Providence Continuing Care Centre

Sisters of Providence of St. Vincent de Paul

The Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston

Queen's UNIVERSITY

KGH KINGSTON GENERAL HOSPITAL

Frontenac Community **Mental Health Services**

COERCION: ETHICS, ISSUES AND THE NEED FOR FURTHER RESEARCH

By Dr. Susan Finch
Assistant Professor
Department of Psychiatry
Queen's University
Director of Psychiatric Emergency
Services

The use of coercive techniques in psychiatry is controversial. Coercion is defined by the Collins English Dictionary as "compelling or restraining by force or authority without regard to individual wishes or desires." Some authors have divided coercion-related behaviours into positive pressures (persuasion and inducements) and negative pressures (threats and force) (McKenna et al, 1999). In the literature, coercion has generally been equated with involuntary treatment, in particular involuntary admission. In most jurisdictions, mental health acts attempt to balance the rights of an individual to adequate medical treatment with the right to be autonomous and make one's own decisions. Legislation allows for the involuntary treatment of the mentally ill if there exists either dangerousness to others (for the good of society) or need for treatment and/or dangerousness to self (for the good of the patient) (Kaltiala-Heino et al, 1997). Mandated treatment is increasingly taking place in community settings (Everett, 2000), although the legal requirements for community treatment orders are not uniform across jurisdictions, even within a country.

One of the ethical rationales for involuntary treatment (detention, medication, restraint, restriction of privileges and/or observation) is that it is of benefit to a person who cannot act responsibly on his or her own behalf because of the effects of a psychiatric illness. The assumption is that it is sometimes necessary to use coercion to ensure that a patient receives needed care, when the patient is too ill to grasp the need for it (Lidz et al, 1998). It has been argued that involuntary treatment can engage the patient in subsequent voluntary treatment and that a successful intervention may change the client's views about the desirability of treatment (Lidz et al, 1998). On the other hand, liberty and autonomy are protected values, and in a free society individuals have the right to make decisions harmful to themselves (Kaltiala-Heino et al, 1997). The attitudes of mental health consumers reflect this dilemma. Some consumers are opposed to all involuntary treatment methods and others are supportive of involuntary treatment (Frese, 1997). Mental health

Editorial

Readers of this issue of Synergy should find much of interest. Our lead article is on the very important issue of coercion in Psychiatry, a subject of research for Dr. Susan Finch. While coercion is at times necessary and in fact life saving, it may be overused or applied in a less-than-optimal manner. The reader will be sensitized to the issues pertaining to the use of involuntary hospitalization, involuntary medication use, and seclusion and restraint.

Dr. Julio Arboleda-Flórez provides an update on recent developments in the department, which include the recent move of the Queen's Department of Psychiatry offices. We also announce the recent appointment of Ms. Linda Peever to the position of Vice-President, Providence Continuing Care Centre Mental Health Services, and wish her the best of luck in her new work.

Dr. Kevin Parker describes how the use of quality improvement research helped the Division of Child and Adolescent Psychiatry to reduce substantially their waiting lists and to become effective and efficient in the provision of service. This article will be of interest to clinicians and administrators alike. Dr. Dianne Delva outlines what is involved in being successful in obtaining external grant funding for research a crucial set of skills for those in academia, of which tenacity may be the greatest! Rev. Grace McBride, formerly the Empowerment Facilitator at Providence Continuing Care Centre Mental Health Services, writes on how the concept of patient empowerment fits with the newly popular recovery model, itself the subject of an article by Ms. Karen Gagnon in the last issue of Synergy. Ms. Sandra Lawn provides an update on the Mental Health Reform Legacy Project, which attempts among other things to maintain the momentum of the huge effort recently expended in the Southeastern Ontario Mental Health Implementation Task Force, of which she was the Chair. Finally, an interesting description of their ongoing research on attitudes toward individuals with dual diagnosis who come into conflict with the law is provided by Dr. Jessica Jones and Ms. Jennifer Passey.

Readers will also see an invitation to secondary school students in our area to submit a piece of work on the subject of mental health or mental illness. A prize will be awarded in each of three categories: visual art, poetry, and an essay of 500-1000 words. It is hoped that this contest will assist high school students to be more informed about, and comfortable in discussing and dealing with mental illness, and at the same time foster communication between the generations.

In closing, Synergy congratulates Dr. Leslie Flynn, who won the 2003 Synergy Author contest. A similar contest will reward one of the 2004 contributors to this publication!

CONTEST FOR SECONDARY SCHOOL STUDENTS

Mental illness affects nearly everyone at some point, either directly or though its effects on relatives or friends. The teenage years see a burgeoning of artistic talent, and at the same time a greater realization of the problems of the human condition. In an effort to increase awareness and to foster open discussion about mental illness, Synergy is sponsoring a contest for area secondary school students, who are invited to submit a piece of work on the subject of mental health or mental illness. A prize of $100 will be awarded in each of three categories: visual art, poetry, and an essay of 500-1000 words. The winning entries will be published in the Summer 2005 issue of Synergy. The deadline for receipt of submissions is April 30, 2005.

From the Department Head
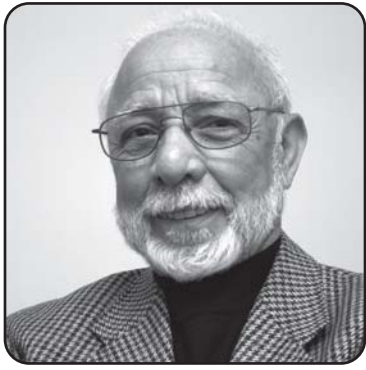
By Dr. Julio Arboleda-Flórez
Professor and Head
Department of Psychiatry
Queen's University

The past months have been filled with news. From the motor vehicle accident in which my wife and I almost lost our lives while doing some mental health services work in Chile to the successful accreditation of the Department by the Royal College, and from changes in Synergy to the multiple successes of our colleagues in obtaining research grants, this has been a momentous year for the Department of Psychiatry at Queen's.

Memories about the accident, while deeply etched in our minds, have rapidly been losing their emotional impact as our recovery has progressed and as we reintegrate into our activities full time. What will remain forever is our deep gratitude to all members of the Department and elsewhere who went out of their way to help us during those trying times. A deep thanks to all of you.

While lying in bed in Punta Arenas in the Chilean Patagonia, my main concern was the Royal College review of our Department's postgraduate teaching program, which had in the recent past been accorded only provisional accreditation. Dr. Louis van Zyl, the Director of Postgraduate Education at the time, made an all-out effort to meet the challenge and to make sure we would receive full accreditation. His efforts were fully rewarded. In addition, the College made very positive comments about the thorough documentation provided and the new portfolio structure implemented for the Residency Program Committee. The Department owes a major debt of gratitude to Dr. van Zyl for his dedication and stewardship of the Committee and the push for full accreditation.

Synergy is changing as it starts assuming the role of the official journal of the Department with a mix of peer reviewed academic papers and news from our partners in the mental health system in Southeastern Ontario. The logos of our partners on the cover page of Synergy is proof of the commitment of each one of these agencies to high quality and timely provision of clinical services to our patients, clients, and their families, as well as a commitment to excellence in education and research. The hope for our region is to have an integrated, seamless, and accessible mental health system that is of the best quality and respectful of patients' clinical needs, dignity, and civil rights. Synergy aims to foster these core values.

Research has had a banner year, with multi-million dollar grants to the research programs of Dr. Jeannette Holden and new grants received by Dr. Hélène Ouellette-Kuntz as well as the many clinical trials in progress within the Psychopharmacology Division under Dr. Singh. These research projects have already spurred a wealth of scholarly presentations and publications by members of the Department. Similarly, the Department has hosted a number of conferences at the national and international levels, notably "Together against Stigma", which attracted delegates from twenty-four countries. A note of thanks to Dr. Heather Stuart for the superb organization of this major event.

Finally. a move that was in the making for over a year has finally been completed: the Department of Psychiatry offices have migrated to Providence Continuing Care Centre Mental Health Services. Ms. Debbie Ball (Secretary), Ms. Jo-Ann Black (Administration), Ms. Heather Beveridge (Research and Publications) and I have already moved. Others will follow.

STAFF ATTITUDES TOWARD INDIVIDUALS WITH DUAL DIAGNOSIS WHO COME INTO CONTACT WITH THE LAW

By Jessica Jones, DClinPsy,
Department of Psychiatry and
Jennifer Passey, BA,
Department of Psychology,
Queen's University

Attitudes have been described as latent or inferred psychological constructs or processes that reside in the self and have several components: affective, cognitive, and behavioral (Antotak and Livneh, 1988; Olson and Zanna, 1993). Attitudes predispose to evaluative responses, and may be created from affective, behavioral or cognitive information, and may also have many consequences (Olson and Zanna, 1993).

Livneh (1988) describes the origins of attitudes toward people with intellectual disabilities as complex and intertwined, and based on several dimensions: societal/psychological, affective/cognitive, consciousness, experience, externality, and theoretical/empirical basis. Negative attitudes toward persons with disabilities can result in obstacles to goal achievement and impediments to vocational possibilities (Antonak and Livneh, 2000), as well as exert an influence on public policy decisions and funding priorities (Henry et al, 1996).

Acceptance is essential for the inclusion of people with disabilities into society (Antonak and Livneh, 2000; Bailey et al, 2001), and by identifying the underlying dimensions of negative attitudes, researchers may uncover specific areas and differential change procedures necessary for elimination of these barriers to integration (Antonak and Livneh, 2000; Krajewski et al, 2002). For people with dual diagnosis (who have an intellectual disability and a mental illness) negative attitudes may be even more prominent as manifestations of their disorders may make their behavior less manageable. This problem increases even more so for people with dual diagnosis who come into contact with the law, as they are stigmatized for their disability as well as for being offenders.

The attitudes of key professionals in the community are critical (Bailey et al, 2001) as they can impact the crucial treatment/care decisions that are made (Gelder, 1998; Wolraich and Siperstein, 1986) and the day-to-day experiences of individuals in care (Henry et al, 1996). Henry and colleagues (1996) illustrated how differences in job level for community staff members were associated with significant differences in attitudes toward empowerment, exclusion, and sheltering of clients with intellectual disabilities, with support workers (who provide the most one-on-one support) displaying the most negative attitudes. Wolraich and Siperstein (1986) examined the responses of 383 professionals from medicine, education, psychology and social work regarding the capabilities and most appropriate residential placement for targets with intellectual disabilities. Physicians had lower expectations of people with moderate intellectual disability than educators and social workers, and chose considerably more restrictive placements than any other professionals.

The interest in and amount of research relating to offenders with intellectual disabilities have increased over the last 20 years (Lindsay, 2002a). Reviews of the literature have revealed a huge variation in the methodology and results: some studies find no evidence that the presence of an

WEBSITE INFORMATION

Frontenac Community Mental Health Services
   www.fcmhs.ca

Hotel Dieu Hospital
   www.hoteldieu.com

Kingston General Hospital
   www.kgh.kari.net

Providence Continuing Care Centre
   www.pccchealth.org

Queen's University Department of Psychiatry
   meds.queensu.ca/medicine/psychiatry/psychome.htm

Southeastern Ontario Mental Health Reform
   www.mentalhealthontario.ca

intellectual impairment may predispose an individual to criminality, while others find persons with intellectual disabilities to be over-represented in the criminal population (Lindsay, 2002b). Clare and Murphy (1998) stated that, "the extent to which people with intellectual disabilities are alleged or convicted offenders is unknown and the association with particular offences (such as arson and sexual offending) unclear" (p. 155). A recent study by Taylor and colleagues (2003) revealed that knowledge and general attitudes of direct care workers to sexual offenders with intellectual disabilities could be improved with training but did not assess particular stereotypes held by staff. Overall, there has been very little research examining the attitudes or stereotypes of staff members towards people with dual diagnosis who come into contact with the law.

The Southeastern Ontario Community-University Research Alliance in Intellectual Disabilities will assess attitudes towards individuals with intellectual disabilities of staff from community agencies as part of a comprehensive research design to examine issues related to community integration. Attitudes toward individuals with intellectual disabilities in general, as well as spe-cific questions concerning offenders with dual diagnosis will be assessed in about 500 staff. The alliance will also examine the attitudes of the general population towards people with intellectual disabilities in the same communities in order to compare "actual attitudes" of staff and community members as well as the "perceived attitudes" or stigma experienced by people with intellectual disabilities and their caregivers. The alliance will also examine several other variables that influence integration in relation to attitudes such as belonging, social interactions, and caregiver stress.

This study will use an adapted version of the Community Living Attitudes Scale Mental Retardation form (CLAS-MR) (Henry et al, 1996). This scale is a 40-item measure with four subscales. In order to obtain attitudes specific to offenders with dual diagnosis the following questions will be added to the scale.

Empowerment:
1. Offenders with dual diagnosis should be dealt with and receive treatment differently in the corrections system.

2. Offenders with dual diagnosis do not benefit from treatment and therefore should be incarcerated with other offenders.

Exclusion:
3. Offenders with dual diagnosis should remain in correctional institutions after sentencing.
4. Offenders with dual diagnosis should be dealt with in the community after sentencing.

Sheltering:
5. Offenders with dual diagnosis should live together in segregated housing in the community.
6. Offenders with dual diagnosis should not live independently in the community.

Similarity:
7. Offenders with dual diagnosis should be able to make their own decision and choices.
8. Offenders with dual diagnosis should be supervised and monitored at all times.

In conclusion, the policies and service philosophies of many governments around the world recommend that offenders with intellectual disabilities should be provided with a least restrictive alternative and support and supervision by community-based services whenever possible. In addition, it is also recognized that an individual's sense of belonging, level of integration, and treatment within any environment depends in large part on the attitudes held and expressed by others. In community agencies within the developmental, mental health and criminal justice systems, the direct care staff come into contact with individuals with intellectual disabilities and dual diagnosis on a regular basis and therefore can have a significant impact on their quality of life. The potential negative attitudes held by staff members therefore can have a serious stigmatizing effect on individuals with intellectual disabilities and their day-to-day living. It is therefore important that staff attitudes are identified and prevalence established in order to evaluate and challenge any biased perceptions of and attributions to individuals with intellectual disabilities who come into contact with the law. We hope that our research will shed light on this issue.

References

Antonak RF, Livneh H. Measurement of attitudes toward people with disabilities: methods, psychometrics, scales. Springfield, IL: Charles C. Thomas Pub., 1988.

Antonak RF, Livneh H. Measurement of attitudes towards persons with disabilities. Disabil Rehabil. 2000;22(5):211-224.

Bailey A, Barr O, Bunting B. Police attitudes toward people with intellectual disability: an evaluation of awareness training. J Intellect Disabil Res. 2001;45(4):344-350.

COERCION: ETHICS, ISSUES AND THE NEED FOR FURTHER RESEARCH

professionals also face this dilemma (Everett, 2000).

As physicians, psychiatrists are trained to provide care and treatment for consenting ill patients. Clinicians use negative pressure coercion when there appears to be no safe, practical alternative. These incidents of coercion usually occur in emergency and inpatient settings, where the most acutely ill patients are seen. Some mental health professionals leave workplace environments where coercion is frequently encountered as a result of their discomfort with these techniques (Everett, 2000). However, in some respects coercion is unavoidable; one could argue that all psychiatric physician-patient relationships have an element of coercion present by virtue of the psychiatrist's power to hospitalize and treat involuntarily. In spite of the complex ethical issues surrounding coercion and the regular use of involuntary and restrictive treatments in psychiatry, there is little research examining the subject.

A number of studies have explored the relationship between specific involuntary psychiatric interventions and demographics. Involuntary admission has been the subject of most research, with less on seclusion, restraint and involuntary medication use. In these reports, patient populations differ and the definition of involuntary admission varies with jurisdiction. Most studies support expectations that the typical patients undergoing involuntary admission are psychotic patients with few social supports, as well as those at risk to harm themselves or others. Some troubling findings have shown up in the literature including: an apparent direct relationship between staff workload and increased rates of involuntary admission (Segal et al, 2001); diagnosis of borderline personality disorder as a predictor of seclusion and restraint (Swett, 1994); and initial involuntary admission being a risk factor for subsequent involuntary admission (Fennig et al, 1999).

Only one study in the literature (Kaltiala-Heino et al, 2000), from Finland, reports on the overall use of involuntary and restrictive interventions for psychiatric inpatients, which techniques are used most, and in which patients these are applied. Unlike other jurisdictions, Finland has made an attempt to reduce involuntary treatment by careful legislation (Kaltiala-Heino, et al, 2000). These authors found that about a third of patients had been subjected to some form of restriction, the most common being limits on leaving the ward. Mechanical restraints were used in ten percent of the patients and forced medication in eight percent. Seclusion and restraint were used most commonly for organic and substance use related disorders.

The use of mandatory treatment could be further justified by evidence that it improves the health of the patient. There are very few studies in the literature looking at long-term outcomes related to experiences of coercion of any kind during hospitalization. Many involuntary interventions can actually be traumatic, such as seclusion or forced medication (Meyer et al, 1999). Yet only two studies in the literature comment on trauma related to treatment, and these are based only on patients with symptoms of psychosis. One study (Meyer et al, 1999) differentiated traumatic symptoms due to illness from those due to treatment. Illness caused most of the traumatic symptoms (69%), but treatment nevertheless caused 24% of trauma symptoms. Additionally, coercion has the capacity to undermine trust and may thus adversely affect therapeutic and family relationships and adherence to treatment regimes (Kaltiala-Heino et al, 1997).

The views of patients on the potentially coercive quality of psychiatric treatments have been examined over the last ten years. Some interventions that seem voluntary may be perceived as coercive and vice versa. For example, involuntary admission is not always associated with the perception of coercion (Kaltiala-Heino et al, 1997). A number of factors have been identified which seem to decrease the perception of coercion, such as: explanation, therapeutic relationship, perceived genuine concern, perceived respect, feeling of being heard, feeling of being validated and involved in treatment decisions (McKenna et al, 1999; Kaltiala-Heino et al, 1997). However, there are many patients who continue to experience negative emotional effects from the use of coercion despite their later acknowledgement that intervention was required (Kaltiala-Heino et al, 1997).

Most clinicians believe that involuntary and restrictive measures are at times indispensable working tools to ensure safety or permit treatment. Intuitively, one might expect that an increase in violent incidents and/or suicide would result from a decrease in coercive treatments. I am not aware, however, of any published studies relating the risk of suicide or violence to the use or lack of use of coercive measures. At the 2003 American Psychiatric Association (APA) annual conference, a workshop conducted by the APA Council on Quality presented data from several state hospitals working toward elimination of seclusion and restraint. Interestingly, at

USING QUALITY ASSURANCE/IMPROVEMENT IN MAKING A SMALL ACADEMIC CHILD & ADOLESCENT PSYCHIATRY DIVISION EFFECTIVE AND EFFICIENT
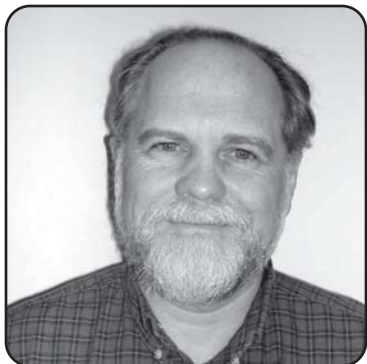
By Kevin CH Parker PhD, C. Psych.,
Associate Professor
Department of Psychiatry
Queen's University

This article summarizes a poster presentation co-authored by Rebecca Cabell, OT, Reg(Ont), Elizabeth deGrace, MA, CPsychAssoc, Dr. Renee Fitzpatrick, Dr. Cherie Jones-Hiscock, Dr. John Leverette, Dr. Nasreen Roberts, and Sara Wright, MSW, RSW, and presented at the Canadian Academy of Child & Adolescent Psychiatry, Halifax, November, 2003.

The Division of Child and Adolescent Psychiatry has had a number of successes in recent years. We use a shared care model, seeing our services as embedded in a community of service providers and our role as a partner within that community. Establishment of the shared care model took several years, and was implemented in phases, using an effective Quality Improvement/Assurance process that has been ongoing for at least twenty years. These procedures have provided a base of measurement to assess needs, outcomes and effectiveness.

A unified, data based approach to service delivery has made staff roles simpler and has reduced the amount of opinion-based debate that previously consumed many hours of staff time. Discussion of change is certainly not taboo, but there is a sense that it needs to be backed with evidence backing the need for change and a willingness to take responsibility for implementing and evaluating a trial run of the new idea.

> We use a shared care model, seeing our services as embedded in a community of service providers and our role as a partner within that community.

Waiting lists

One of the first problems we tackled was that of waiting lists. With a growth in demand and stagnation in staffing levels in the 1980s, waiting lists began to grow. Our waiting list reached an equilibrium point when families and children were waiting about 12-18 months to be seen for a first appointment. When the number of cases on the waiting list is in equilibrium, there is a match of input and output. Thus there may be a way to treat the same number of cases promptly, without making the families and children wait for a year, and without increasing workloads. We sought a way to substitute sensible triage for spontaneous withdrawal from the waiting list, in an effort to respond to patients in a more orderly way. The job was to sort out who to see and who to turn away.

In an initial study (Brooker et al, 1986), we determined that the year-long wait did not substantially change the case mix. An exception to this was that families in crisis tended to show early or not at all. In another study we looked at what predicted no-show behavior and how we might use this to handle the waiting list (Parker and Froese, 1992). It was clear from these studies that the "waiting-list-exhaustion" approach to managing caseload was removing cases ranging from those with trivial needs to those with very important ones. Furthermore, those who waited for a year were no more needy than those who gave up waiting. Parents who were more organized or literate were the ones more likely to complete forms and keep appointments after a long wait. Thus the forms had the potential to be barriers to service. We concluded that waiting lists were doing indiscriminate triage.

Referral process

We reviewed and experimented with other ways to address the problem. We examined the referral forms to determine how to increase the amount of information that was provided to those doing triage. Our referral sources told us that special referral forms for our small service got lost on their desks and were a pain to complete. We ended up asking for a simple referral letter something that made the referral process easier.

We asked referral sources to tell us the basics: clear identification of the patient, how to contact the patient, and the problem we were being asked to address. Whenever we receive a letter that is

USING QUALITY ASSURANCE/ IMPROVEMENT IN MAKING A SMALL ACADEMIC CHILD & ADOLESCENT PSYCHIATRY DIVISION EFFECTIVE AND EFFICIENT

incomplete, we telephone the referral source and ask for another letter that is complete. The referral letters that we receive are useful in doing triage, and we are able to do sorting, including redirection of referrals to other agencies dealing with children. By developing consultation relationships with these agencies we are able to recapture cases that we redirected inappropriately.

Switch from intake to consultation
An important change in our outpatient approach involved switching from "intake interviews" to "consultations". We no longer understood every referral to be a request for the provision of treatment. In the early stages, some referral sources were uncomfortable with the return of children after a consultation, preferring that we take over care as we had typically done in the past. Direct, prompt, useful communication with the referral source (always a letter, sometimes a telephone call as well) has proved fairly popular with family physicians. We also have Continuing Medical Education events aimed at recurrent themes in our individual dialogues with family physicians. Two projects from this era (Froese, 1991; Simola et al, 1999) reflect some of the research we did to supplement the clinical consultation and decision making.

Outreach initiatives
With our waiting list issues in hand (or at least nearly so), we developed and assessed the process of outreach consultation to a local children's mental health agency (Froese et al, 1997). The success of this initiative led to further contracts, allowing us to consult to virtually all the children's mental health agencies in our catchment area. In the early stages, we had difficulties when we tried to control the selection of cases within the other agencies. We had more success when we simply provided the psychiatrists and allowed agencies to determine the case mix that they brought to appointments. We had difficulty when agencies sent children without the workers, and success when we asked the agencies to produce both the children and the workers that knew the children best for the consultation. Both changes reflect respect for the shared care approach.

The outreach consultation service provided a very convenient linkage for our triage service. A close liaison with the children's mental health agencies in our area enabled us to divide up the caseload in a systematic manner. The Division agreed to be responsible for primary psychiatric disorders and the children's mental health centres (CMHCs) agreed to take responsibility for more behavioral issues. With our psychiatrists consulting to the CMHCs, we could bring children back to our services if our services were more suitable. This simplified the task of triage staff members who were redirecting cases. If a child was referred to us and we believed that one of the CMHCs was more appropriate, we could reassure the referral source that patients at CMHCs still had access to our agency if things did not go as we expected. We currently redirect about 25% of our referrals to agency partners-in-care.

Inpatient unit
In the mid-1990s we were given the opportunity to establish a child psychiatry service within the Paediatric Inpatient Unit. Although we were able to work fairly well together as a mixed team, we all breathed more easily when we were able to segregate the psychiatric patients from the medical patients a few years later. As we developed the role of an independent adolescent inpatient unit, we struggled with a number of issues. Overnight admissions from the Emergency Room were necessarily at the discretion of the house staff and staff psychiatrist on call. The next morning, the psychiatrist responsible for the inpatient unit needed to sort out the disposition of a young person who was no longer in crisis and whose parents were not immediately available.

The strategy that best addressed overnight admissions was to provide an alternative for patients seen in the Emergency Room. We decided to provide a next day urgent appointment that could be booked by the Emergency Room staff without consulting anyone (Parker et al, 2003). Now the clinicians that see adolescent patients in the Emergency Room have three choices: admit, send to Urgent Consultation, or discharge. Adolescents are seen promptly, out of crisis mode, and assessed for the need for admission. This appointment is never used as an alternative to an outpatient consultation or as a shortcut to outpatient services. It is reserved exclusively for decisions about whether to admit the child or not. As a result it can be a fairly quick assessment.

Evidence based practice
We are committed to an evidence based approach to service delivery. Our model of what counts as evidence is broadly based,

and includes published evidence, the oral tradition of experienced staff, and data collected in the context of quality improvement initiatives. A very narrow perspective on evidence risks choking off innovation and change. If the only acceptable criterion for evidence based practice were data from randomized control trials, then we would be limited largely to ideas that are developed and funded by industry or government agencies. Most clinical work is too mundane to attract the interest of industry or government, so we typically (but not always) use less expensive means of evidence gathering than the randomized control trial. We are developing our expertise in N-of-one designs, quasi-experiments and correlational designs. We publish the results of quality initiatives on a regular basis as posters at conferences or as articles in the peer-reviewed research literature.

References
Brooker BH, Joynt M, Froese AP. Impact of removing the waiting list upon clinic intakes. Can J Psychiatry. 1986;31:521-525.
Froese AP. Minors' right to psychiatric treatment.

Can J Psychiatry. 1991;36:452-455.

Froese AP, Dwyer-Sepic P, Parker KC. Child psychiatric consultation service to community agencies: a collaborative approach involving three community agencies. Can J Psychiatry. 1997;42:656-658.

Parker KC, Froese AP. Waiting list information strategies in child psychiatry: an intervention and measurement approach. Can J Psychiatry. 1992;37:387-392.

Parker KC, Roberts N, Williams C, et al. Urgent adolescent psychiatric consultation: from the accident and emergency department to inpatient adolescent psychiatry. J Adolesc. 2003;26:283-293

Roberts N, Parker, KC, Woogh C, et al. Bipolar illness in growing attention deficit hyperactivity disorder children [letter]. J Am Acad Child Adolesc Psychiatry. 2000;39:678-679.

Simola SK, Froese AP, Parker, KC. Relational V-code conditions in a child and adolescent population: do they warrant treatment? J Marital Fam Ther. 1999;25:224-236.

Clare IC, Murphy GH. Working with offenders or alleged offenders with intellectual disabilities. In Emerson E, Hatton C, Bromley J, Caine A, editors. Clinical psychology and people with intellectual disabilities. Chichester: Wiley;1998. p. 154-176

Gelder MG. A core curriculum in psychology for medical students. Curr Opin Psychiatr. 1998;11(5):491-492.

Henry D, Keys C, Jopp D, Balcazar F. The Community Living Attitudes Scale, Mental Retardation Form: development and psychometric properties. Ment Retard. 1996;34(3):149-158.

Krajewski JJ, Hyde MS, O'Keefe MK. Teen attitudes toward individuals with mental retardation from 1987 to 1998: impact of respondent gender and school variables. Educ Train Ment Retard Dev Disabil. 2002:37(1):27-39.

Lindsay WR. Integration of recent reviews on offenders with intellectual disabilities. J Appl Res Intellect Disabil. 2002a;15(2):111-119.

Lindsay WR. Research and literature on sex offenders with intellectual and developmental disabilities. J Intellect Disabil Res. 2002b;46:74-85.

Livneh H. A dimensional perspective on the origin of negative attitudes toward persons with disabilities. In Yuker HE, editor. Attitudes toward people with disabilities. New York: Springer, 1988.

Olson JM, Zanna MP. Attitudes and attitude change. Ann Rev Psychol. 1993;44:117-154.

Taylor JL, Keddie T, Lee S. Working with sex offenders with intellectual disability: evaluation of an introductory workshop for direct care staff. J Intellect Disabil Res. 2003;47(3):203-209.

Wolraich ML, Siperstein GN. Physicians' and other professionals' expectations and prognoses for mentally retarded individuals. Am J Ment Defic. 1986;91(3):244-249.

Questions or comments regarding this article may be directed to Jennifer Passey at passeyj@post.queensu.ca or Jessica Jones at jonesj@post.queensu.ca

SUCCESSFUL GRANT APPLICATIONS

By Dr. Dianne Delva,
Associate Professor
Department of
Family Medicine
Queen's University

This article is based on two workshops: "Writing Successful Grant Applications," presented by Drs. Heather Stuart and Julio Arboleda-Flórez as part of the Queen's University Department of Psychiatry Annual Research Day (Kingston, June 16th, 2003); and "An Analysis of Common Pitfalls in Primary Care Grant Proposals," presented by Daniel Longo and Kevin Everett at the 31st annual meeting of the North American Primary Care Research Group (Banff, October 27, 2003).

Writing research proposals for grant funding is a challenging process that will enjoy greater success if the applicant employs a strategic approach. New writers of grant proposals should consult with experienced colleagues and may best start by collaborating on projects with experienced principal investigators.

The process of obtaining grants occurs in the competitive environment of university research. Most grant proposals are not funded, particularly on the first attempt. New researchers may not be able to access intramural funds when universities direct their scarce resources toward operating costs. Any internal funding is generally too small to support the meaningful research that is needed. To obtain valid and generalizable results, multi-centered and collaborative approaches are often required.

The process of applying for grants can be divided into three stages:

The Idea Stage
The researcher begins with an idea. Is the question a good one? Can the work be done and if so, who and what will be needed to complete the study? There are many good questions to ask, but if the question is too diffuse, has already been researched extensively or a feasible way to approach the question cannot be determined, then this is the time to STOP and consider other ideas. If it is a good idea, then one might ask oneself what the counter arguments might be. There may be good reasons for not doing the study. On the other hand, one could argue that although much research has been done, the area needs to be reassessed in a way that will give new insights, or one could indicate that systematic errors in the research conducted to date, conflicting results, or low power study designs necessitate further work.

The Concept Stage
At this point the aspiring applicant is ready to consider the study design that will best address the question, do a literature review, estimate costs and look for potential funding sources (see Box).

At this stage, writing a concept paper will help clarify the ideas and research strategy. Some preliminary work can be accomplished with the intramural funds available to new researchers at Queen's such as the Principal's Development Fund.

This stage will also help decide whether a research project or a research program is required. Grant applications are more often successful if they focus on a single question. Complex projects that depend on the success of the first steps are vulnerable as the reviewer may question what will happen if the first steps fail. The applicant should describe how the current proposal fits into the overall plan, but the proposal should focus on one question that can be answered.

> Grant applications are more often successful if they focus on a single question.

Funding agencies can be approached to determine their interest in the project. Funding agencies may require evidence from pilot work and in this case the application may have to be held back if the pilot work has not been completed. If the agencies show interest, the applicant can then move from the conceptual stage to the submission stage by organizing the research team.

Examples of Funding Sources for Mental Health Researchers

International Options:
    National Institute of Mental Health, USA
    Pharmaceutical firms
    Illness-based foundations (e.g., Cure Autism No Foundation)

National Options:

Canadian Institutes of Health Research
Social Science and Humanities Research Council
National Science and Engineering Research Council
Canadian Health Services Research Foundation
Private foundations (e.g., Scottish Rite Charitable Foundation, EJLB Foundation)

Provincial and Local Options:
Ontario Innovation Trust
Premier's Research Awards
Ontario Mental Health Foundation
Queen's University awards and funds

These are databases of funding agencies at Research Services at Queen's and at the Research Office of the Department of Psychiatry.

The Submission Stage
At this point the researcher is ready to establish a timetable and the tasks to be completed before submission. This plan is essential for the best possible proposal. Without it the proposal will be written at the last minute, there will be no time for review from colleagues, and the result may be a grant proposal that not only wastes the valuable time of your colleagues, but may also damage the applicant's reputation for further submissions. The applicant should know the deadlines for grant submission and the Research Ethics Board schedule, which are published on the relevant web sites.

Letter of Intent ("LOI")
Most large grants and randomized controlled trials now require a letter of intent (LOI). The LOI helps to reduce wasted time for you and the reviewers. The LOI must, however, be well thought out. In five pages or less the applicant must be able to convince a committee of experts that they should request a full proposal. It does not require details but the conceptualization must be sound. This is the "pitch" that convinces the reviewers that the idea is worth pursuing and the study is feasible.

The methods must be appropriate to the question and promise to produce valid results. Vague, ill-defined, or overly ambitious study designs, or 'black-box' statistical analyses suggest a lack of focus and may raise doubts about the ultimate utility of findings. The team must have the appropriate skills, either as co-investigators or consultants. The method must be clear, concise and understandable to a reader naïve to the field.

At this point it should be understood that rejection is part of the grant funding process. The applicant should ask whether the committee understands his or her enthusiasm and feelings about the importance of the topic? The comments from the reviewers will give an idea of where the idea, methods or team require strengthening. If the LOI is approved, the applicant will be invited to write a full-scale proposal and much of the hard work of conceptualization will have been completed!

The Full Proposal
At this stage the goal is to convince a committee of experts that your team deserves to be funded instead of another! A highly persuasive and polished argument will be needed to show that the proposal will make an important contribution. The first few sentences should state the purpose, the aims, and objectives or hypothesis. Let the reader know what will be learned (i.e., that is not already known) and why it is worth knowing (i.e., if we knew this we could do that!).

The proposal must show that the applicants are up to date with the state of knowledge on the topic, including the historical perspective. This is a brief summary, as the main focus should be on how the study will add to the current knowledge and the methods of doing this. The literature review is a critical appraisal of the literature in the context of the proposal. It is not an exhaustive review of the literature on the subject.

Methods
The methods used must establish that the results will be valid. The best methods available should be used and the study design should be specified. The types of measures and method of collecting the data should be described. Projects that are heavily dependent on yet-to-be developed study instruments cause concern. The analysis must match the objectives. This stage is a check on the objectives. For instance, sequential projects are tricky to fund, particularly if the first step is vague or difficult to achieve. The reviewer will ask what will happen if the first step cannot be achieved.

The applicants should be able to describe the outcomes with the use of straightforward statistics. It is important to consult with a statistician early in the process, at the concept stage, and to have a dialogue with the statistician so that there is clarity on the goals of the project and the methods to be employed to reach the desired conclusions.

It may be worthwhile to consider obtaining the approval of the Research Ethics Board in advance if a vulnerable population is the

SUCCESSFUL GRANT APPLICATIONS

subject of study.

The Team

If the application is to be successful, it is important to have a strong team that includes all of the areas of expertise required to complete the project. Colleagues with more experience can be asked to participate to add credibility to the team. There must be a credible role for all members and a statistician should be included as either a co-investigator or a consultant. It cannot be overstated that the applicant should discuss the proposal with the statistician at an early stage. The statistician may help in choosing an appropriate study design and to ensure adequate sample size and feasibility. The institutional environment and administrative capacity (research clearances, university, hospital) must be assessed and approval for the research will be required.

Budgets

It is important to understand the rules regarding research funding. Compensation for research assistants, students and trainees is acceptable. The operating costs of data collection are not paid by the health care system and nurses and laboratory tests must be paid for by the project. The funding may cover travel costs for data collection, limited travel for presentation to conferences and costs of dissemination of results (workshop with policy makers, non-technical publications, and web pages). Grant funding is not allowed for investigator salaries, extensive travel, overhead (rent, furniture, some types of equipment) or gifts. The applicant can ask to examine other budgets and for help from experienced colleagues. Under-funded studies cannot be completed and studies that have inflated budgets will be cut or not funded at all. Many agencies, in trying to fund as many projects as possible, may offer partial funding. If this will not allow completion of the study, the award may have to be refused unless other sources can be found to support the work.

Other issues

The application is aimed at impressing reviewers and committees who have volunteered to assume a daunting workload. The proposal must be comprehensible and sound. The language must be clear and suitable for multidisciplinary teams. The applicant should not assume that the reviewers have specialized knowledge of the field. Reviewers read a large number of proposals and will be frustrated by short forms, acronyms, jargon and unfamiliar terms. The applicant should make sure that the proposal can be understood! The agency guidelines for layout should be observed. Reviewers will go to certain sections to find relevant information. If it cannot be found, they may look no further. Reviewers will not be impressed by unclear writing, or spelling, grammatical and arithmetic errors. The applicants should check the proposal, have a colleague check it, and then recheck it again!

Peer Review

The allocation of grants is based on a peer review process. In each competition, there is only one chance to be assessed by the committee. Prior to submission, however, as many colleagues as are willing to do so may review the application. This does require planning because the colleagues in question may also be preparing grants, and are unlikely to agree or give meaningful advice if asked to review the grant two days prior to the submission deadline! A completed proposal is not required for internal review, but a near complete proposal offered well in advance of the deadline has the potential to yield invaluable advice. Some colleagues who know the field should be chosen to review the application as well as others who are naïve to the particular area. This allows considered criticism from both perspectives. The naïve reviewer will help check assumptions and the clarity of the proposal. Ideally the reviewers will be experienced and successful researchers. This step will help the applicants to submit the best proposal possible. If one is unwilling to share the proposal with a colleague, then it should not be submitted to the scrutiny of strangers!

Resubmissions

This stage can be considered part of the submission stage. Most grant applications will require resubmission and if this fact of life is made part of the plan, it will help the applicants to make profitable use of the rejection. Researchers who get discouraged and shelve their ideas after rejection will not be likely to have a successful research career. Although rejection rates are high in research, it should be remembered that only eight finalists out of 52,000 submissions were considered for the design of the reconstruction of the World Trade Centre site in New York! The writing of grant applications, just like bids in the business world, is part of the competitive process that has been found to yield the best overall results.

The reviewers' comments are the gold of the first submission. The comments provide the opportunity to strengthen the proposal and must be addressed in your resubmission. Even if the reviewers were not professional in their comments, there must not be expressions of anger, arrogance or hurt in the response. A

professional approach should be employed, and if need be, the arguments should be countered with evidence or considered responses. Resubmission provides the opportunity to strengthen the team, re-conceptualize, re-think and re-focus! The applicants should not hesitate to seek outside help from experienced colleagues and most of all, should learn from mistakes!

Questions that may need to be answered include: Will the research have policy-relevant results?; and Who are the stakeholders? The literature on participatory action research may help you develop communication strategies that foster stakeholder participation and ownership. Building a relationship with stakeholders will ensure long term sustainability of the research program and implementation of your results.

Conclusion
The writing of grant applications is learned through experience. The new applicant can gain this experience by working with experienced colleagues, seeking mentors and by participating as a member of grant review committees either internally or externally. Each proposal should represent the applicant's best effort, using all the resources available.

Further help is available from:

Przeworski A, Salomon F. The Art of Writing Proposals. New York: Social Science Research Council, 1995 [cited 2004 May 12]. Available from: http://www.ssrc.org/publications/for-fellows/art_of_writing_proposals.page

Interagency Advisory Panel on Research Ethics. Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. Ottawa ON: Medical Research Council of Canada, 2003 [cited 2004 May 12]. Available from: http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm

The Chair of the Research Ethics Board, Dr. Albert Clark; Research Services at Queen's University; and the Research Department, Department of Psychiatry, Queen's University.

PROVIDENCE CONTINUING CARE CENTRE - MENTAL HEALTH SERVICES HAS A NEW VICE-PRESIDENT

By Dr. Nicholas Delva,
Editor, Synergy

Ms. Linda Peever has been appointed as Vice-President, Providence Continuing Care Centre Mental Health Services. She accepted this position at the end of May following the relocation to Calgary of Mr. Dale Forbes, who had carried responsibility for the dual portfolios of Vice-President Mental Health Services and Senior Vice-President of Corporate Services at Providence Continuing Care Centre (PCCC).

Ms. Peever has a very strong background in hospital administration. After completing a BSc cum laude in Nursing at the University of Ottawa, she went on to acquire a Masters Degree in Health Administration from the same institution. Her first job was as the Director of Nursing Practice at Brandon General Hospital in Manitoba, and subsequently she took on the responsibilities of Assistant Executive Director, Patient Care Services at Temiskaming Hospital, New Liskeard, Ontario. Since then, Ms. Peever has worked in psychiatric hospitals, first at Brockville Psychiatric Hospital as Assistant Administrator, Patient Care Services and then at Kingston Psychiatric Hospital in the same capacity. Following the divestment of Kingston Psychiatric Hospital from the Government of Ontario to PCCC in 2001, Ms. Peever was promoted to Associate Vice-President, Mental Health Services. Since 1999, she has also held the position of Adjunct Assistant Professor in the School of Nursing at Queen's University.

Ms. Peever is known as a dynamic executive, forward thinking and with the energy and initiative to achieve the implementation of new initiatives. We wish her good luck in her new work.

MENTAL HEALTH REFORM IS EVERYONE'S RESPONSIBILITY

By Sandra Lawn BSc, MPA,
Community Member
Editorial Board, Synergy

During one of the 37 community consultations conducted by the Southeastern Ontario Mental Health Implementation Task Force, a consumer/survivor from the region declared, "the Mental Health System and how it functions is a responsibility of everyone and if it doesn't function…then we have all failed."(En Avant, Volume 1, p. 50, full reference below).

"Everyone" includes consumers themselves, families, professionals and service providers. It also includes communities, teachers, the justice system, family practitioners, employers, landlords, the media, and everyone else.

The task force envisioned a system that does include everyone. Following the publishing of its report En Avant! On The Road to Recovery: A Recovery-oriented Mental Health System Implementation Plan for Southeastern Ontario. Final Report of the Southeastern Ontario Mental Health Implementation Task Force, Volumes One and Two, (Kingston, ON: Southeastern Ontario Mental Health Implementation Task Force, 2002) the Mental Health Reform Legacy Project was implemented. This project emphasizes community development and mental health promotion, prevention, and advocacy. The legacy project also helps maintain the momentum generated by the task force and is a good start to addressing the need for public education and engagement.

Components of the legacy project include the Web site www.mentalhealthontario.ca. Dr. Julio Arboleda-Flórez is the Chair of the Web site Editorial Board and Jeff Moxley of GriDD (Southeastern Ontario's Geographic Registry in Developmental Disabilities) is Web Master. In co-operation with Dr. Michael Cheng at the

Children's Hospital of Eastern Ontario, the site is becoming more comprehensive and useful to people of all ages. It continues to be a work in progress, an important feature being local links to services in Southeastern Ontario. All service providers are encouraged to visit the Web site and provide suggestions for change and content.

A second component of the legacy project is the "libraries project." All public and community college libraries throughout Southeastern Ontario now have copies of:
The Last Taboo: A Survival Guide to Mental Health Care in Canada by Scott Simmie and Julia Nunes; Toronto: McLelland & Stewart Ltd., 2001

Brave New Brain: Conquering Mental Illness in the Era of the Genome by Nancy C. Andreasen; New York: Oxford University Press, 2001 and
Catch a Falling Star: a Tale From the Iris the Dragon Series by Gayle Grass; Smiths Falls: Iris the Dragon Inc., 2001.
The report of the Task Force recognized that in the past much of the burden of creating shared care arrangements with primary care has rested on the shoulders of the general practitioner. The Task Force recommends that the community mental health programs become responsible for creating these shared care arrangements. Family practitioners (900) were polled in the early life of the task force, and as part of the "legacy project" each one has been sent an electronic copy of En Avant!, Volumes One and Two in a searchable PDF format. In the near future we expect to mail CDs to social agencies, police departments, parliamentarians and municipalities.

The fourth component of the legacy project is the "schools project." Gayle Grass' Catch a Falling Star and her special guide for teachers have been sent to every school board for every school in Southeastern Ontario. Over six thousand copies of NAMI's Parents and Teachers as Allies: Recognizing Early-onset Mental Illness in Children and Adolescents (by Joyce Burland; Arlington VA: NAMI, 2003) have been provided for teachers.

This four-part legacy project was initiated to help create a community focus on the need for reform. Specialists, advocates, professionals, volunteers, families and consumers will succeed in creating a truly recovery-oriented system only if the public is engaged in a knowledgeable way. This is the main purpose of the legacy project for mental health reform is truly the "responsibility of everyone."

Ms. Lawn was the Chair of the Southeastern Ontario Mental Health Implementation Task Force.

EMPOWERMENT

By Grace McBride MDiv,
Director of Spiritual and Religious Care,
Royal Ottawa Hospital
Ottawa, Ontario

"Each of us at Blockbusters is empowered, authorized and committed to taking care of you!" I was reassured by this statement on the wall above the checkout counter while standing in line at the video store! I was, however, tempted to ask the young clerks if they could give me the definition of empowerment. Empowerment is certainly in the air, or as some might say, "Empowerment is the flavour of the month." The danger of political correctness and clinical trends is that familiarity breeds contempt, and whatever good is to be found within the concept or theme may be lost due to overuse. Thus the term "empowerment" runs the risk of being disregarded or shunned with a cynical snicker of exhaustion the result of one too many new movements in the field of mental health care.

A quick "Google" search for "empowerment" brings up 1,880,000 hits in a fraction of a second. Not surprising, given The American Heritage Dictionary of the English Language (2000) explanation of the term: "Although it is a contemporary buzzword, the word 'empower' is not new, having arisen in the mid-17th century with the legalistic meaning 'to invest with authority, authorize.' Shortly thereafter it began to be used with an infinitive in a more general way meaning 'to enable or permit'. Both of these uses survive today but have been overpowered by the word's use in politics and pop psychology." This begs the question, "What as an Empowerment Centre are we attempting to enable or permit?" And as an Empowerment Facilitator, whom am I investing with authority and authorizing with what? The moment the door to the Empowerment Centre opens, these questions move from the theoretical to the functional and measurable.

Current literature about empowerment in the field of mental health speaks about sharing power and authority with the patient or client, the one recognized as being more vulnerable and in the position of receiving the diagnosis and prognosis. One quickly realizes, however, that in order to empower the patient one must find ways to empower staff in order to enable them to evaluate critically their actions within the framework of a healing relationship with recovery as the goal. This means encouraging staff to develop their skills in assessing, interviewing and relating to patients as individuals. Core competencies that can benefit from enhancement include: knowledge of transference and counter-transference; understanding of adjustment to illness (which includes loss, grief and stigma); cultural sensitivity (which includes understanding of beliefs and values); and the ability to work in collaboration with vulnerable individuals to help them discover meaning and purpose in their lives, while recognizing the impact of severe chronic mental illness.

The patient becomes the expert in the realm of personal experience. As such, health care providers are not the ones to inject wellness or a desire to recover, but those who will "bear witness" to the courage, strength and power that each individual, especially those in the midst of suffering, needs in order to survive. The care provider is challenged daily to draw deep from the well of personal strength to find and hold a sense of hope if they are to be effective partners in the collaborative work of healing and recovery not cure! As Viktor Frankl (1959) stated, "For what then matters is to bear witness to the uniquely human potential at its best, which is to transform a personal tragedy into a triumph, to turn one's predicament into a human achievement. When we are no longer able to change a situation just think of an incurable disease such as inoperable cancer we are challenged to change ourselves."

The Recovery Model is now being adopted within the field of mental health as a means of empowering both staff and patient. The emphasis of this model is in working collaboratively with the patient, their significant others and even their community, in such a way that they are able to rebuild their lives and learn to live with their illness. The empowering aspect is in recognizing the alchemy that takes place when individuals are willing to share power or abilities, to think creatively and to respond with an attitude of respect. The basic premise is one of hope that people grow and have the capacity to adapt to struggles in life, and that being diagnosed with schizophrenia or depression or bipolar disorder should in no way define one's life.

For too long the diagnosis of a severe mental illness was followed by a prognosis of doom, and well-meaning treatments actually served to increase dependence and hopelessness. A cure would be offered, but if the problem could not be fixed, the end result

was deemed a medical or psychiatric failure. How does one survive when diagnosed with a chronic disorder that has no "cure"? Perhaps recovery is about accepting our essential reality. Psychiatry can often control symptoms but cure is not the answer, as the very essence of the disease may also mean coping with aspects of living that are beyond medication: stigma, poverty, homelessness, unemployment and isolation. As a society, how then do we respond to the existential and societal ills of the disorders and diseases we are called to heal?

Empowerment and Recovery are about sharing hope and working to regain and keep a sense of meaning and purpose in life, as full and equal members of the community. Empowerment and Recovery are also about strengths, talents, interests and what makes an individual unique.

Empowerment and Recovery are about staff as well as patients, and the ability to reflect critically, work with and bring to others the desire for wellness and lives that are meaningful and lived to the fullest. This means sharing knowledge as well as experience, learning together to find better ways, such that we can say we are not alone in our struggles with mental illness.

References

The American Heritage Dictionary of the English Language, Fourth Edition. Boston: Houghton Mifflin, 2000.

Viktor E. Frankl. Man's Search For Meaning. New York: Washington Square Press, 1959, p. 135.

Rev. McBride was until recently the Empowerment Facilitator at Providence Continuing Care Centre Mental Health Services

---

AWARDS AND PRIZES 2003 - 2004
Awarded at Spring Research Day, June 2004

Resident Awards
Excellence in Teaching Award - sponsored by Pfizer Canada, and awarded for the best teacher in undergraduate, postgraduate, or allied health care programs: Dr.Regina du Toit

Best Presentation Award sponsored by Eli Lilly Canada, and awarded for the best presentation at Grand Rounds, Research Days, Psychotherapy Day or an external conference: Dr. Eric Prost

Research Prize sponsored by Janssen-Ortho, and awarded for excellence in research either conducted during the academic year of the award, or for sustained and significant involvement in research over two or more years of residency: Dr. Oleg Savenkov and Dr. Sherese Ali

Child Psychiatry Award sponsored by Solvay Pharma, and awarded for excellence in one or more of the following areas: conducting a literature review on a topic; developing or participating in a divisional CQI project; developing a presentation for conference submission; submitting an article to a journal for publication; or developing or participating in a research project (not necessarily given each year): Dr. Oleg Savenkov

Outstanding Contribution to the Residency Training Program sponsored by Bristol Myers Squibb Canada, and awarded for all-round contributions in the following areas - clinical, administrative, teaching, research and social convening: Dr. John Chan

Faculty Awards
Excellence in Teaching Award: Dr. Susan Finch

Excellence in Research Award: Dr. Jeannette Holden

Excellence in Clinical Services Award: Dr. Simon O'Brien

Exemplary Service to the Department Award: Dr. Louis Van Zyl

COERCION: ETHICS, ISSUES AND THE NEED FOR FURTHER RESEARCH

each of the facilities, a reduction in the use of seclusion and restraint actually led to a decrease in violent incidents.

Both specific psychiatric interventions and the perceptions of these interventions by the patients are aspects of the general area of coercion in psychiatry. Moreover, the association of coercion and psychiatry in the collective consciousness of the general public contributes to both an expectation of coercion in psychiatric treatment and to stigma associated with psychiatry and mental illness. On the other hand, a lack of the appropriate use of coercive measures could lead to devastating individual and social consequences. It is important that all aspects of coercion in current psychiatric practice are studied. This will allow a fuller understanding of the relationships between psychiatric practice, perceived coercion, risks and outcomes. Awareness of the impact of these measures would be likely to ensure the appropriate use or omission of coercion, and the establishment of clinical practice guidelines. Alternate treatment strategies may be developed along the way. The ultimate goal would be to provide optimal care for psychiatric patients.

References

Everett B. Community treatment orders: the ethical challenge of coercive care. Psychiatry Rounds. 2000; 4(8)

Fennig S, Rabinowitz J, Fennig S. Involuntary first admission of patients with schizophrenia as a predictor of future admissions. Psychiatr Serv. 1999;50(8):1049-1052.

Frese FJ. The mental health consumer's perspective on mandatory treatment. New Dir Ment Health Serv. 1997;75:17-26.

Kaltiala-Heino R, Korkula J, Tuohimaki C, et al. Coercion and restrictions in psychiatric inpatient treatment. Eur Psychiatry. 2000;15:213-219.

Kaltiala-Heino R, Laippala P, Salokangas RKR. Impact of coercion on treatment outcome. Int J Law Psychiatry. 1997;20(3):311-322.

Lidz CW, Mulvey EP, Hoge SK, et al. Factual sources of psychiatric patients' perceptions of coercion in the hospital admission process. Am J Psychiatry. 1998;155:254-1260.

McKenna BG, Simpson AIF, Laidlaw TM. Patient perception of coercion on admission to acute psychiatric services. Int J Law Psychiatry. 1999;22(2):143-153.

Meyer H, Taiminen T, Vuori T, et al. Posttraumatic stress disorder symptoms related to psychosis and acute involuntary hospitalization in schizophrenic and delusional patients. J Nerv Ment Dis. 1999;187:343-352.

Segal S, Laurie TA, Segal MJ. Factors in the use of coercive retention in civil commitment evaluations in psychiatric emergency services. Psychiatr Serv. 2001;52(4):514-520.

Swett C. Inpatient seclusion: description and causes. Bull Am Acad Psychiatry Law. 1994;22(3):421-430

CORRECTION

In the Winter 2004 issue (Volume 8, Number 1) there was an error regarding the description of Assertive Community Treatment Teams (ACTTs) in the article "Meeting the Community's Needs The Evolving Role of Brockville Psychiatric Hospital." On page 10 it was incorrectly stated that Brockville Psychiatric Hospital manages three ACTTs for persons suffering from Dual Diagnosis. There is in fact only one such team, which covers the counties of Lanark, Leeds & Grenville, and Stormont, Dundas & Glengarry. In addition to this, there are three regular ACTTs one for Prescott & Russell, one for Stormont, Dundas & Glengarry, and one for Leeds & Grenville and South Lanark.

DR. LESLIE FLYNN WINS SYNERGY AUTHOR PRIZE FOR 2003

Congratulations to Dr. Leslie Flynn, who was one of the many individuals who wrote articles for Synergy in 2003. The Editorial Board decided that the best way to reward the contributors was to hold a draw for the prize, which is a gift certificate for dinner for two at a local restaurant. The draw took place at the Editorial Board meeting on May 13th. Each article published in 2003 constituted an entry for the contest (Board members were excluded). A similar draw will take place next year for articles published in 2004.

Night's Beauty

The night sky is full
With bright twinkling stars
Millions of them shining
Against the black velvet sky

The moon is so bright
In all its splendor
As the Big Dipper hangs near by
As do all the other constellations

The breeze is warm
The air is very mild
As it whips softly through the trees
Ruffling the leaves ever so gently

A wonderful night to see
To see the night in all its beauty
To just stop and look around
As God meant for it to be

J.B. Stonehouse
April 15, 2002