular order.

4.4.1 Certification Process

Signing Certificates

There were some concerns discussed by psychiatrists, GPs, nurses and other mental health professionals specifically around signatures in rural areas of the province. It was suggested that in some areas of the province there are few physicians and even fewer psychiatrists. Consequently, requesting that a first signature be signed by a GP, nurse practitioner, or psychiatrist and then the second signature be signed by a psychiatrist is not always realistic. It was suggested that at least one of the two signatures be from a psychiatrist; not necessarily only the second signature. There were mixed views about who should sign the certificate. It was also suggested that two signatures from nurse practitioners might also be considered under some circumstances. A mental health professional from the Labrador Grenfell region went so far as to suggest that nurses in the community should be permitted to assess and sign first certificates.

“...the nurses that are classified as registered nurses, but not nurse practitioners, I think the privilege to allow them to make that decision – they’re the sole people in these communities who provide all the health care, and I think that that privilege should be extended to them.”

This suggestion was echoed by mental health professionals from the Central region, *“Case managers and ACT team people, who know these clients, assess them regularly and then they’re expected to bring them in to somebody who’s in a lot of cases, a GP or a nurse practitioner who’s never seen the client before...”*

The majority of the Central Health focus group made up of nurse practitioners stated that they have never signed a first certificate of involuntary admission and they would feel uncomfortable if put in this situation. All agreed that they have regular contact with GPs in their clinics and if the need arose for an assessment for involuntary admission under the Act, they would call for the advice of a GP. *“A lot of the time in these cases where you’re going to have to certify somebody, you’re collaborating with a physician and where both [nurse practitioner and physician] are there the physician probably signs.”*

The participants of the Eastern Health psychiatrist and GP group suggested that psychiatry residents should be permitted to sign in place of a GP. As explained by a psychiatrist, *“They’ve all gone to medical school ...in most cases their training is very similar to that or very close to that of all the physicians within the province. So I think certainly they have the knowledge and the skills to be able to make an appropriate judgment.”*

A resident who participated in the focus group suggested, *“I wonder if there’s a way of handling it in the same way that we handle prescription writing privileges so we can’t have those on day one of our residency when we are effectively interns and... you can get it in your second year once you completed the internship.....something like that seems appropriate.”*

Another psychiatrist in the group held a different view *“allowing a resident to certify an individual encourages better safety for the individual under assessment and the safety of the public because a psychiatrist must examine and assess the individual themselves; they cannot take the word of a resident.”*

Vague Certification Language

There were mixed points of view relating to the language of the MHCTA and the degree to which discretion is used by the professionals within the health authorities. Almost all participants in all focus groups agreed that the certification criteria involving the risk of physical or mental deterioration is a great addition to the Act. It allows for the inclusion of some individuals who, under the previous Act, may not have gotten early intervention. However, it was suggested that the language of this criteria is vague and is open to interpretation by physicians and psychiatrists. One psychiatrist stated,

“I think there’s a lot of discrepancies to what we would see as a risk of deterioration and what other people presume it to be and there’s different levels of tolerance, and I guess, for risk of deterioration so an interpretation on it I think that really difficult because you got a case manager in the community saying ‘well, he’s at risk of deterioration’ and I’m like, ‘well, that’s how you interpret it.’ And so sometimes that’s related to families and clients and it gets into tricky situations.”

A case manager agreed, *“...it looks great on paper and it makes perfect sense on paper, but it’s not necessarily working in practice.”* She went on to say, *“I think we need further clarification on that and its purpose kind of needs to be explained to all parties.”* This case manager suggested that by using such vague language and leaving the interpretation up to individual physicians and psychiatrists lends itself to a paternalistic way of practicing medicine.

4.4.2 Community Treatment Orders

Compliance with Requirements for Treatment Plan

The criterion (Section 40 (2) (v)) stating that an individual must be capable of complying with the treatment plan of the CTO has limited some cases of which an individual may have benefited by being on the order. If an individual does not comply with signing the agreement, the order cannot take place. This has created a barrier to getting the CTO signed. As suggested by a participant,

“the criterion (Section 20 (2) (iii)) stating that an individual must have a mental disorder and as a result cannot fully comprehend the consequences and is unlikely to voluntarily participate in the CTO treatment plan, seems to contradict the criteria around the compliance of the individual to the CTO and plan.”

Participants agreed that this criterion often prohibits the sickest patients from being placed on a CTO and allows them to fall into the 'revolving door syndrome' of being released from hospital, becoming non-compliant to medication regime, and resulting in a readmission to the hospital.

Previous Involuntary Admissions

It was suggested that because an individual must have been an involuntary patient on three or more separate occasions in the last two years, there are patients who may have benefitted from being on a CTO; however, because they were not involuntarily admitted three or more separate occasions they do not meet the criteria for a CTO. A participant commented that you should not have to discharge a patient from hospital in order to have them come back as an involuntary patient in order to place them on a CTO when it is evident that they would benefit from a CTO. Another participant reported that this particular criteria was put into place so that not just anyone could be placed on a CTO and only the sickest and most severe cases of those who continue to stop taking their medication and, as a result, are repeatedly certified should be placed on a CTO. Some participants suggested that if the number of current CTOs goes beyond 40, then a review of the legislation should be mandatory. This was also recommended by Judge Luther in the Inquiry into the deaths of Norman Reid and Darryl Power (Luther, 2003).

Lack of Availability of Community Services

Services that allow for an individual to live in the community without the risk of harming themselves or others and decrease the likelihood of substantial mental or physical deterioration or physical impairment are required to be available, and to be provided to the individual when on a CTO. Participants agreed that this criterion presents challenges, particularly outside the St. John's area. Specific services that need attention include case management, home support/home care, housing, recreational activities, income and employment services, and the cost of medications. In particular, the issue of housing was identified to be a critical area of importance. Participants agreed that in many cases housing and living conditions sometimes further contribute to deterioration in mental health. A participant suggested that being in hospital is sometimes better than living in poor living conditions.

Another gap in fundamental services and supports is a feasible drug plan for mental health consumers. As stated by participants, while in hospital patients have access to medications that enable them to stabilize; however once a patient is discharged, whether on a CTO or not, he or she no longer has access to many of their medications (i.e. some anti-psychotics and mood altering medications). It was also suggested that the Newfoundland and Labrador Prescription Drug Program be re-evaluated to include such medications. It was suggested that CTOs often become *“forced medication only.”* It was suggested that some consumers on CTOs are only

getting medications because the other services and supports that should be in the community to support them are not accessible or available.

Education and Involvement of Peace Officers

It is necessary for all professionals involved in a CTO to have the education, knowledge and involvement necessary to carry out the CTO and treatment plan. It was suggested that it may be beneficial to have more involvement from peace officers when implementing CTOs. For example, it may be beneficial for peace officers to be notified that an individual is being placed on a CTO so that response time may be made quicker if needed. Also, it was suggested that education may be needed for all those involved in involuntary admission and CTOs.

4.4.3 The Role of Peace Officer in Detainment and Apprehension

Process of Detaining

Peace officers explained that the MHCTA offers more grounds for detainment; therefore quicker access to mental health services. The MHCTA outlines several processes for grounds for detainment. They include a judge's order for involuntary psychiatric assessment and apprehension by a peace officer. It was suggested that there have been few, if any, orders of conveyance by a provincial judge. As explained by a peace officer, "...you will find that applications before the court are extremely, extremely rare. For the most part what happens is these individuals are in crisis and the police get called." Applications to a court judge can be made by health care professionals and/or families. Peace officers agreed that the police should be involved in involuntary admission cases only as a last resort. They agreed that such cases are health care issues and not criminal in nature. For example, one officer shared that he is frustrated when he is called upon by a health care professional and asked to detain an individual who is no longer taking his or her medication. He believed that this is not a policing issue, but rather a health care issue that should be managed by health care professionals instead of police.

Under the previous Mental Health Act, peace officers were obliged to observe behaviours that indicated a serious risk; under the current MHCTA peace officers can now detain and apprehend someone who is at risk of deterioration. Peace officers can obtain witness accounts of observers and detain based on what has been told to them. For example, a case manager may call upon the police to detain a client who they believe is at risk of deteriorating. Family members or individuals who have contacted the police may also provide accounts to police. This was thought to be a positive aspect of the MHCTA, as described by nurses, nurse practitioners, other health care providers, and peace officers, it gives family members peace of mind and a voice in the apprehension and care of their loved one. However, it was also cautioned by some nurse practitioners, nurses, case managers, and social workers, that some families may exaggerate behaviours in an attempt to have the family member admitted so that they can alleviate stress or burnout associated with caring for an individual with severe mental illness. Another challenge discussed by peace officers is that families sometimes downplay behaviours of an individual.

"When we get to the scene the parents downplay the behaviours but we can see that he's in jeopardy and we're left with our hands tied again. We need to have that statement or we need to see the behaviour in front of us."

The peace officer further explained that families are sometimes shamed by the behaviours of their loved one and are embarrassed by having the police involved. This criminalization of mental illness often leads to and feeds the stigma associated with fear, criminal behaviour and mental illness.

Challenges with Detainment and Conveyance

Participants in focus groups from all health authorities suggested that they have had some challenges with having peace officers detain and convey individuals at their request. RNC and the RCMP have requested that a copy of the first certificate or a letter from a psychiatrist requesting the detainment and conveyance of the individual before they will proceed. As explained in the focus groups, this is not outlined in the MHCTA. In certain circumstances this cannot always happen. It was thought that the reluctance to detain and bring an individual to a medical facility without an order may contradict the protocols used by the RNC and RCMP and may be a liability issue for peace officers. The participants in the RNC focus group suggested that they are reluctant to pick up an individual under the MHCTA without a court order because they feel they have no grounds for detainment. *“When you have individuals that have been showing deterioration that’s not going to be clear and present when we arrive, then we need documentation.”* The differing opinions expressed by health care professionals and the RNC group allude to confusion under that section of the MHCTA and protocols associated with detainment and conveyance.

Question of Liability

While peace officers agreed the MHCTA gives them more grounds for detainment; the Act is inefficient in terms of the process after detainment. For example, if an officer brings in an individual under the MHCTA, and the psychiatrist or physician assess the person and decides they do not meet the criteria for involuntary admission, the individual is free to leave. A peace officer indicated that they are expected to escort the individual back to where they were first detained. Peace officers suggested that some individuals may be at risk of harming themselves while in their custody and therefore, have concerns over liability issues. Peace officers may detain and bring in the same individual to the mental health facility two or three times during their shift. One officer shares his frustration,

“You sometimes bring somebody there and then they’re released and they want to be there, the patient wants to be there. They have to leave because the doctors won’t admit them and the next thing you’re being called back...so where does that leave us?”

Another officer explains, *“It’s still a revolving door. They’ve made the change in the Act giving us more ability to detain more people but, it’s not fixing anything if none of these people are getting any treatment.”*

The Role for Paramedics

There were conflicting views between groups of health care professionals and peace officers regarding the use of paramedics and ambulance service in conveying and transporting individuals to health facilities. While acknowledging provisions in the MHCTA, some peace officers offered their own opinion that some of their calls could be handled by paramedics.

“...how many times do we get a call, so and so is overdosing and we have to take it. Why is it the police? Why can’t the paramedics go and take that person in the ambulance because it’s a medical issue and transport them to the psychiatric unit?”

A participant from a mental health provider group explained:

“The transportation of the aggressive client is a challenge and the police as far as I know and they were telling me that they’re refusing to actually transport the patient to the hospital. That the ambulance has to do it so I don’t know where that leaves the ambulance attendants if the client gets aggressive in the back of the ambulance.”

The participant goes on to say,

“The other side to that, the RCMP have come back to us with if they’re taking a patient who is medicated and then there are medical issues where do they stand if something happens? It’s kind of a catch twenty-two for both.”

A participant from Central Health talked about their memorandum of understanding with the RCMP. Ambulances that are transporting mental health patients are often followed by the RCMP in case the patient becomes aggressive. The paramedics will pull to the side of the road and let the peace officer intervene as appropriate. While this was acknowledged to be outside of the MHCTA, it was suggested by both mental health professionals and peace officers that it may be useful to explore the role of paramedics in the transport of patients under the MHCTA.

Wait times in Hospitals

A major challenge discussed by the RNC and the RCMP was of the long wait times once an individual is detained and brought to a medical facility. Under the MCHTA a peace officer is required to stay and wait with the individual until they are assessed by a physician, psychiatrist or nurse practitioner. Peace officers reported that the wait is anywhere between two to seven hours. The main concern from the perspective of the RNC and RCMP is that it ties up resources. As one officer stated, “Last week there were five cars there at the one time. That’s five cars off the road.” There was concern in smaller areas that if a peace officer is waiting for an assessment at a medical facility, then there are no other officers available to take urgent calls.

“We have to sit and wait on that person who is assessed, it creates resource issues with the police, I know that is not a concern of healthcare nor is it an issue of the Mental Health Act, but it is a reality of police. Because if you’re sitting there with two police officers for hours on end and you’re called to other calls because we don’t have a large amount of resources to back up those absences from those detachments.”

The nurses and mental health professionals from Eastern and Western Health stated that peace officers do not always wait with the individual until the assessment is done.

Stigma and the Criminalization of Mental Illness

Another issue relating to peace officers having to wait with an individual until he or she is assessed is that of the stigma associated with mental illness and criminal activity. Emergency rooms in hospitals that are not dedicated mental health facilities are open to the general population of patients. A waiting area may contain people with a range of health conditions, such as heart conditions, motor vehicle accidents, and respiratory problems. As an RNC officer explained,

“...that individual is sitting with a police officer on either side of their stretcher...you walk by and it’s your neighbor...there’s that concern and that privacy and the level of dignity that goes with that, but that’s a huge impact on policing.”

Some participants stated that one of the main goals of this legislation is to move away from criminalizing mental illness; many participants suggested that there is still room for improvement in this regard.

Safe rooms

Some participants used the terms “safe room” and “seclusion room” interchangeably, while some differentiated between safe rooms as being a room near the Emergency Department and a seclusion room as being on a psychiatric unit or general ward. Participants indicated that some sites have safe rooms that are up and running as outlined in the Act; while other sites are still waiting for the construction of their safe rooms. Safe rooms were thought to be an essential improvement in the treatment of individuals with mental illness; however it was thought that all safe rooms, as outlined in the Act are still not in place. Many of those that are in place are not operating as specified, for example, some safe rooms are being used as office space. A mental health professional from a rural area stated, “*it [safe room] was built, but not utilized, and it’s actually being used now by one of our counselors, as a counselors office space.*” A GP indicated that although safe rooms are described under the MCHTA, often there are mental health patients who have other health care needs who are placed in safe rooms. For example, the GP recalled a situation in which someone with a mental illness was placed in a safe room for their own protection and the protection of others; however, the individual was simultaneously under the Communicable Disease Act as well. The GP suggested that protocols should be in place to deal with patients who have multiple health conditions.

Some mental health professionals from the Labrador Grenfell group indicated that although some of the safe rooms have been set up, they are not designed the way it was planned. A GP explained that due to poor set up, one of the safe rooms was demolished by an individual. “*...they’re [safe rooms] not safe. I don’t know if they’re up to the code under the Act, and that’s just not good enough if ours aren’t up to code.*” She went on to describe the situation, “*...and they lit the mattress on fire...nearly killed them.*”

As indicated by peace officers (both the RNC and the RCMP), in their opinion, the safe rooms are not well resourced with proper staffing who are trained to handle aggressive individuals. Although, as indicated in the Act, peace officers are required to stay with an individual until he or she has been assessed by a psychiatrist, some peace officers believed that they were not required to stay once the individual is placed in a safe room. Some suggested that this is not a policing issue and it should be the responsibility of the health care professional. Another participant explained the health care facilities do not have staff that are trained to deal with aggressive individuals. It was suggested that this may be a role for security guards.

Police Holding Cells

As indicated by all participants in all focus groups across disciplines, the police holding cells (the lock-up) are not an ideal location to hold individuals while awaiting assessment. As discussed by participant’s placement of individuals in police holding cells contributes to the criminalization of those living with mental illness and the stigma associated with mental illness and criminal activity. A RCMP officer suggested,

“You’re infringing on a person’s right. I don’t see it as being the right thing because it’s contrary to the care part of it...a lot of the time, especially when we’re dealing with involuntary patients it can be traumatizing ten times over by us [RCMP] being involved.”

Many of the participants, particularly those in urban areas, insisted that lock-ups are not used as holding places for individuals waiting for assessment. It was explained that this is an old practice that may have occurred under the previous MHCTA, but it is now a rare occurrence.

Mental health professionals, nurses, and GPs from Labrador Grenfell explained that lock-ups are used in rural areas of Labrador to hold individuals who are aggressive or intoxicated until they can be transported or assessed by a GP. As explained by a participant in Labrador,
“...it’s not just the safety of that person it’s the safety of the general public...even though no it’s not ideal to hold somebody with a mental illness in a lockup...sometimes you do what you have to do to protect that person as well as the general public.”

A nurse from a clinic in Labrador explained that often it is only herself or another nurse and herself working in the clinic at any given time. She stated that she often calls upon the RCMP (who have a detachment and holding cells near the clinic) to assist her when a patient becomes violent, aggressive or is under the influence of alcohol or drugs. Although she acknowledged that often such individuals are mentally ill, she explained that she often needs assistance in handling such situations so as not to endanger herself, the public, or the individual themselves. Although she insisted that the RCMP and health care team work well together she stated that the peace officers sometimes acknowledge that it is not their job to hold individuals who are mentally ill. She stressed the need for a safe room, especially in some of the smaller clinics in rural areas of Labrador.

Intoxicated Individuals

As discussed, individuals held in police lock-ups are often individuals who are intoxicated and are exhibiting or have known mental health problems. A frustration shared by the RNC and the RCMP is when they go to a mental health call and the individual is suicidal and is intoxicated. The individual is detained and transported to the medical facility and is turned away by the physician because of their intoxication. An RCMP officer explained,

“...the doctors for whatever reason refuse to accept them [intoxicated individual]. And our members [RCMP officers] have been in the situation as to what they would do. They [doctors] don’t want to do an assessment of the person because they’re intoxicated or under the influence that leaves the member [RCMP] in a quandary as to their rights and what he can do.”

A similar situation has been described by the RNC, physicians are refusing to assess individuals while they are under the influence of alcohol. An RNC officer described the trauma associated with being locked up while suicidal and intoxicated, *“Here’s somebody who’s trying to kill themselves and they wake up the next morning and they’re surrounded by bars. What kind of worse trauma do you want?”* The RCMP group concluded that it is less desirable for peace officers to be holding an individual with a mental illness, while they receive training in mental illness; they are not medically trained professionals.

4.4.4 Patient Rights

Contents of Certificate may be Damaging to Patient-Physician Relationship

The certificate that is given to patients includes the explanation of certification including the supporting evidence from the physician who has signed the first certificate. It was discussed by nurses and mental health professionals in the group that this information may be detrimental to the relationship between physician and patient. As stated by a rights advisor, allowing the

patient to read their certification form may escalate the situation, it is the right of the patient to have a copy of the form and to have the certification explained to them. A nurse explained,

“It’s very frustrating that the first thing that we’re doing is giving the patient a copy of their certification papers with the reasons written on it why they’re certifiable. The doctor is trying to develop a relationship and put themselves in the position of being the helper and the trust and ‘you’re writing these things about me?’ And not only that but in the review hearing, you’re having to sit there with the patient in the room and tell everything and I know the psychiatrists are very challenged with it, we all are in that situation but the patients get very upset with them and yet they’re the ones who’ve got to continue the treatment...and try to build trust again for the next certification. There’s a lot of damage.”

Access to Private Telephone

Under the MHCTA, patients should be allowed access to the telephone and be permitted to make phone calls. A nurse in Eastern Health stated that they have a private room available for patients to make telephone calls. However, she expressed some concern over patients constantly wanting to use the phone. She suggested that patients are often too unwell to make phone calls. She shared that some of the phone calls are inappropriate calls to family members or government officials. Contrary to this, a rights advisor expressed concern that patients are not given access to a private telephone. It was suggested that patients are allowed to use the telephone at the nurses’ station where there are staff and other patients around. *“There needs to be a room with a phone and a pen and paper so these people can write down what they need to write down. And that’s not happening.”*

A rights advisor suggested that patient access to pen and paper for writing letters is out of date and should be replaced by access to email. It was also noted that internet access should be added to the legislation.

Patients receive copies of certification

Many participants expressed concern about giving patients a copy of their certificate. A nurse explained that patients are often unwell at the time they are given copies of their certificate and they do not understand why they are given copies. *“They’re so psychotic, we had patients posting them up in their windows and putting them all over the place, they’re left everywhere for everyone to see.”* The concern is that patients are leaving copies of their certificates around their rooms and on the unit and therefore their personal health information is open for anyone to read. It was suggested that certificates should be reviewed with the patient and a copy be placed on the patient’s file; however, patients should not be given a copy of the certificate as there is a risk of breaching confidentiality.

4.4.5 Rights Advisors

In general, all participants across disciplines were in support of the rights advisor role and thought that it is a step forward in patient rights. The major concern from many of the participants was the timing of when the rights advisor first meets with the patient. It was thought that the rights advisor meets with the patient too soon after the patient is certified. The MHCTA states that the rights advisor should meet in person or by other means as soon as possible or at the latest within 24 hours after an individual is detained or admitted to a psychiatric unit. It was thought that an individual who is involuntarily detained or admitted to a psychiatric facility would be too unwell within 24 hours of detainment or admission to understand or remember their rights

as given by the rights advisor. It was suggested that patient rights should be discussed with the patient on an ongoing basis, involving multiple visits from the rights advisor. It was also thought that the rights advisor should be available to the patient upon request from the patient.

As noted by many participants, rights advisors meet with patients within 24 hours of detainment or admission and are explaining that the patient can apply to the review board to have their case appealed. A psychiatrist explained, *"The rights advisor sees them on one signature and they'll get them to sign an appeal before they are even fully certified."* He further explained, *"I think they should be fully certified before they see the rights advisor and had the opportunity to appeal the certification."* Some patients are still unwell when the rights advisor meets with them. One psychiatrist gave an example, *"I've had one patient who is catatonic and the next day they somehow signed the appeal. It didn't make sense to me and when the appeal finally came out the following week she didn't even know what she was going to."* The timing of the rights advisor's meeting was also thought to be a factor associated with the increase in appeal applications to the Review Board.

Rights advisors suggested that their role is to give the patient their rights; it is not a patient advocate role. They stated that they do not meet with or discuss the patient's care and treatment with any other professionals. However, one rights advisor stated,

"I feel this position, as great as it is, can be and should be much more. Here you have the Mental Health Care and Treatment Act...in trying to improve the lives of people who have been certified and in ensuring everybody is accountable. And then you have rights advisors who are hired on a contract basis...there's a huge gap in what we could be doing above and beyond what we do...it's a full-time position that people need to support some version of a rights advisor or some advocacy role. Or maybe there's another position that could fill the gap of what the rights advisor is not able to do because the short amount of time that we're in there, it's not enough time to help."

The process of communicating with the rights advisor was discussed by the legal aid representative as well as by a patient. Both participants agreed that the process is cumbersome; although many participants agreed that rights advisors are doing the best they can do with limited resources. It was explained that when a patient is detained or certified a nurse calls a toll-free telephone number and leaves a message to notify the rights advisor of a new patient. The rights advisor is then informed and arranges to meet with the patient. As indicated by the legal aid representative and patient, because the rights advisor works full-time in an unrelated position, they meet with the patient at their earliest convenience, which is usually after work hours. The patient suggested that they felt unable to access the rights advisor during a crisis situation and felt the rights advisor should be available 24 hours per day. The legal aid representative recognized that involuntary admission is not a criminal offence but stressed the fact that individuals are being held against their will as involuntary patients and as it states in the Charter of Rights and Freedoms, individuals have the right to legal counsel immediately if they are taken into custody in the criminal system. The legal aid representative thought that individuals do not have timely access to rights advisors and should be provided the opportunity to speak with their rights advisor immediately.

A participant reminded the group that under the MHCTA, rights advisors are supposed to meet with an individual as soon as possible after they have been detained or admitted to a psychiatric facility. The participants from Labrador Grenfell suggested that this is not happening within their region. The Labrador Grenfell region does not have a rights advisor and the communication of rights to an individual who has been detained is left to the nurses and or peace officer. It was

suggested that the Labrador Grenfell region have a rights advisor; although many of the patients in this region are transferred to other health regions, there are psychiatric units and individuals are being held with one signature. Patients are sometimes held while awaiting transfer without knowing their rights. A participant from Labrador Grenfell explained, *“Even though we’re not a designated psychiatric facility...we’ve had situations where we haven’t been able to get anybody transferred to a designated psychiatric facility and people have had to stay here.”*

4.4.6 Patient Representatives

Two main challenges discussed regarding the role of patient representatives involve the patient either deciding to not have a representative (which is the patient’s prerogative), or the patient choosing an inappropriate individual. Many participants suggested that patients may not choose a representative because of the lack of insight into their illness and their paranoia. Another participant reminded the group, *“Just because somebody is certified doesn’t necessarily mean that they’re not competent and if someone is asked about a patient representative and they decline to identify the patient representative...we really shouldn’t be pursuing that line of questioning or thought.”*

There was some confusion around whether health care professionals can contact the patient’s next of kin when the patient does not identify a patient representative. It was suggested that some psychiatrists, physicians and social workers contact the family. *“I’ve gotten mixed messages that yes, they’re certified so you can contact next of kin or whoever you need to contact to plan around the patient’s care and discharge. I’m uneasy with that explanation.”* Within the same focus group another participant explained, *“My understanding is you can’t, you’re involuntary and that you can’t...just because someone is next of kin does not mean that they have any power in any way over that patient.”*

Several mental health professionals suggested that if a patient states that they do not want family involvement it may be detrimental to the relationship between the patient and health care provider if they contact the family. The suggestion that it may be useful to outline the rights of families in the MHCTA was thought to be cautioned. *“I think that it could be a dangerous thing to put that right of families in the Act because not lots of families are very supportive and appropriate, but there are also people who don’t want their families to be involved in that way or who may even contribute to their sickness.”*

From the perspective of the mental health professional, it is also difficult to not be able to tell concerned and supportive family members about the care and treatment of their loved one.

“I struggled with not being able to tell the mother about a particular situation with her daughter when all along she was here. We couldn’t tell her she was here, we couldn’t tell her nothing. So when the client was well, her mom was by her side continuously, and when she was unwell, she didn’t want her mom.”

A case manager explained the risk of excluding family members who have been supportive. *“The fear is okay, mom is going to get frustrated with this and say, ‘Hey, well if you don’t need me during this crisis, I’m done.’”* If a patient refuses a supportive family member as a patient representative or refuses to have the family involved, there is a risk of causing strain and conflict between their relationship, which could be detrimental to the patient once they are discharged and living in the community.

Another concern raised by many of the participants from all regions was when patients choose an inappropriate individual to be their patient representative. Sometimes, as some participants suggested, “*The individual is an outrageous representative. We’ve had patients picking the Queen of England,*” but other patients have picked individuals who are on their care team. This leads to a conflict of interest in which it is inappropriate for an individual to be on the treatment team and also fill the patient representative role. “*We had an issue a little while back about a lawyer who was the patient representative and had a conflict of interest related to a review board hearing.*”

4.4.7 Review Board

A new Chair of the Review Board was newly appointed in October 2011. In addition to this, new Review Board members were recently chosen in 2011. It has been acknowledged by the Chair and others that this may be a good opportunity for the review of processes and procedures relating to the Review Board.

This following section has been taken directly from the ***Board’s Annual Activity Report 2009-2010 and 2010-2011*** (Tables 31-37; Figure 11 and narrative). The section following the Board’s Annual Activity Reports, presents the findings from the focus group and interview discussion pertaining to the review board.

Reports

The Mental Health Care and Treatment Review Board is outlined under Section 56 of the MHCTA. The main role of the board is to review the applications that have come in to appeal certifications of involuntary admission, community treatment orders or other claims of denial of patient rights and to undertake automatic reviews.

Table 31: Mental Health Care and Treatment Review Board Activity by Fiscal Year, 2007-2011

Review Board Activity	Total 2007-2008⁷	Total 2008-2009	Total 2009-2010	Total 2010- 2011	Grand Total
Status of Applications	Number of Applications				
Received	91	101	107	102	401
Summarily dismissed by	2	2	6	8	18
Cancelled¹	52	39	43	42	176
No hearing set²	6	12	10	17	45
Rescheduled³	10	5	9	4	28
Postponed⁴	0	1	0	0	1
Hearings convened⁵	21	42	39	31	133
	Result of Hearings by Review Board Panels				
Certificates upheld/	16	35	28	27	106
Certificates not upheld / not confirmed	5	5	10	4	24
Community Treatment Orders upheld /confirmed⁶	0	1	1	0	2
Panel lacking jurisdiction	N/A	1	0	0	0
Decision communicated	21	42	39	31	1

Source: Mental Health Care and Treatment Review Board Annual Activity Report 2009-2010 and 2010-2011.

¹Applications cancelled include those that had been scheduled and did not proceed because the applicant or his/ her representative choosing not to proceed (i.e. withdrew) or the applicant was decertified and no longer required a hearing.

²No hearings were set means that the applicant was decertified and/or discharged prior to the scheduling of the hearing

³Hearings were rescheduled due to factors such as non-availability of psychiatrist, adverse weather conditions

⁴Hearing was postponed to obtain further evidence, but not rescheduled to another date

⁵Hearings convened means that review board members met in person or used communications technology to hear and decide upon an application.

⁶The first application for review of a Community Treatment Order was heard in 2008-2009.

⁷Column was taken directly from the Review Board's Annual Activity Report 2009-2010.

Table 32: Goal Indicators, 2008-2011 (taken from 2010-2011 report)

Planned	Actual Activity
Number of applications received from mental health services	The total number of applications received during 2008-2011 was 310. A total of 102 applications were received in 2010-2011, which were 5 less than in 2009-2010 period, and only one more received than in 2008-2011.
Number of panels convened / Number of hearings held	Thirty one (31) review panels were convened and subsequently 31 hearings were held, representing 30% of the 102 applications received in 2010- 2011. This is approximately the same number of applications as received in 2008-2009. There were 42 hearings cancelled and this is consistent with other years covered by this plan.
Number of certificates confirmed / cancelled Note: The term “cancelled” is not appropriate in this context. Certificates are either “confirmed (upheld)” or “not confirmed (terminated)”	<p>There were 27 of 102 applications or 26% certificates confirmed or upheld for 2010-2011 representing 30% of the total (90) certificates upheld since 2008-2011. This is generally consistent with the number and percentage of applications for two of the three years covered by this report.</p> <p>There were no community treatment orders reviewed in 2010 - 2011 and only 2 since the legislation was introduced in 2008.</p> <p>There were 42 certificates cancelled, 17 with no hearing set due to decertification and/or discharge and 4 of 102 certificates not upheld/confirmed representing 62% of the total applications received this year. While the number of certificates not upheld peaked at 10 in 2009-2010, the number for this year is consistent with other years.</p>
Yearly reports provided	The Review Board has provided 3 Annual Activity Reports on the 2008-2011 Activity Plan.

Source: Mental Health Care and Treatment Review Board Annual Activity 2010-2011

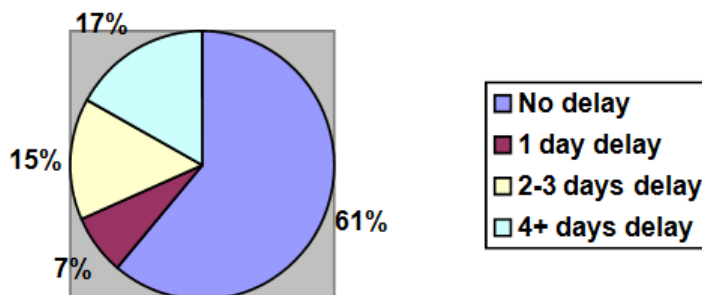
Table 33: Length Of Notice Provided For Cancelled Applications By Applicant/ Regional Health Authority, 2008-2009 to 2010-2011

Number of Applications Cancelled		Less Than 24 Hours Notice	1 Day Notice	2 or More Days Notice
2008-2009	38 ³	9	7	22
2009-2010	43	18	4	21
2010-2011	42	12	5	25

Source: Mental Health Care and Treatment Review Board Annual Activity 2010-2011

³ Table 2, page 11 (of report) indicated 39 cancellations for 2008-2009, however, the required data for Table 4 was not available for one applicant so the data is based on 38 for that year and in the above table.

Figure 11: Timeliness of Decisions Rendered and Delivered Per Section 71(2) of the Act (Percentage) (taken from 2009-2010 report)



In the 39 hearings in 2009-2010 in which decisions were rendered, 61% of decisions were delivered to the Applicant and the Health Authority in accordance with the legislative requirements. Seventeen percent (17%) of decisions were rendered 4 or more days after the hearing date. This is a significant increase from 2008-2009.

The remaining 22% of decisions were delivered with delays of 1-3 days, usually as a result of time taken to obtain signatures from Panel members, adverse weather issues, and emergent matters arising with Panel members. Further work will be done in 2010-2011 to address the timeliness of rendering board decisions that fall outside of the legislative timelines and arrive at meaningful solutions.

Table 34: Timeliness in Appointing Panels and Setting Hearing Dates Per Sections 66(2) and 67(2) of the Act By Number

Same Day as Application Received	13
Next Day after Application Received	24
1 Clear Day after Application Received	9
2 Clear Days after Application Received	7
3 Clear Days after Application Received	9
4 Clear Days after Application Received	10
5 Clear Days after Application Received	0
More than 5 Clear Days after Application Received	5
Total	76

Source: Mental Health Care and Treatment Review Board Annual Activity 2010-2011

Table 35: Timeliness of Hearings Scheduled to be Heard Per Section 67(1) of the Act by Number and Percentage 2010-2011

Number of Days Within which Hearings are Scheduled to be Heard from Receipt of Application	Decisions Rendered and Delivered	
	Number #	Percentage %
One to Four Clear Days	1	17
Five to Ten Clear Days	5	68
Eleven to Thirteen Clear Days	1	15
More than thirteen Clear Days	0	0
Tot	7	100

Source: Mental Health Care and Treatment Review Board Annual Activity 2010-2011

Table 36: Timeliness of Decisions Rendered and Delivered Per Section 71(2) of the Act by Number and Percentage 2010-2011

Number of Days After Hearing to Rendered Decision	Decisions Rendered and Delivered	
	Number #	Percentage %
Next Day	6	2
One Clear Day	2	6
Two Clear Days	5	1
Three Clear Days	4	1
More than Three Clear Days	14	4
Total	31	10

Source: Mental Health Care and Treatment Review Board Annual Activity 2010-2011

Table 37: Delay of Decisions Rendered and Delivered Per Section 71(2) of the Act by Number and Percentage 2010-2011

Delay in rendering Decision	Decisions Rendered and Delivered	
	Number #	Percentage %
Four Clear Days Delay	2	14
Five Clear Days Delay	8	58
Six Clear Days Delay	2	14
Twelve Clear Days Delay	1	7
Twenty One Clear Days	1	7
Total	14	100%

Source: Mental Health Care and Treatment Review Board Annual Activity 2010-2011

Of the 31 hearings in 2010- 2011, seventeen (17) or 55% of the hearing decisions were rendered and delivered to the Applicant and the Hospital Authority with no delay in accordance with legislative requirements. Fourteen (14) or 45% of the decisions were rendered and delivered after the time frame required by the legislation, the particulars of which are set out in the above Table.

Review Board Focus Group and Interview Findings

The following themes emerged from the discussion in relation to the Review Board procedures and processes.

Timeline Confusion

Misinterpretation of the timelines outlined in the MHCTA, particularly with regard to the Review Board applications, hearings, and decisions was discussed by participants in most of the focus groups and interviews. The interpretation of “clear days” and the inclusion and/or exclusion of holidays and weekends was questioned. It was suggested that clearer timelines should be outlined in the Act rather than the interpretation of individual users of the Act.

Hearing Decisions and Social Context

Although discussed by participants from groups, particularly those in rural areas of the province, the social context and resources available in the community was thought to be an important factor for consideration when an individual is appealing their admission; it was thought that such resources should not be a deciding factor in an appeal. For example, a participant from the Labrador Grenfell region suggested that the review board should be given “*What the needs and resources are and making sure that information gets presented...so the Review Board has the resources to understand what the realities of Labrador.*” The participants in the Review Board focus group agreed that resources should be taken into consideration; however, as explained,

“...if the patient does not meet the criteria in the Act to be certified, then we have to say that they are to be decertified and the fact that they have poor home circumstances and etcetera, there’s no support systems really isn’t within the legislation, we aren’t allowed to consider that.”

Another participant from the Review Board focus group agreed that when a patient no longer meets the certification criteria the board must decertify the patient; however when considering the patient’s best interests, for example, the social supports outside of the hospital, “*You get into*

a very slippery slope when you get down to what's in the best interests...I think we cut off fairly, fairly brutally from that slope. Here are the criteria do they meet them or do they not?"

Appealing Review Board's Decision

The Review Board focus group participants discussed the idea of appeals of the review board's decisions. To their knowledge, this has never happened and they were unsure of the process to be taken if it were to occur in the future. The allowance of a four hour hold from nurses was discussed and was thought to be used as a way of appealing the review board's decisions. If a nurse feels that a patient, who has been found to no longer meet the certification criteria by the review board, is deteriorating, a nurse can hold a patient for up to four hours until a psychiatrist has assessed the patient. One participant held the view that this section of the Act was originally put into place so that nurses could hold voluntary patients whose condition had deteriorated so that a psychiatrist could assess and certify the patient if necessary; it was not originally intended to be used as a way of recertifying a patient after the review board had made a decision to decertify.

Judicial Atmosphere of Review Board Hearings

Many participants suggested that the atmosphere of Review Board hearings tends to be similar to that of a judicial hearing. A psychiatrist said, *"It's like a criminal case where you have to defend yourself."* A psychiatrist presents their case to the panel and the psychiatrist is then open for cross examination and questioning. A nurse stated, *"Our charting is scrutinized to the point of what we coded something at two on one day and one on another day is scrutinized."* Another nurse added, *"And you better be able to back it up."* Another nurse explained, *"It's the psychiatrist defending the certification...it's the psychiatrist who is on trial."* A member of the Review Board focus group suggested that sometimes questioning at hearings tends to place emphasis on the diagnosis rather than on the process of certification or on whether the individual meets the certification criteria. He stated, *"I think most would agree that...we should put our emphasis on the actual Act and why the patient is being held under it as opposed to the broader medical questions."* He thought that the purpose of the Review Board is not to question the competence of the psychiatrist or their decision making, but rather to ensure patient rights are being adhered.

It was suggested by many participants that there is legal representation for the patient; psychiatrists do not have legal representation. Psychiatrists are required to present their case to the panel; however, they have never received training in putting together a case. It was thought that psychiatrists should either have legal representation who could present the case to the panel or the psychiatrist's themselves should be given training on how to present a case. One psychiatrist expressed concern, *"Well, the onus is still on the psychiatrist and it's not that the patient is not certified it's just that the psychiatrist has not proven the case."* Another psychiatrist added, *"We're not lawyers."*

Review Board Administrative Support

A recommendation by both the Review Board members and another participant was to reallocate the administrative duties of the Review Board from the Department of Health and Community Services to either the Chair of the Review Board or an outside organization with resources available. Comments were made regarding possible conflicts of interest and conflicts with the MHCTA. As currently stated in the Act under Section 60(1), the administrative duties, such as managing and planning applications and assigning members of the panel, are to be held by the Chair of the Review Board, but traditionally the administrative support has been provided by a staff member at the Department of Health and Community Services.

Rules and Policies Governing Review Board Processes

A participant stated that there are limited rules and policies governing the board's processes, maintaining, "*the board is not operating as a board.*" The member suggested that guidelines for procedures should be followed, for example, currently lawyers on the panel often only receive the name of a client without any other information pertaining to the case. Preferably, the lawyer should be given a report on the client and allowed at least 24-48 hours to review before the hearing. As indicated by this participant, receiving the file on the day of the hearing is not beneficial to the lawyer or the client. The member further explained, "*the board should be entitled to all [information] that is relevant.*"

Increase in Cancellations

Another concern discussed by members of the Review Board was the increasing number of cancellations of hearings. It was suggested that many cancellations are due to applicants being decertified before the hearing or the application is withdrawn by the applicant. Further investigation into why the number of cancellations is increasing was suggested.

5 Conclusion and Recommendations

5.1 Strengths and Limitations of the Study

The following section outlines some strengths and limitations of this evaluation. The strengths and limitations are presented in no particular order.

Strengths

This evaluation employed both qualitative and quantitative research methods, allowing for triangulation of the findings. This multi-method approach allowed for presentation of the facts, relating to administration data collected on certifications as well as discussion of the concerns and issues relating to the MHCTA through the focus groups and interviews held with stakeholders involved in the everyday use of the Act.

Although the patient survey response rate was low, it was beneficial to provide the opportunity for patients to provide their experience of having been involuntarily admitted under the MCHTA, as they are recipients of the care and treatment.

The interest expressed by professionals involved in the use of the Act was tremendous. Invitations to express facilitators and challenges associated with the MHCTA were sent to professionals across the province resulted in an excellent response. Requests for additional focus groups and interviews for those who could not attend the initial sessions were received and accommodated for where possible.

Limitations

There were some challenges in conducting this evaluation. It was recognized prior to the administration of the patient surveys that the response rate would probably be low due to the generally low number of involuntary admissions. It may have been useful to have provided a longer period of time for the administration of the patient surveys to therefore increase the response rate. As a result of the low response rate, statistical significance testing was not carried out and caution should be taken when interpreting findings.

One of the challenges related to focus groups is that the views of more vocal people may dominate the discussion. There is a possibility that the views of those who are uncomfortable in sharing their thoughts and feelings around the MHCTA may not be well expressed.

The stakeholder focus groups and interviews and the patient survey and interview may be biased in that the options expressed are those of an individual or a small group of individuals only. We do not have the perspective of all stakeholders involved for each individual circumstance; consequently, it is difficult to get a picture of the whole story.

The patient survey involved recalling a time in a patient's life that may have been traumatic and affected by severe mental illness symptoms. This should be taken into consideration when interpreting patient survey results.

5.2 Summary of Key Findings

Several key facilitators and benefits as well as barriers and challenges were highlighted throughout the administrative data, patient surveys, and focus group and interview discussions. The key findings are listed below.

Facilitators and Benefits

One of the main facilitators of the MHCTA identified by many participants is that the MCHTA provides standards and structure. One nurse stated, *“It’s much more pragmatic, the steps are laid out, it’s much more structured and ...there’s a tendency for clinical reasons, everybody to be more attentive to it.”* The timelines and automatic review leads to more accountability and therefore, better care for patients.

The MHCTA is patient-centered and allows for better informed patients and respect for patient rights. A member of the Review Board stated,

“I think it has really paid a great deal more attention to the individual rights of the person. We’ve had many more applications for the review than had happened previously...but certainly there has been that vigilance that an oversight that wasn’t available before.”

From a policing perspective, they now have more grounds to detain and convey an individual to a psychiatric facility. Under the old Mental Health Act, peace officers were required to observe behaviors that indicated someone was at risk of harming themselves or others; the new Act provides the opportunity for peace officers to take the word of family or friends, a mental health professional and may detain and apprehend an individual under the Act.

Although there were some concerns expressed over the vagueness of the risk of deterioration certification criteria, many participants agreed that this criteria allows for earlier treatment so that individuals do not deteriorate to the point of harm themselves or others. This also leads to shorter hospital stays and faster recovery. A psychiatrist stated, *“I think it is a good thing because we are picking up patients earlier and treating them and sort of preventing a further deterioration and further consequences of their mental illness.”*

Barriers and Challenges

A challenge described in this evaluation revolves around the need for education and clarification of the roles of individuals involved in certification. This includes the role of individuals from the detention through discharge and reintegration into the community. Many participants questioned the responsibilities of both their own roles and the roles of other professionals. There was also some confusion over the language used in the Act; the vagueness of the language used was thought to contribute to inconsistencies. Regular training was thought to be needed for all professionals across disciplines.

Another key finding that is woven throughout the report involves the lack of support services, particularly in rural areas of the province. Without services and proper resources in communities, the Act cannot be used as intended. Resources and supports such as those required for CTOs, safe rooms, and health care personnel are limited or non-existent in many rural areas of the province.

Only seriously mentally ill individuals are involuntarily admitted under the MHCTA. During the time of involuntary admission many individuals are so ill that they may not be able to comprehend their illness or understand the magnitude of what is happening to them. Currently,

the Act outlines protocols for Rights Advisors in explaining patient rights within the first 24 hours of detainment or certification. Many participants thought that this occurs at a time when a patient is too unwell to understand. Another example from the Act in which a patient is asked to make a decision regarding their care is when they are asked if they would like to have a patient representative. Patients are also asked to choose a representative. As discussed in the focus groups, patients often assigned inappropriate individuals or do not assign a patient representative at all.

5.3 MHCTA Evaluation Recommendations

Emerging from the evaluation findings are 9 recommendations related to the MHTCA criteria and procedures. They are presented for consideration in an effort to improve the care and treatment of individuals who are involuntarily admitted under the MCHTA as well as improve the current processes for the various stakeholder groups. The recommendations are supported by findings of the evaluation, mainly through the feedback obtained in focus groups and key informant interviews. Recommendations are presented in no particular order of importance.

It is recommended that:

1. There be an increase in the availability of support services, particularly in rural areas of the province, to enable the implementation of CTOs. The lack of resources such as supportive housing, access to employment and prescription drug plans is thought to be a barrier to the implementation of CTOs, in particular those individuals residing in rural areas. It was thought the lack of support services should be addressed in order to better realize the benefits of CTOs.
2. Consideration be given to the review of the criteria relating to CTOs (outlined in Section 41(2) of the Act). Currently, the criteria for CTOs require that the individual “contain an undertaking” with the requirements as set out in the CTO. There are challenges related to individuals agreeing to sign the CTO. This criterion may limit the implementation of CTOs in the province; consequently, individuals who may benefit the most from CTOs do not agree to comply.
3. Annual training sessions be available for all professional groups involved with the MHCTA. Professional development is an important aspect of maintaining skill sets and keeping up-to-date with processes and protocols. The training should be specific to individual roles, but also should include an introduction to the role of other professionals who are involved with the Act in order to facilitate a better understanding of each other’s roles. Training should also be provided to new hires. The sessions should include (but not limited to) an explanation of specific sections in the Act that cause confusion and are often interpreted differently by different professionals such as the timelines, assessment for certification, and the CTO criteria.
4. The Review Board pursue their plans to review procedures and administrative support functions for ways to maximize the functioning of the Review Board Appeal process. As outlined in Section 60 of the Act, the Chairperson of the review board is responsible for the administration of planning and conducting applications for the board, assigning members of each panel, and referring applications. Traditionally, the administrative support functions are provided by a staff member at the Department of Health and Community Services as

there is no dedicated staff position assigned to the Chair position. There are many logistics that must be organized in a very short time to meet the required timelines and suggestions were made regarding improving the process.

5. Guidelines and limitations be developed so that appropriate patient representatives are chosen by patients. Involuntary patients are currently able to choose their patient representative or choose to not have a patient representative. Lack of guidelines outlining appropriate representatives has led to inappropriate assignment of patient representatives who may have conflicting interest in the care of the patient or may not be available.
6. Rights advisors meet with patients beyond 24 hours after detention or admission. The communication and understanding of patient rights is a pivotal component of the MHCTA. Currently, rights advisors visit or communicate patient rights to involuntary patients within 24 hours after detention or admission. It is thought that this timeframe may be too early for some patients to be well enough to fully comprehend their certification. For this to occur, the role of the rights advisors may need to be expanded to allow for their continuous involvement in the patient's admission.
7. Safe rooms be made available in facilities as outlined in the Act and that the rooms be reserved for individuals under the MHCTA and not used for other purposes. When a room is used for a dual purpose (e.g. office), it is difficult to quickly accommodate a seriously ill patient who may require certification. Safe rooms are up and running in some larger medical facilities in urban areas of the province; however many smaller facilities are still not equipped with safe rooms.
8. Options for exclusive safe rooms be explored, particularly those in rural areas of the province, in which individuals may be waiting to be transferred to larger facilities. The use of police holding cells is still a common occurrence in rural areas of Labrador. Small clinics are not equipped to deal with aggressive patients both in terms of health care personnel and the structural environment.
9. Consideration be given to implementing procedures that may reduce the amount of waiting time in emergency rooms. The current system of triage needs to be reviewed regarding accommodations that can be made to provide timely access to assessment and treatment. Emergency room wait times, although outside of the scope of the MCHTA, is a concern for peace officers as they are required to wait with individuals until they are assessed by a psychiatrist. They reported being at the Emergency department for excessive waiting time on many occasions. Although outside of the scope of the Act, excessive wait times for patients requiring certification have implications for the delivery of health care to the individual patient, other patients in the waiting room, and the available police resources in the community.

5.4 Concluding Remarks

This evaluation could not have been completed without the support and involvement of stakeholders from across the province. The involvement of stakeholders throughout the evaluation process over the past four years was excellent and greatly appreciated. Mental Health Services involve cooperation and collaboration between and a community of

stakeholders from inside and outside the health care system. It is only from sustained partnerships between such stakeholders that improvement can be made.

It is hoped that through continued partnerships, the recommendations from this evaluation may be considered and may influence future change for improved delivery of services for those living with mental illness across the province.

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Appendix A: Evaluation Framework Discussion Guide

Evaluating the Newfoundland and Labrador Mental Health Care and Treatment Act: Preliminary Key Informant Interviews

1. What is your role as a member of the Mental Health Care and Treatment Act Legislation Stakeholder Committee?
2. From your perspective, what are the goals or objectives of the Mental Health Care and Treatment Act?
3. What are your expectations in evaluating the Mental Health Care and Treatment Act?
4. What specifically would you like to see included in the evaluation?
5. Would you like to be involved in the evaluation? If so, how?

Appendix B: Evaluation Framework Consent Form

**Faculty of Medicine, Schools of Nursing and Pharmacy of Memorial
University of Newfoundland; Eastern Health; Dr. H. Bliss Murphy Cancer Centre**

Consent to Take Part in Health Research

TITLE: Evaluation of the Newfoundland and Labrador Mental Health Care and Treatment Act: Development of an Evaluation Framework

INVESTIGATOR(S): Don MacDonald, Kayla Collins, Kim Bonia

SPONSOR: Newfoundland and Labrador Centre for Health Information

You have been invited to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

The researchers will:

- **discuss the study with you**
- **answer your questions**
- **keep confidential any information which could identify you personally**
- **be available during the study to deal with problems and answer questions**

If you decide not to take part or to leave the study this will not affect your professional status.

1. Introduction/Background:

Newfoundland and Labrador's Mental Health Care and Treatment Act was passed in 2006. The 2006 Act includes changes in patient rights, community treatment, and the role of health professionals, police officers, and the stakeholder committee.

The Act's Stakeholder Committee and the Department of Health are interested in reviewing the Act. This stage of research will be used to guide this evaluation.

2. Purpose of study:

At this preliminary stage, the main interests for the evaluation will be discussed with the Stakeholder Committee, in an attempt to establish the research objectives for the evaluation.

3. Description of the study procedures and tests:

As a member of the Stakeholder Committee, you are invited to take part in an interview. The focus of the interview is to discuss your wishes in evaluating the Act. The interview will take place either in person or over the telephone. Interviews will be recorded and transcribed.

4. Length of time:

The interview will take about 30 minutes of your time.

5. Possible risks and discomforts:

There are no expected risks or discomforts involved in this study. You may be inconvenienced by the time required to participate in the interview.

6. Benefits:

It is not known if this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. Confidentiality:

All personal information will be removed from transcripts. All material will be stored in a locked cabinet or on a password protected computer. As well, all members of the research team have signed an oath of confidentiality.

9. Questions:

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is:

Don MacDonald (709) 752-6008

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Office of the Human Investigation Committee (HIC) at 709-777-6974

Email: hic@mun.ca

Signature Page

Study title: Evaluation of the Newfoundland and Labrador Mental Health Care and Treatment Act: Development of an Evaluation Framework

Name of principal investigator: Don MacDonald

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent [and information sheet].	Yes {} No {}
I have had the opportunity to ask questions/to discuss this study.	Yes {} No {}
I have received satisfactory answers to all of my questions. received enough information about the study.	Yes {} No {} I have
I understand that I am free to withdraw from the study	Yes {} No {}
• at any time	
• without having to give a reason	
• without affecting my future professional status	

I understand that it is my choice to be in the study and that I may not benefit. Yes {} No {}

I agree to take part in this study. Yes {} No {}

Signature of participant

Date

Signature of witness

Date

To be signed by the investigator:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of investigator

Date

Telephone number: _____

Appendix C: MHCTA Evaluation Framework

**Evaluating the Newfoundland and Labrador
Mental Health Care and Treatment Act**

Evaluation Framework
September 2010

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1. Introduction

Since the move from the de-institutionalization of mental health patients to community based services in the 1960s, mental health reform has evolved in provincial and territorial mental health acts. Societal values and issues tend to dominate the discussion surrounding mental health reform. Issues of mental health reform often focus on the need to protect and provide assistance to the vulnerable, the need to protect other members of society from those who are not responsible for their actions (due to mental illness), and the need to live as free from legal interruptions as possible. Specifically, reform has often focused on reducing the number of patients who may be involuntary admitted and protecting individuals (who are involuntary admitted) (Gray, Shone, & Liddle, 2008).

The Newfoundland and Labrador Mental Health Care and Treatment Act (NL MHCTA) was proclaimed in 2006 and came into effect on October 1, 2007. The community treatment order (CTO) provisions were deferred until January 1, 2008. The need for new

legislation was highlighted following the Luther Inquiry (2003) into the sudden deaths of Norman Reid and Darryl Power. Before the current Act was put into place, provincial legislation around mental health had not been revised in more than 30 years. The new Act has replaced the earlier legislation.

As stated in Section 6 of the Act, a review of the Act is required to be undertaken every five years:

The minister shall, every 5 years, conduct a review of this Act and the regulations and the principles upon which this Act is based and consider the areas in which improvements may be made and report his or her findings to the Lieutenant-Governor in Council.

1.1 Purpose of the NL MHCTA (2006)

The purpose of the Mental Health Care and Treatment Act, SNL 2006 (the Act) is to provide criteria and procedures for the delivery of mental health services to involuntary mental health patients. This Act replaces the Mental Health Act of 1971. As stated in the new Act, the purpose of the legislation is:

- (a) to provide for the treatment, care and supervision of a person with a mental disorder that is likely to result in dangerous behaviour or in substantial mental or physical deterioration or serious physical impairment;
- (b) to protect a person with a mental disorder from causing harm to himself or herself or another and to prevent a person with a mental disorder from suffering substantial mental or physical deterioration or serious physical impairment;
- (c) to provide for the apprehension, detention, custody, restraint, observation, assessment, treatment and care and supervision of a person with a mental disorder by means that are the least restrictive and intrusive for the achievement of the purpose set out in paragraphs (a) and (b); and
- (d) to provide for the rights of persons apprehended, detained, restrained, admitted, assessed, treated and cared for and supervised under this Act (the Act).

The Act takes a rights-based approach to guide involuntary admission to a health care facility and considers the patient's right to health and safety and the health care system's obligation to provide interventions and support services. Essentially, involuntary admission takes away the rights of individuals; however, safeguards have been put into place to decrease the likelihood of the violation of patient rights. This evaluation will touch upon many of these safeguards, including, but not limited to, the following: the role of rights advisors, patient representatives and procedural rights.

Rights Advisor

Protection of the rights of patients involves providing information around patient rights to the patient upon admission, increasing the opportunity for appealing decisions; some jurisdictions give involuntary patients the right to refuse treatment. Under the NL MHCTA, an individual is required to be advised of the following rights: to know where and why he or she has been admitted, to have access to a telephone and have access to visitors, to obtain and instruct legal counselling, to be involved in treatment decisions (to the extent to which they are able), and to have access to a patient representative and rights advisor (the Act).

Patient Representative

In preserving a rights-based approach, a new role of patient representative has been added to the Act. A patient representative refers to:

“...a person, other than a rights advisor, who has reached the age of 19 years and who is mentally competent and available who has been designated by, and who has agreed to act on behalf of, a person with a mental disorder and, where no person has been designated, the representative shall be considered to be the next of kin, unless the person with the mental disorder objects” (the Act).

Procedural Rights

The following are procedural rights of a person who is involuntary admitted to a psychiatric facility:

12. (1) A person who is an involuntary patient shall not be denied
 - (a) the right to consult and instruct his or her legal counsel in private at any time either in person or by other means;
 - (b) access to a telephone to make or receive calls;
 - (c) access to visitors during scheduled visiting hours;
 - (d) access to the rights advisor;
 - (e) access to his or her representative; and
 - (f) access to materials and resources necessary to write and send correspondence, and reasonable access to correspondence that has been sent to the person.

Upon admission the involuntary patient shall be provided with an oral explanation and written statement setting out rights. Patient rights shall also be posted in public areas of the unit. The attending physician shall provide a copy of the certificate, advise of rights such as the right to instruct counsel, meet rights advisor, the function of the board and the right to apply to the board. If the involuntary patient does not speak the language, he or she also has a right to an interpreter. Administration shall provide a copy of all certificates and related information to the involuntary patient and his or her representative.

2. Evaluation Framework

The Centre's evaluation framework requires that the evaluation team work closely with key stakeholders impacted by the implementation of the new legislation. This includes provincial government departments (e.g., Ministry of Health), administration (e.g., Regional Mental Health and Addictions Directors), and health professionals (e.g., clinicians). The scope of deliverables for the evaluation needs to be defined in collaboration with all parties through a priority setting exercise. The framework used by the Centre was informed by the previous work of Heather Heathfield and the PROBE Project in the United Kingdom (Heathfield, 1998, 1999). It employs a series of 7 steps, that can be used to evaluate comprehensive legislation, or one or more specific domains of the legislation.

Step 1: Identification of Key Stakeholders in Each Jurisdiction

Step 2: Orient Key Stakeholders to the Centre's evaluation framework and Reach Agreement on **WHY** an Evaluation is Needed

Step 3: Agree on **When** to Evaluate

Step 4: Agree on **What** to Evaluate

Step 5: Agree on **How** to Evaluate

Step 6: Analyze and Report

Step 7: Agree on Recommendations and Forward Them to Key Stakeholders

Step 1: Identification of Key Stakeholders in Each Region

In further developing the framework for the NL MHCTA evaluation it will be necessary to engage relevant stakeholders from across the province. It is important that a wide range of stakeholders be involved in and/or apprised of the evaluation efforts as it will improve the likelihood that: (1) information/data exchange will be facilitated; (2) greater strategic alignment between the goals of the broader health system and the goals of the MHCTA will occur; and (3) champions for the evaluation of the MHCTA will be identified and engaged.

Table 1
Proposed Key Stakeholders to Initially Engage in Planning for
Evaluation of the NL MHCTA

Provincial Government	Health System Administration	User Groups
<ul style="list-style-type: none"> • Department Of Health And Community Services 	<ul style="list-style-type: none"> • Directors of Mental Health and Addictions • Frontline Managers 	<ul style="list-style-type: none"> • Physicians • Nurse Practitioners • Nurses • Patients • Family Members • Lawyers • Royal Newfoundland Constabulary • Royal Canadian Mounted Police • Schizophrenia Society • CHANNAL • CMHA - NL branch • others

Step 2: Orient Key Stakeholders to the Centre’s evaluation framework and Reach Agreement on WHY an Evaluation is Needed

A review of the Act, as described in the Section 6 of the Act is required by the Lieutenant-Governor in Council.

*Step 3: Agree on **When** to Evaluate*

Section 6 of the Act states that the Act be evaluated every five years. Interim evaluation reports will be provided in December 2010, December 2011 and a final report in March 2012.

*Step 4: Agree on **What** to Evaluate*

A priority setting exercise involving key informant interviews and workshops took place as a way to: (a) identify the questions that are important to answer (versus the questions that are easy to answer), and (b) insure that all key stakeholders have an investment in the evaluation that is undertaken. The core components of the evaluation will focus on: 1) certification, 2) CTOs, 3) detention, 4) patient rights, and 5) the review board.

While not considered to be a core component of the evaluation, the stakeholder committee suggested, where possible, to integrate rural versus urban, cultural, age, and gender issues throughout the evaluation.

Note that Assertive Community Treatment Teams (ACT teams) are not included in the MHCTA, however discussion surrounding the ACT teams may develop due to the close involvement of the teams in the implementation of CTOs. Also, training and implementation of the new Act will not be a focus of this evaluation, as an evaluation of the training has already been completed.

*Step 5: Agree on **How** to Evaluate*

Considering resources available to devote to the evaluation and accessibility to data sources, a multi-method approach has been identified. Data sources will include administrative data, key informant interviews and focus groups, and patient surveys.

Step 6: Analyze and Report

The task of consolidating the findings of a multi-method evaluation may be the most difficult component of the study of complex policies. It is likely that most groups will select one or more evaluation questions to address and the evaluation effort will consist of several sub-components which are in fact separate evaluation projects, involving different methods and disciplines. Findings from each evaluation project within the evaluation of the MHCTA initiative should be shared with those key stakeholders identified in Step 1, preferably in a workshop setting. This approach will permit fuller discussion of the interpretation and implications of the results obtained through different projects, or through the use of multiple methods within each project.

Step 7: Agree on Recommendations and Forward Them to Key Stakeholders

The network of key stakeholders invited to the MHCTA evaluation workshop are also those who should be involved in generating the recommendations which arise from the findings of the evaluation. This increases the likelihood that common stances on at least some of the key issues will be found if those involved are: (a) familiar with the main issues from the start; (b) aware of the different perspectives each team member brings to the discussion; and (c) comfortable that the variety of methods used in the evaluation produced the most unbiased results possible.

While not considered to be a core component of the evaluation, the stakeholder committee suggested, where possible, to integrate rural versus urban, cultural, age, and gender issues throughout the evaluation.

Note that Assertive Community Treatment Teams (ACT teams) are not included in the MHCTA, however discussion surrounding the ACT teams may develop due to the close involvement of the teams in the implementation of CTOs. Also, training and implementation of the new Act will not be a focus of this evaluation, as an evaluation of the training has already been completed.

3. Proposed Research Questions and Approach

The following research questions and methods have been identified through key informant interviews, stakeholder workshops and meetings.

Table 2
Proposed Core Research Questions and Methods

Research Question	Indicator	Data Sources
<p>Certification</p> <p>How is the Mental Health Care and Treatment Act being used?</p>	<p>Number of certifications before and after the new Act</p> <p>Adherence to timelines</p> <p>Length of certifications for old and new Acts</p>	<p>Administrative data (i.e. nursing checklist, audits) at Waterford, HSC, GF & CB</p> <p>Interviews/focus groups with psychiatrists, treatment team (including case managers, nurses, etc.)</p>
<p>Community Treatment Orders</p> <p>Why are CTOs not being used?</p> <p>Are CTOs accessible to patients who may benefit from them?</p>	<p>Use of CTOs</p> <p>Facilitators and barriers to using CTOs</p>	<p>Interview/focus group with various stakeholders (i.e. psychiatrists, consumers, team leaders, regional directors, etc.)</p>
<p>Detention</p> <p>How and where are individuals being detained pending transfer to a psychiatric facility?</p> <p>How has the new Act impacted the</p>	<p>Use of safe rooms & police holding cells</p> <p>Facilitators and barriers to using safe rooms</p> <p>Workload of peace officers</p>	<p>Interviews/focus groups with RCMP, RNC, managers of mental health facilities.</p>

workload of peace officers?		
<p>Patient Rights</p> <p>What impact has the new Mental Health Care and Treatment Act had on patient rights?</p> <p>Are the new roles of patient representative and rights advisor helping to safeguard patient rights?</p> <p>Are there patient rights that are not addressed in the new Act?</p>	<p>Patient satisfaction</p> <p>Use of rights advisors and patient representatives</p> <p>Facilitators and barriers to meeting requirements</p>	<p>Patient survey at discharge</p> <p>Interviews/focus groups with rights advisors</p> <p>Administrative data (nursing checklist, rights advisor records)</p>
<p>Review Board</p> <p>Is there improved efficiency and effectiveness in the operation of the review board?</p> <p>How is the review board functioning?</p>	<p>Review board timelines</p> <p>Roles and functions of the review board</p> <p>Facilitators and barriers</p>	<p>Interviews/focus groups</p> <p>Administrative records</p> <p>Patient survey at discharge</p>

4. Methods

There are three primary data collection approaches that will be used in the evaluation of the MHCTA: 1) administrative data; (2) surveys; and (3) interviews/focus groups. Each approach is briefly described below:

1) Administrative Data

Data will be collected from hospital information systems from each health authority. Data collection spreadsheets will be used and anonymous data (all identifiers removed) will be collected and sent to the Centre for analysis.

2) Surveys

Surveys will be administered to patients at discharge from involuntary admission under the Act. The survey packages will be prepared by the Centre. The return envelope will be addressed to the Centre and all completed surveys will be returned to the Centre for data entry and analysis; no identifiable information will be collected on the surveys.

3) Interviews/Focus Groups

Key informants will be identified through the evaluation process and will either be interviewed one-on-one or through a focus group setting. All interviews and focus groups will be carried out and analyzed by the Centre's staff, with the interviews and focus groups potentially taking place in all health authorities across the province. It is expected that a certain amount of support will be needed from each health authority to complete this activity.

5. Estimated Timelines

The proposed timelines from September 2009 to March 2012 are as follows:

September 2009-September 2010 – Evaluation framework developed and finalized
December 2010 – Interim Report
December 2011 – Interim Report
March 2012 – Final Report

6. Budget

Funding will be requested for the 2011-2012 year to assist with data collection through focus groups and interviews and related transcription.

7. Ethical Considerations

The proposed evaluation study will be submitted to the Human Investigations Committee (HIC) of Memorial University of Newfoundland and the Secondary Use Committee at the Centre.

Reference List

Gray, J.E., Shone, M.A., & P.F. Liddle. (2008). *Canadian Mental Health Law and Policy* (2nd ed.). Toronto: Butterworths.

Heathfield, H., Pitty, D., & R. Hanka. (1998). Evaluating information technology in health care: Barriers and challenges. *BMJ*, 316(7149):1959-1961.

Luther, D.S. (2003). *Report of Inquiries into the Deaths of Norman Reid and Darryl Power*. Provincial Court of Newfoundland and Labrador.

Mental Health Care and Treatment Act SNL 2006 cM-9.1

Appendix D: Invitation Letter

DATE

Dear NAME:

You have been identified as a potential informant in an evaluation of Newfoundland and Labrador's Mental Health Care and Treatment Act (MHCTA). The MHCTA was proclaimed in 2006 and came into effect on October 1, 2007. The community treatment order (CTO) provisions were deferred until January 1, 2008. As mandated in the legislation, a review of the Act is required to be undertaken every five years.

In consultation with stakeholders from across the province, the following areas have been identified

You are invited to take part in a face-to-face interview (a telephone may be required, if an in-person interview is not possible). The interview will take approximately 45-60 minutes of your time and will be audiotaped and transcribed, with your permission. All personal identifiers will be removed from the transcript.

If you are interested in taking part in this evaluation or if you have any questions, you can meet or contact me at: 752-6068 or by email: kimberly.bonia@nlchi.nl.ca

Thank you very much for taking the time to inform yourself about this important evaluation.

Kim Bonia

Appendix E: Focus Group/Interview Guides

Mental Health Care and Treatment Act Evaluation Psychiatrist/GP/NP/Nurse/Mental Health Team Focus Group Guide

1. What is your experience with using the new Mental Health Care and Treatment Act?
2. Is the legislation achieving its goals or intention?
Purpose: Section 3. (1)
 - (a) *To provide for the treatment, care and supervision of a person with a mental disorder that is likely to result in dangerous behaviour or in substantial mental or physical deterioration or serious physical impairment.*
 - (b) *To protect a person with a mental disorder from causing harm to himself or herself or another and to prevent a person with a mental disorder from suffering substantial mental or physical deterioration or serious physical impairment;*
 - (c) *To provide for the apprehension, detention, custody, restraint, observation, assessment, treatment and care and supervision of a person with a mental disorder by means that are the least restrictive and intrusive for the achievement of the purpose set out in paragraphs (a) and (b); and*
 - (d) *To provide for the rights of persons apprehended, detained, restrained, admitted, assessed, treated and cared for and supervised under this Act.*
3. What problems/issues, if any, have you experienced?
4. What elements/processes have worked well?
5. Thinking of a typical course of involuntary admission under the Act, what are the challenges of the legislation
(i.e. *apprehension, transfer, assessment, 1st and 2nd certificates, timelines, forms, patient rights, nursing checklist, review board, discharge, etc.*)?
6. In your opinion, are the timelines around certification being followed? Why? Why not?
7. What suggestions would you have for improving the Act?

Additional Questions for Stakeholder Focus Groups

Caregiver Network Experiences of Involuntary Psychiatric Admission in Newfoundland and Labrador: A Multi-Case Study

8. In your experience how has the new Mental Health Care and Treatment Act impacted family/caregivers?
9. In your opinion, what are the facilitators in using the Mental Health Care and Treatment Act for family/caregivers?
10. In your opinion, what are the barriers in using the Mental Health Care and Treatment Act for family/caregivers?
11. In your opinion, do you feel that family/caregivers have an understanding of involuntary admission/Mental Health Care and Treatment Act?
12. Is there anything else you would like to add?

Mental Health Care and Treatment Act Evaluation RNC/RCMP Focus Group Guide

The NL Centre for Health Information has conducted some interviews and workshops to inform the evaluation of the Mental Health Care and Treatment Act. From those meetings, we have come up with areas to focus upon for the evaluation; one of those areas is the involvement of peace officers in the detention, apprehension, and transfer of mental health consumers to psychiatric facilities. Today, we would like to focus specifically on your experiences and your role with the MHCTA, in particular the facilitators and barriers to detaining, apprehending, and transferring mental health consumers to psychiatric facilities.

1. How and where are people being detained pending transfer to a psychiatric facility?
2. How are holding places being used?
3. In your experience, are individuals being held in a lock-up? How often does this happen? Why is this happening?
4. How has the new Act impacted the workload of peace officers?
5. How long are individuals waiting to receive assessment? Who is waiting with these individuals?
6. How are individuals treated while they wait for assessment?
7. How long are individuals waiting to be transferred to a psychiatric facility (i.e. to St. John's) for assessment?
8. Overall, what challenges or barriers have emerged?
9. Is the legislation achieving its goals or intention?
10. Is there anything else you would like to add?

Additional Questions for Stakeholder Focus Groups

Caregiver Network Experiences of Involuntary Psychiatric Admission in Newfoundland and Labrador:
A Multi-Case Study

1. In your experience how has the new Mental Health Care and Treatment Act impacted family/caregivers?
2. In your opinion, what are the facilitators/barriers in using the Mental Health Care and Treatment Act for family/caregivers?
3. In your opinion, do you feel that family/caregivers have an understanding of involuntary admission/Mental Health Care and Treatment Act

Mental Health Care and Treatment Act Evaluation Rights Advisor Focus Group Discussion Guide

1. How is the Mental Health Care and Treatment Act being used?
2. Is the Mental Health Care and Treatment Act being used effectively? Why? Why not?
3. In your opinion, are the timelines around certification being followed? Why? Why not?
4. What impact has the MHCTA had on patient rights?
5. Are the new roles of rights advisors (and also patient representatives) helping to safeguard patient rights?
6. Are there patient rights that are not addressed in the Act?
7. Overall, what challenges or barriers have emerged?
8. Is the legislation achieving its goals or intention?
9. Is there anything else you would like to add?

Additional Questions for Stakeholder Focus Groups

Mental Health Care and Treatment Act Evaluation/Caregiver Network Experiences of Involuntary Psychiatric Admission in Newfoundland and Labrador: A Multi-Case Study

1. In your experience how has the new Mental Health Care and Treatment Act impacted family/caregivers?
2. In your opinion, what are the facilitators/barriers in using the Mental Health Care and Treatment Act for family/caregivers?
3. In your opinion, do you feel that family/caregivers have an understanding of involuntary admission/Mental Health Care and Treatment Act?

Appendix F: Consent Form



Evaluation of the Newfoundland and Labrador Mental Health Care and Treatment Act

You have been identified as a potential informant in an evaluation of Newfoundland and Labrador's Mental Health Care and Treatment Act. The Newfoundland and Labrador Centre for Health Information has been asked to conduct this evaluation for the Department of Health and Community Services. You are invited to take part in a focus group. The purpose of the focus group will be to discuss the facilitators and barriers of the Act as it relates to your role as a peace officer. The focus group will take approximately 45 minutes of your time.

Your involvement is voluntary. With your permission, this focus group will be audio recorded and transcribed. You will be given a pseudonym name and all identifying information will be removed from transcripts. All material will be stored in a locked cabinet or on a password protected computer. As well, all members of the evaluation team have signed an oath of confidentiality.

Please respect the confidentiality of the other members of the group by not disclosing the contents of this discussion outside the group.

Information discussed during this focus group may also be used as part of a PhD dissertation entitled, "Caregiver Network Experiences of Involuntary Psychiatric Admission in Newfoundland and Labrador: A Multi-Case Study."

Signing this form gives us your consent to be in this evaluation. It tells us that you understand the information about the evaluation.

If you have any questions about taking part in this evaluation, you can meet or speak with the investigator who is in charge of the evaluation at this institution. That person is:

Pam Elliott (709) 752-6182 or email: pam.elliott@nlchi.nl.ca

OR

Kim Bonia (709) 752-6068 or email: kimberly.bonia@nlchi.nl.ca

**Evaluation of the Newfoundland and Labrador
Mental Health Care and Treatment Act**

Your Signature:

I have read and understood the description provided; I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the evaluation understanding that I may withdraw my consent at any time. A copy of this Consent Form has been given to me for my records.

Signature of participant

Date

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the evaluation, any potential risks of the evaluation and that he or she has freely chosen to be in the evaluation.

Signature of investigator

Date

Telephone number: _____

Email address: _____

Appendix G: Patient Survey



Dear Liaison Nurse,

This survey is intended to capture the opinions and satisfaction level of involuntarily admitted patients under the new Mental Health Care and Treatment Act (2006) and is part of the larger evaluation of the Mental Health Care and Treatment Act (2006) that is being conducted by the Newfoundland and Labrador Centre for Health Information.

Instructions for Nurse:

Upon discharge as an involuntary patient, each patient should be asked if they would like to take a 5-10 minutes to fill out a survey on their experience as an involuntary patient and told that they will receive a Tim Horton's gift card (value of \$10) for completing the survey. The survey along with an envelope should be given to the consumer. Once they have completed the survey they should place it in the envelope, seal it and return it to the discharge nurse. The nurse may provide help to the patient if they feel it is needed. The nurse will provide a Tim Horton's gift card to each patient who completes and returns a survey.

Mental health patient involvement in this survey is voluntary.

We thank you for your time and cooperation in helping us with this important evaluation. If you have any questions or concerns about this patient survey or the evaluation of the Mental Health Care and Treatment Act please contact Kim Bonia (709) 752-6068 or email:

kimberly.bonia@nlchi.nl.ca

You are invited to fill out this survey about your hospital stay under the new Mental Health Care and Treatment Act (2006). This survey is part of a larger evaluation that is being conducted by the Newfoundland and Labrador Centre for Health Information.

Instructions for Patient:

This survey should take about 5-10 minutes to fill out. Your responses will be kept private. Do not place your name on this survey. After you complete the survey place it in the envelope, seal it and return to the nurse. The nurse will provide a Tim Horton's gift card (value of \$10) to you when you have completed and returned the survey.

It is up to you whether or not you complete this survey. Your decision will not impact your future care in any way.

Thank you for your help with this survey. Your opinions will be used to help with the evaluation of the Mental Health Care and Treatment Act (2006).

Facility Location:

- St. John's Grand Falls-Windsor Corner Brook

Please check your response to the statements below. Please check one response.

1. I was told that I was certified.

- Yes No Not Sure Does Not Apply To Me

2. I was told why I was hospitalized.

- Yes No Not Sure Does Not Apply To Me

3. I was told about my rights as a patient.

- Yes No Not Sure Does Not Apply To Me

4. During my hospital stay I was treated with respect.

- Yes No Not Sure Does Not Apply To Me

5. I knew that I could contact a lawyer.

- Yes No Not Sure Does Not Apply To Me

6. When I was hospitalized I spoke with my rights advisor.

- Yes No Not Sure Does Not Apply To Me

7. I think the rights advisor helped me to understand my patient rights.

- Yes No Not Sure Does Not Apply To Me

8. I had a patient representative.

- Yes No Not Sure Does Not Apply To Me

9. I think the patient representative and my treatment team worked well together.

- Yes No Not Sure Does Not Apply To Me

10. I was told about my treatment plan

- Yes No Not Sure Does Not Apply To Me

11. I think I needed to stay in the hospital longer.

- Yes
- No
- Not Sure
- Does Not Apply To Me

12. I have an appointment for follow up with a mental health care provider.

- Yes
- No
- Not Sure
- Does Not Apply To Me

13. I will have access to help if I need it.

- Yes
- No
- Not Sure
- Does Not Apply To Me

14. What is your home region ?

- Eastern Health
- Western Health
- Central Health
- Labrador-Grenfell Health
- Out of province - Specify province _____
- Out of country - Specify country _____
- Not sure

15. Are you: Male Female

16. Living arrangements:

- Alone
- With friends or family
- Supportive housing
- Other please specify _____

17. Level of education:

- Less than high school
- Completed high school
- Some college/ university
- College/ university completed

OTHER COMMENTS

If you would like to talk to someone on the evaluation team
 about your experience please call (709) 752-6068.
 Thank you for your time!



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