Winnipeg's Psychiatric Nurses: Opinions and Knowledge of Psychiatric Patients' Rights

by

Paul J. Lewis

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Abstract

Since the general duty nurse is probably the patients' primary source of information about patients' rights (Laves and Cohen, 1973; Lewis, 1981; Romoff and Kane, 1982), and is often put in the position of acting as the patients' advocate (Travelbee, 1969; Wilson and Kneisl, 1979; Lewis, 1981; Romoff and Kane, 1982), this study was designed to assess whether or not the nurse is equipped to do so. Two hundred-eighty-nine general duty nurses were asked to complete a pencil and paper questionnaire designed to evaluate their current levels of knowledge concerning psychiatric patients' rights. Eighty-one psychiatric nurses (46% of all such nurses in Winnipeg) representing 11 different inpatient psychiatric units, and 43 non-psychiatric nurses (the control group) responded. As compared to their non-psychiatric counterparts, psychiatric nurses were more knowledgable of psychiatric patients' rights, but 85 percent of the psychiatric nurses knew less than half of what nurse-supervisors felt the patient should know (Lewis, 1981), and their mean score on the "Knowledge" measure, eight of 21 (38%) reflected this. The latter score was slightly higher (2 points) than the non-psychiatric control. Results also showed that the length of time a nurse has been employed in psychiatry does not add to the prediction of how familiar she/he will be with patients' rights. In addition, formal exposure to materials concerned with patients'

rights, either as part of a basic nursing curriculum or as continuing education (inservice), was unrelated to knowledge of psychiatric patients' rights.

It is concluded that, at present, the general duty psychiatric nurse is ill-prepared to act as the patients' primary source of information. Pursuant to this finding, it is recommended that advocacy services, extended to psychiatric patients in Manitoba, be improved in accordance with the recommendation made by the Manitoba Law Reform Commission (1979) which stated that, "a patients' rights advocate should be made available in all psychiatric facilities to intercede in matters concerning the rights of patients" (p. 65). It is further recommended that psychiatric patients should be given a written précis of rights when admitted to a psychiatric facility. In the current study 89% of the professional psychiatric nurses who responded were in favour of introducing such a summary.

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WINNIPEG'S PSYCHIATRIC NURSES: OPINIONS AND KNOWLEDGE OF PSYCHIATRIC PATIENTS RIGHTS.

Researchers have observed that legal rights which are guaranteed to individuals confined in psychiatric facilities are not always enforced by mental health professionals (Cohen, 1970; Laves and Cohen, 1973). Recently, a study has shown that psychiatric patients, previously committed in Manitoba, felt uninformed of their rights with only eleven percent (N=61) claiming to have been informed (Toews, El-Guebaly, and Leckie, 1981). Related to the problem of upholding psychiatric patients' rights is the issue of "capacity", i.e.; ability to comprehend deserves consideration. Avoiding a legal definition of "capacity" the implication is that a person's ability to know and/or to decide may be impaired if they are mentally ill. Assuming that a psychiatric patient can recognize instances where rights are denied one must ask, "is that person well enough informed so that corrective action can be taken?" If the patient doesn't have the capacity to recognize a breach of right, do persons who have day-to-day contact with them have the knowledge necessary to intervene on the patient's behalf?

The Manitoba Law Reform Commission (1979) reports that, in Manitoba, there has never been an appeal to a court to determine the legality of a medical certificate.[1] The

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[1] A "medical certificate" is a legal document issued for the purpose of detaining a person as a psychiatric patient against his/her will.

Commission suggests that one reason no such challenge has been issued is that, under the current system, the onus of coming forward to initiate such proceedings is wholly on the patient. Pursuant to this belief the commission recommended that "a patients' rights advocate be made available in all psychiatric facilities to intercede in matters concerning the rights of patients" (Manitoba Law Reform Commission, 1979, p. 65). However, when the mental health statute was reformed in 1980 (Am. S.M., 1980, c. 62 s. 26) this advice was overlooked by those who drafted the amending bill.

Recently a pilot study, assessing opinions of twenty-one of Manitoba's thirty "first echelon" psychiatric nurse supervisors[2] concerning nurse/patient knowledge of psychiatric patients' rights, revealed that a majority (62 percent) of the supervisors felt the general duty nurse is the most important patients' advocate[3] (Lewis, Note 2). The project also indicated that nearly half of the respondents (48 percent) simultaneously held the opinion that the general duty nurse did not have a working knowledge of the current mental health

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[2]"First echelon psychiatric nurse supervisor" refers to a nursing position at the first level of management above the general duty nurse, and excludes individuals who periodically act as "person in charge." The term "supervisor" was adopted because, depending on the facility, a variety of titles may refer to similar positions, e.g., "Team Leader," "Unit Coordinator," etc.

[3]"Patients' Advocate" refers to a person who promotes patients' awareness of legal status, avenues of appeal, and who provides information concerning patients' rights to patients and members of the treatment team (Dobson and Hansen, 1976).

statute. This is significant because it is mainly in this statute (The Manitoba Mental Health Act) that many of the rights guaranteed psychiatric patients are defined.

Recognition of the fact that the general duty psychiatric nurse[4] is probably the patients' primary source of information about patients' rights identifies a need to investigate whether or not the nurse is equipped to do so. If not, then it may be advisable to establish such continuing education, curriculum changes, or advocacy services, as may be necessary to aid the nurse in meeting the demands placed upon them.

The goals of this project are therefore twofold. First, the study was designed to assess general duty psychiatric nurses' knowledge of patients' rights. This serves to provide health care educators with a means of assessing directions for future inservice programs and/or curriculum changes. In addition, such information may supplement the Manitoba Law Reform Commission's (1979) recommendation which stated that a "patients' rights advocate" should be made available to psychiatric patients (p. 39-41). Second, information was obtained concerning whether or not psychiatric nurses in Manitoba would be in favour of introducing, in mental health facilities, a summary of patients' rights (see Appendix B) which would

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[4]A "psychiatric nurse" is a general duty nurse, i.e., a nurse other than a supervisor, who is a Registered Nurse, or a Registered Psychiatric Nurse employed at an inpatient psychiatric facility.

be given to each patient either at the time of admission or shortly thereafter. The "summary" would be helpful in that it could share with the nurse, and other mental health professionals, the burden of providing specific information to psychiatric inpatients about their rights.

Historical Considerations

In his book, The Canadian Patient's Book of Rights, Rozovsky (1980) maintains that it is the "black-robed priests of our temples of justice" who make the law seem as if it is something "divorced from life" (p. 117). This assertion is relevant to the mental patient because too often the only thing as mysterious as the "illness" is the person's legal status. A likely result of this circumstance is confusion among patients, family members, and friends, about what can/should be done. In such an enigmatic situation those who are involved will probably discover that the law is designed to serve the interests of the society as opposed to those of the individual. The point being that law cannot, and is not designed to, provide static nor specific rules to fit every situation. Law also includes a dichotomy between "criminal" and "civil" law, that is of importance. A crime punishable under the Criminal Code can be defined as, "an act committed or omitted in violation of a law [The Criminal Code of Canada] forbidding or commanding it for which an adult can be punished, on conviction, by incarceration or other penalties." (Ellison and Buckhout, 1981, p. 426; Brackets added). In contrast,

civil law delineates a class of legal action "relating to private rights and remedies sought by action or suit distinct from criminal proceedings" (Webster, 1976). The present discussion will be concerned only with action initiated under civil law.

Rights

The meaning of "right" is both simple and complex. It is something a person is entitled to as well as something someone else is duty bound to confer (Rozovsky, 1980). The complexity resides in "what" a person is entitled to and "who" has a duty to convey it. The "what" and "who" challenge is of course subject to inquiry in court. In 1859, philosopher John Stewart Mill proposed that,

> (t)he only purpose for which power can rightfully be exercised [removal of civil liberties] over any member of a civilized community against his will is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. He cannot rightfully be compelled to do so, because it will make him happier, because in the opinion of others, to do so would be wise, or even right (1859, p. 15; Brackets added).

Mill urges that we, society at large, restrict the liberties of an individual only to prevent "harm to others." However, the notion "harm to others" is elusive. "Harm" is, in the context of civil proceedings, a subjective event dependent

upon the nature and gravity of a given act. Mill does, however, tender the concept of "power" implying that under certain circumstances the state may revoke or restrict an individual's privileges. Where does this "power" originate? More specifically--in the case of the mentally ill individual, what basis is there in law for removal of her or his civil liberties?

Power

Kittrie (1971), in his book, The Right to be Different, points out that traditionally, criminal law has been the major "tool" for insuring conformity. He also asserts that criminal law is undergoing a process of divestment which means it is relinquishing jurisdiction over many events previously dealt with as if they were crimes. The result being that while North America goes about the business of revising its criminal statutes it has subsequently utilized a different system of imposing social control (other than criminality). What then of the person who is deviant, e.g., the psychiatric patient, but whose behaviour is no longer considered "criminal?" How do we, society, revoke this person's privileges?

One model of intervention is the parens patriae doctrine. This doctrine originated in seventeenth century England where it was believed that the King was patriarch of his country. Under parens patriae, state intervention into the life of a mentally disturbed person, is carried out to serve the best

interests of the deviant individual (Wexler, 1981). Weisstub (1980) claims that the exercise of this power has, in modern times, passed from the throne to the legislature, and has become chief justification for state intervention into the lives of its citizens. It should come as no surprise that objections to parens patriae centre on a question of the limits of its paternalistic premise. That is, how far can the state go in its attempts to improve the individual by imposing majority standards for his/her own good (Szasz, 1965; Kittrie, 1971)?

Another source of "power" underlying criteria for involuntary detention of, or withdrawal of the privileges of, the mentally ill person is the doctrine of public protection (Weisstub, 1980). This model of intervention is exactly the opposite of parens patriae. It justifies the revocation of rights or privileges under the aegis of public safety as opposed to doing what is best for the individual. In short, public interest supersedes the rights of a given individual. Weisstub (1980) posits that the exercise of this power, in the public interest, is "the least limitable" of governmental authority. He adds that, in Canada, if a statute is valid legislation, it it essentially immune from attack on constitutional grounds. This, claims Weisstub, is because Canada has had no entrenched bill of rights (p. 333). However, since the proclamation of the new Canadian constitution in April, 1982, immunity such as this may no longer prevail.

The primary question confronting the public protection doctrine is when is public safety jeopardized? Consequently, there is an ongoing debate over the use of the "dangerousness criterion" which is often included in Provincial mental health legislation (e.g., the Ontario Mental Health Act: R.S.O., 1978). If danger, to others or to oneself, is considered justification for detention under the public protection paradigm one must ask, at what point does the person who is declared "mentally ill" become dangerous? As with Mill (1859), the contention that removal of liberties should only be based on the criterion of "harm to others", presents an impasse. Clearly, there is an inherent "looseness" in the concept of "harm" and/or "danger." An illustration of the "looseness" of the danger/harm criteria is, that in Ontario, research has shown that even though the "danger" criterion is emphasized in the Ontario Mental Health Act, physicians have demonstrated a noticeable disregard for it when preparing medical certificates for institutionalization (Page and Yates, 1973; Page and Firth, 1979). Furthermore, Richert and Moyes (Note 3) found that certificate completion practices of Manitoba physicians do not differ greatly from those of their counterparts in Ontario. This conclusion is relevant because the Manitoba Mental Health Act (Am. S.M. 1980, c. 62) does not include "dangerousness" as the foremost criterion for involuntary admission.[5] One would therefore expect Ontario

[5]The "dangerousness criterion is explicitly stated only as justification for change of status, i.e., from noncompulsory to compulsory.

physicians to emphasize "dangerousness" as justification for detention of psychiatric patients, at least when compared to Manitoba's physicians, but they do not. The Page et al. (1974, 1979) results may reflect discovery, by Ontario physicians, of the ambiguity inherent in the term "danger." Knowledge of the contentious nature of the concept of "dangerousness" could serve to hinder the use of this criterion and thus account for the lack of differences between physicians described by Page and his colleagues (1974, 1979). Another possible explanation for Ontario physicians' apparent inattention to the "danger" criterion might be inadequate knowledge of the content of the mental health statute in either Ontario, Manitoba, or both. Either way these alternative explanations of the Page et al. (1974, 1979) findings might be subject matter for future inquiry.

Broader Criteria

According to Kittrie, (1971) there has been a progressive broadening of criteria for commitment over the last century. He maintains that the expansion is due to changes in commitment practices, which have subsequently been facilitated by changes in the "language" of different statutes. An example of broader criteria in Manitoba is the "in need of treatment" clause which, under the current mental health statute (Am. S.M. 1980, c. 62, s. 26), has become justification for involuntary admission to a psychiatric facility.

The liberalization of civil commitment statutes appears

to be rooted in a decision made in 1845 by Chief Justice Shaw of Massachusetts who ruled that an insane person could be detained for remedial treatment. This judgement was of considerable impact because, in North America, the procedures inherent in English Common Law (a paradigm of law allowing legal debate based on a decision made in the past by a recognized court, i.e., "precedent") are the primary mode of legal discourse (Sussman, 1976; Gall, 1977). The Shaw decision meant that the criteria of "danger", or "harm" to self/others, were no longer considered the sole justification(s) for the revocation of liberties (Deutsch, 1937). Knowing this, one can understand the importance of the interaction of the paradigms described above (parens patriae, public protection) with the procedures of English common law. Jointly, they provide the framework for legal discourse if civil commitment is contested or imposed. Also, it becomes clear how "precedent" can exert a great deal of influence on the language of regional statutes.

Given that the state (Province), under certain circumstances, has the power to restrict the civil liberties of the mentally ill, that statutes governing civil commitment are necessarily vague, and that the advocacy services are, at best, minimal, there is a need to investigate the means by which psychiatric patients in Manitoba are being informed of their rights.

The Study

Researchers have examined the question of whether or not current laws, especially with respect to involuntary commitment, have been properly administered (Swardon 1964; Sopinka and Howie, 1977; Affleck, Peszke, and Wintrob, 1978; Page and Firth, 1979). Another approach has been to assess the safeguards that exist in mental health law (Reitsma, 1973). Results have not been encouraging. Affleck et al. (1978) found that many of the psychiatrists in their sample (N=294) were in fact unfamiliar with the law governing civil commitment. Furthermore, the psychiatrists in this study often invented their own criteria for committal. In 1977, Sopinka and Howie, working independently, found that 70 percent of 200 physicians' certificates used for compulsory admission to Whitby and Lakeshore psychiatric facilities failed to comply with the Ontario Mental Health Act (Toronto Globe and Mail, 1977). In 1973, Laves and Cohen completed an investigation concerning attitude toward, and knowledge, of the legal rights of mental patients. They included psychologists, social workers, and psychiatric nurses in their experiment. Nurses and psychiatrists were found to be more knowledgeable of patients' rights than were either the psychologist or the social worker. Laves and Cohen (1973) concluded that, "cognizance of the pertinent laws is, undoubtedly, the sine qua non for the protection of the legal rights of those committed to mental hospitals" (p. 61). Laves and Cohen also found that

it is often the nurse who is the first to receive a request for information concerning the patients' legal rights. This is not surprising as the boundaries of intervention within which the psychiatric nurse operates include giving assistance, to individuals, aimed at preventing or coping with the whole experience of mental illness (Travelbee, 1969). Also, nursing, since the seventies, has been implementing a new model of practice called "primary nursing" (Romoff & Kane, 1982). The primary nursing model requires that one nurse, a registered professional nurse, be responsible for the total care of the patient from the time of admission until discharge (Manthey, Ciske, Robertson, and Harris, 1970). It should be added that, though many modern psychiatric facilities employ a multidisciplinary approach to treatment, the primary nursing model maintains that it is

> the responsibility of the primary nurse to know clinically and be involved therapeutically in all facets of care, including such issues as the patients' legal status voluntary or involuntary (Romoff and Kane, 1982, p. 77).

Patients must be able to rely on the primary nurse not only for direct patient care and the coordination of that care, but also for explanation and understanding of relevant information. In other words, the role of the primary nurse includes patient advocacy (Romoff & Kane, 1982).

An additional concept of providing care, which influences

the role of the nurse is patients' accountability for his/her own behaviour. Thus, patients are no longer passively treated by psychiatric professionals, but instead they are supported in their efforts to develop new perspectives by considering alternatives and making self-directed choices. In this way psychiatric services currently offered by nurses are consultive and advocative rather than directive (cf. Wilson & Kneisl, 1979).

A psychiatric patient has limited access to information concerning what his/her legal rights are because too often mental health professionals themselves are unfamiliar with the patients' rights (Laves and Cohen, 1973; Affleck, Peszke, & Wintrob, 1978; Lewis, Note 2). According to Richert and Moyes (Note 3) two issues must be resolved: 1. Does lack of knowledge of statutes outlining patients' rights, among mental health professionals, serve to jeopardize the rights of the psychiatric patient? 2. Are mental health workers, especially those employed by inpatient psychiatric facilities, aware of the rights of psychiatric patients? This study focuses on the latter of these two issues, i.e., the issue concerning mental health workers' knowledge of patients' rights. Furthermore, because the general duty nurse appears to have assumed responsibility for providing information about patients' rights, i.e., acting as patients' advocate (Travelbee, 1969; Laves and Cohen, 1973; Wilson and Kneisl, 1979; Romoff & Kane, 1982; Lewis, Note 2) this project looked

specifically at psychiatric nurse and the current level of their knowledge of psychiatric patients' rights.

The present study sought answers to several questions. First, to what extent are Manitoba's general duty psychiatric nurses acquainted with the legal rights of psychiatric patients? Familiarity was assessed by a questionnaire (see Appendix C) and is labelled "knowledge". Items on the "knowledge" measure were derived from a domain of 12 patients' rights content areas which were identified in a pilot study (Lewis, Note 2). The twelve content areas were: 1. Patient admission status; 2. right to refuse treatment; 3. systems of appeal; 4. right to communicate; 5. discharge procedure; 6. right to examination; 7. period of hospitalization; 8. possible extention of hospitalization; 9. rights abdicated; 10. authority/responsibility of the psychiatric facility; 11. probation; 12. confidentiality. Additional information concerning level of "knowledge" was provided by a comparison between nurses working in psychiatry ("Psychiatric Nurses"), and nurses working in other areas of the general hospital who have not worked in psychiatry ("Non-psychiatric Nurses"). The study examined (1) whether psychiatric nurses would demonstrate superior performance on the "knowledge" measure when compared to their non-psychiatric counterparts. The study was also designed to (2) assess whether

or not "knowledge" is affected by "Type Nurse."[6] That is, among psychiatric nurses, do R.P.N.s, R.N.s, and B.N.s, etc., differ on their demonstrated familiarity of patients' rights. Also the project investigated (3) the effect of months of experience on "knowledge", i.e.; to what extent is a nurse's knowledge of patients' rights predictable based on months of experience. (Months of experience, estimated as full-time equivalency where applicable, was measured as two separate variables: 1. months in area, e.g., psychiatry, and 2. total months in nursing.) The study (4) sought to determine who general duty psychiatric nurses feel is currently the "most important" patients' advocate. Finally, (5) the study examines whether or not general duty psychiatric nurses in Winnipeg are in favour of introducing a précis of psychiatric patients' rights to be given to the psychiatric patient at the time of admission or shortly thereafter.

Method

Subjects

Subjects were 124 general duty nurses representing varying levels of "months of experinece" and "type of nurse"

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[6] "Type Nurse" is a variable consisting of five categories of nurses: 1. "RN."--a registered nurse whose basic preparation in nursing is graduation from a diploma program and who has not acquired a baccalaureate degree; 2. "BN"--an RN whose basic preparation in nursing has been a baccalaureate degree in nursing; 3. "RPN"--a registered psychiatric nurse whose basic preparation in nursing has been a diploma psychiatric nursing program, and who has not acquired a baccalaureate degree; 4. an RN or RPN who has acquired a baccalaureate degree in an area other than nursing; 5. any combination of 1, 2 and 3, e.g., RN+RPN.

who volunteered to participate in the study. They represented six Winnipeg area general hospitals. Research materials were distributed to all psychiatric nurses employed in these six general hospitals with the following exceptions: Outpatient personnel, nursing supervisors, nurses working on adolescent units, and Licensed Practical Nurses.

Selection of non-psychiatric nurses (the control group), for the comparison between psychiatric and non-psychiatric nurses on the "knowledge" measure proceeded via a four step random sampling procedure. First, four of the six hospitals were randomly selected. Second, from each of these four facilities, using the appropriate intrahospital telephone directory, three non-psychiatric inpatient units were selected. Third, a day was randomly selected for administration of the questionnaire ("knowledge" measure). The questionnarie was then distributed to all general duty non-psychiatric nurses on all three shifts (day, evening, and night) on each unit.

The Survey Instrument

Items for the "knowledge" measure were selected based upon the twelve "patients' rights content areas" (see p. 14) identified by psychiatric nurse supervisors, during a pilot study (Lewis, Note 2), as being information that the psychiatric patient should be familiar with. Following identification of the content areas, five to ten questions were developed for each area. Initially, these questions were then

submitted to a PhD Psychologist at the University of Manitoba, and to a Nursing Supervisor, RN, BScN (Psychiatry) for their editorial comments and suggestions. Items agreed on were compared to pertinent statutes, and, where necessary, rephrased. Some items employ a format identical to that used by Laves and Cohen (1973), but these have been adapted for use in Manitoba. Questions (n=40) were then referred to a panel of five experts for final evaluation. Participating in the final item evaluation were: A clinical instructor of psychiatric nursing, RN, MScN; two Nursing Supervisors (both managers of adult inpatient psychiatric units), one an RN, BA, the other an RN, BScN; a Clinical Nurse Specialist (psychiatry), RN, MA; and a PhD Psychologist.

Based on the results of the item evaluation, a "knowledge" measure (questionnaire) consisting of 22 items was developed. A trial administration using a small number (N=8) of general duty psychiatric nurses was then carried out. This produced a Kuder-Richardson (formula twenty) reliability coefficient (Anastasia, 1976) of .80 across the 22 items on the "knowledge" measure. It also revealed that, on the average, each subject would require about 19 minutes to complete the questionnaire.

The final "knowledge" measure, consisting of 21 items (having deleted one item after the trial phase), can be seen in Appendix C. Also, attached to the "knowledge" measure was a two item Opinionnaire (see Appendix C, p. 50) which asked

participants (1) whether they were in favour of introducing a written summary of patients rights, and (2) to rank various professionals, according to the nurses perception of how important these individuals are, as patients' advocate.

Procedure

The Director of Nursing, and/or the appropriate research committee, at each facility was asked to grant written permission allowing the cooperation of general duty staff and nursing supervisors on each unit sampled. Once the project was approved by hospital authorities each unit supervisor was contacted and arrangements were made to distribute "packets" containing the research materials. At this time total numbers of each "type nurse" on that unit were obtained and recorded for later determination of actual sample size as compared to the total number of psychiatric nurses in the target population. Also, each unit supervisor was asked to provide last names and first initial of each nurse on the unit. These names were written ONLY on the "packets" which contained the "knowledge" measure/opinionnaire. Included in the packet were requests for debriefing (see Appendix D), letter of introduction asking the potential subject to participate in the study (see Appendix E), and where required, a consent form (see Appendix F). A stamped envelope (addressed to the researcher) was included in the package allowing completed materials to be submitted. The unit supervisors were asked to distribute the packets during daily "report". Such

a procedure insured that all nurses were exposed to the materials, and at the same time guaranteed privacy and anonymity.

For both groups (psychiatric and non-psychiatric) a follow-up letter was sent to each nursing unit within ten days after materials were made available, reminding subjects of the need and value of their participation. As a token of appreciation a "Western Express" lottery ticket was included in the reminder.

A deadline for materials received was fixed at three weeks after the last materials were distributed, so all participants had at least twenty-one days to submit completed forms.

Results

One hundred-seventy-five psychiatric and 114 non-psychiatric nurses were asked to participate in the study. Eighty-one psychiatric nurses (46%) and 43 non-psychiatric nurses (39%) responded. The psychiatric nurses were employed at eleven different inpatient adult psychiatric units which were distributed among six participating Winnipeg area general hospitals. The non-psychiatric control subjects were employed within the same facilities as the psychiatric nurses and were selected via a random sampling procedure (see Subjects). Because two of the 45 non-psychiatric nurses had previously been employed on psychiatric units, these individuals were not included in the control sample. The approximate breakdown

of types of psychiatric nurse in the parent population as well as the specific groupings of respondents can be seen in Table 1. Within the parent group the numbers of nurses falling into the two categories, RPN + RN, and RPN (or) RN with baccalaureate degree in an area other than nursing were

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INSERT TABLE 1 ABOUT HERE

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an approximation because specific information regarding membership in these two groups was not always available. Eighty-five percent (n=69) of the psychiatric nurses reported that they had read the section of The Manitoba Mental Health Act (Am. S.M. 1980, c. 62) that pertains to psychiatric patients, 42 percent (n=34) of these claimed to have had some education concerning the content of "The Mental Health Act" as part of their nursing school curriculum, and 38 percent (n=31) stated that they had received some type of "inservice" education regarding the above mentioned statute. Eleven percent (n=9) of the psychiatric nurses had been exposed to the mental health law both while in school and as part of a continuing education program. Among the 34 individuals who received some instruction about patients' rights as part of their basic nursing education, 23 were RPNs. On the average it had been 83 months (SD = 75.3) since their basic nursing curriculum had been completed. The average amount of time

that had passed between the time an individual attended an "inservice" program and the time they completed the "knowledge" measure was 17 months (SD = 4.0). The relationship between "score" and "formal exposure" (during nursing school or as inservice education) to material concerning patients' rights was assessed by using the computer program "NONPAR CORR," from Statistical Package for the Social Sciences (Nie, Hull, Jenkins, Steinbrenner, and Bent, 1975), to compute Kendall's correlation coefficient (Hayes, 1981; Glass & Stanley, 1970). The resultant correlation between "score" and "inservice" education was $\tau = -.05$ ($p = .30$). The correlation between "score" and "exposure during nursing school" was $\tau = .17$ ($p < .04$).

Evaluation of the reliability of the "knowledge" measure via the Kuder-Richardson method (formula twenty) (Anastasia, 1976) yields, among psychiatric nurses ($n=81$), a reliability coefficient of $r = .81$ ($z = 10.0$, $p < .01$) and a standard error of measurement of 2.0 (95% confidence). The same procedure, when used for the non-psychiatric group ($n=43$), produced a Kuder-Richardson reliability coefficient of $r = .66$ ($z = 5.0$, $p < .01$) and a corresponding standard error of measurement equal to 1.9 (95% confidence).

Depending upon the degree to which each subject had command of information concerning patients' rights, respondents were ranked according to their score out of a possible twenty-one (see Table 2). The overall mean score among

psychiatric nurses (n=81) was 8.0 (SD = 2.4). Among non-psychiatric nurses the overall mean score was 5.6 (SD = 1.7).

INSERT TABLE 2 ABOUT HERE

Comparing mean scores between psychiatric and non-psychiatric nurses was complicated because types of nurse, BN, RN, RPN, etc. found within these groups is not equivalent, e.g., the non-psychiatric group would not have RPNs. Therefore, it was not possible to employ a fully-crossed factorial design. A second complication was that within three of the five categories of "type nurse" (see footnote 6), the observed frequency of respondents was too small to allow valid statistical inferences (see Table 1). Given the observed distribution of types of nurse, analysis of the hypothesis that psychiatric nurses' performance on the "knowledge" measure would be superior to that of their non-psychiatric counterparts, consisted of a comparison between psychiatric RNs (n=31), RPNs (n=31), and non-psychiatric RNs (n=40). This was accomplished using one-factor, fixed effects, ANOVA. The computer programs used were "ANOVA" and "ONEWAY," from Statistical Package for the Social Sciences, Release 9 (Nie, et al., 1975; Hull and Nie, 1981). The ANOVA summary data (see Table 3) indicate that there is a statistically significant increase in between groups variation on "score" due to

to group membership (F = 22.31, $p < .01$, α = .05) even after

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INSERT TABLE 3 ABOUT HERE

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adjusting for the covariates, months of experience total (F = 10.53, $p < .01$, α = .05), and months in area (F = 7.97, $p < .01$, α = .05). Post hoc examination using Scheffe's method (Hayes, 1981) shows that the difference in average score among nurses employed in psychiatry, as compared to those who are not, accounts for a significant amount of the between groups variation (range = 1.05, $p < .05$, α = .05).

The question of whether mean scores would differ between types of nurse within psychiatry was examined by contrasting RNs (n=31) and RPNs (n=31). Mean scores for both groups of psychiatric nurses, i.e., RNs and RPNs, were 7.2 (SD = 2.4) and 9.0 (SD = 2.3) respectively. Post hoc investigation via Scheffe's method revealed statistically significant differences between these two groups (range = 4.39, $p < .01$). Differences between psychiatric RNs and RPNs on observed frequency of correct responses (see Table 4) were also found to be statistically significant (χ^2= 34.89, df = 20, $p < .05$). Specific items on the "knowledge" measure that explain the

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INSERT TABLE 4 ABOUT HERE

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dissimilar frequency distributions of psychiatric RPNs, as compared to psychiatric RNs, were item(s) number 1 (χ^2= 3.13, df = 1, $p < .10$), number 6 (χ^2= 4.0, df = 1, $p < .05$), number 7 (χ^2= 4.0, df = 1, $p < .05$), number 9 (χ^2= 4.84, df = 1, $p < .05$), and number 10 (χ^2= 6.72, df = 1, $p < .01$). Observed frequencies of correct responses among non-psychiatric nurses are shown in Table 5.

Utilizing Scheffe's method to evaluate remaining pairwise comparisons between group means, i.e., psychiatric RNs

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INSERT TABLE 5 ABOUT HERE

(n=31) versus non-psychiatric RNs (n=40) (range = 4.39, $p < .01$), and psychiatric RPNs (n=31) versus non-psychiatric RNs (n=48) (range = 4.39, $p < .01$), it was shown that both contrasts are statistically significant. The mean score among non-psychiatric RNs was 5.5 (SD = 1.8).

Examination of the question concerning the contribution of "experience" (measured as: 1. total months in nursing; and 2. months in area) to the explained variance in score, was accomplished by investigating the magnitude of the between-groups variation. This strategy reveals that, when all independent variables are combined, about 34 percent (ω^2 = .34) of the variance in score can be explained by a combination of group membership (psychiatric RN, or RPN,

non-psychiatric RN) and the covariates (total months in nursing, and months in area). The compound effect of knowing both how long a subject has been a nurse and how long they had worked in a given area was to increase the explained variance in score by about 6 percent ($\omega^2 = .06$).

Regarding the issue of who psychiatric nurses feel is the "most important" patients' advocate (see Opinionnaire, Appendix C), frequencies of responses were tallied and are presented in Table 6.

INSERT TABLE 6 ABOUT HERE

When respondents were asked whether they would be in favour of distributing a summary of rights, which would provide specific information to psychiatric patients (see Opinionnaire, Appendix C), the following observations were made. Among the 81 subjects who gave their opinions, nine did not feel that such a summary should be introduced, twenty-two agreed to the introduction of the précis, but felt that discretion should be used, and the remaining fifty individuals stated that a summary of this type should be given to psychiatric patients as a routine procedure. The relationship between "score" and "choice" of whether or not a compendium of patients' rights should be introduced was assessed by using the computer program "NONPAR CORR," from

Statistical Package for the Social Sciences (Nie et al., 1975), to compute Kendall's correlation coefficient (Hayes, 1981, Glass & Stanley, 1970). The resultant correlation was $\tau = .02$ ($p > .40$).

Discussion

Having established earlier that psychiatric patients are likely to query the general duty nurse first about their rights (Laves and Cohen, 1973; Lewis, Note 2), and that the nurse is often placed in a position of acting as patients' advocate (Travelbee, 1969; Laves and Cohen, 1973; Wilson and Kneisl, 1977; Romoff and Kane, 1982; Lewis, Note 2), one of primary objectives of this study has been to assess current levels of nurses' knowledge about patients' rights. The purpose of this undertaking being to establish, in an empirical context, whether or not the general duty psychiatric nurse is equipped to act as the patients' primary source of information about patients' rights (cf. Romoff and Kane, 1982).

The results of the current study, concerning nurses' knowledge of mental patients' rights (as defined by what supervisors felt patients should know) in conjunction with other findings (Swardon, 1964; Laves and Cohen, 1973; Reitsma, 1973; Sopinka and Howie, 1977; Affleck, Peszke, and Wintrob, 1978; Lewis, Note 2), are interpreted as firm support for full implementation of the Manitoba Law Reform Commission's (1979) recommendation which stated that a patients' rights advocate should be made available "in all psychiatric

facilities" (p. 39-41).

Results show that the 81 general duty psychiatric nurses in this study (46% of the population of psychiatric nurses in Winnipeg) did not have command of information about patients' rights. When compared to their non-psychiatric counterparts, psychiatric nurses demonstrated superior performance on the knowledge measure, but 68 (84%) of the psychiatric nurses knew less than half of what nurse-supervisors felt the patient should know, and their mean score, eight of 21 (38%), reflected this. This latter score was only slightly higher (2 points) than the non-psychiatric control. Even though this difference is statistically significant its application is open to question. Results would indicate that general duty psychiatric nurses have not mastered the material specified by their supervisors as information important to the psychiatric patient, and are ill-prepared to fulfill the responsibility of acting as "advocate" in matters concerning patients' legal rights. This finding requires serious consideration because a large number of individuals may find themselves in need of advocacy services. Winifred Norton, a Registered Nurse who works exclusively as advocate for psychiatric patients in the Windsor/Essex region of Ontario recently stated (March, 1982) that one-in-eight Canadians can expect to be treated in a hospital for a mental illness at least once during their life (Winnipeg Free Press, p. 2). Norton pointed out that according to Statistics Canada, 119,417 Canadians were

admitted to psychiatric facilities during 1978, and that one-third of these admissions were compulsory. She concluded that there is a definite need for improved advocacy services for psychiatric patients throughout Canada.

The finding, that psychiatric nurses are unfamiliar with patients' rights, does not imply that attitudes among professional nurses are such that psychiatric patients are treated unfairly. In fact, Laves and Cohen (1973) found that though mental health professionals (psychiatrists, nurses, social workers, and psychologists) in their study were "laboring under a debilitating lack of knowledge", such individuals still felt strongly about enforcing patients' rights (p. 61). The current project seems supportive of this conclusion in that 72 (89%) of the professional psychiatric nurses were in favour of introducing a summary of patients' rights which would share with hospital staff the responsibility of supplying information to psychiatric patients. Fifty of these 72 (70%) felt that a summary of rights should be given to patients as a routine procedure. This finding is in agreement with results of an earlier study which showed that 76% of twenty-one first echelon psychiatric nurse supervisors also favoured the introduction of a compendium of rights (Lewis, Note 2). These 21 supervisors represented 72 percent of such "supervisors" in Manitoba.

However, because professional nurses possess a positive attitude toward enforcing patients' rights (Laves and Cohen, 1973)

this does not mean that these rights are properly conveyed (cf. Towes, El-Guebaly, and Leckie, 1981). Every patient should be given adequate opportunity to object to "treatment" even if the medical staff feel that intervention would be in the patient's best interest. In Manitoba, if a psychiatric patient is being detained involuntarily, the order allowing enforcement of the detention automatically includes the right to appeal (Am. S.M., 1980, c. 62, s. 26). It is felt that the prerequisites for such an appeal are: 1. knowing that one can; and 2. having access to information concerning "how" to initiate such a process. Even though most psychiatric units do provide some information about the appeal process (Lewis, Note 2), only 15 of the 81 psychiatric nurses in this study were able to identify two sources, other than an attorney, whom the patient could contact regarding such an appeal (see Table 4, Item 5). Also of interest was the fact that the Provincial Ombudsman was frequently cited as one individual who can be approached if a patient wishes to contest involuntary detention. However, the Ombudsman can only act after other means of appeal have been exhausted (Manitoba Law Reform Commission, 1979, p. 20).

This project was also aimed at providing data to health care educators about possible directions for continuing education relating to patients' rights. Though the data collected provide some useful information about what might be done to rectify the current situation, i.e., lack of knowledge about

patients' rights among nurses (and among other mental health professionals), such information needs to be cautiously interpreted. One should be aware of the fact that, at present, there is no single law defining what a patient's rights actually are (Finnbogason, Note 1). Also, since the ratification of the new Canadian Constitution in April, 1982, which included an entrenched Bill of Rights, many of the regional statutes outlining individual rights may be subject to challenge.

Laves and Cohen (1973), referring to their finding that mental health workers are uninformed about patients' rights, concluded that, " the remedy to this lack of knowledge, honored in tradition, is education" (p. 61)--however, this may be somewhat oversimplified. For example, one of the respondents (a "psychiatric nurse") in the current study reported that she/he had attended an inservice program (about patients' rights) one hour prior to having completed the "knowledge" measure--yet, this individual only scored 5 (out of twenty-one), and was unsuccessful in identifying only two individuals to whom a patient could appeal. Also, knowledge of patients' rights was unrelated to whether or not a nurse had attended an inservice program ($\gamma = -.05$, $p = .30$). In addition, the finding that exposure, while in nursing school, to materials concerning patients' rights was positively related to "score" ($\gamma = .17$, $p < .04$) may be misleading because among the 34 individuals who reported having had this

experience, 24 were RPNs. That is, it is unclear what factors are responsible for the observed relationship between "exposure" while in school and "knowledge" because RPNs' basic educational program is divergent from, for example, that of RNs. Thus, it is realized that in this kind of learning process there are many variables, e.g., focus of basic education, quality of education, student experience, etc., that may be responsible for the observed relationship between "knowledge" and "exposure." Therefore, the finding that those who were exposed to the material during nursing school knew more about patients' rights than other subjects cannot be interpreted as direct support for the inclusion of material concerned with psychiatric patients' rights in nursing curricula.

Specific content areas that should provide a focus for education about psychiatric patients' rights are those which were identified by nurse supervisors as information the patient should be familiar with (Lewis, Note 2). These were the 12 content areas (see p.14) that were employed in the construction of the "knowledge" measure. Items that the nurses in this study found to be particularly difficult, e.g., items number 4, 6, 8, and 12, might provide some guidance for educators, but, because the mean score among psychiatric nurses was low (38%), it is realized that remediation should include broad coverage of psychiatric patients' rights. Furthermore, caution is indicated when assessing the relevance

of specific items because the survey instrument ("knowledge" measure) was designed as a measure of "general familiarity" and should be interpreted as such.

The present inquiry concerning the contribution of months of experience (total months in nursing, and months in a given area within nursing), relative to how much a nurse would know about patients' rights, indicated that neither the length of time a person has been a nurse nor the time spent in psychiatry are important. After considering the unique contribution of the combined affects of, total months in nursing, and months in psychiatry, on "knowledge" it was found that together these variables add little (less than 4 percent) to prediction of how much knowledge a given individual would possess. Therefore, it cannot be assumed that, because a nurse has worked in psychiatry for varying lengths of time, he/she will have more, or less, knowledge about patients' rights.

The nurses in this study did not feel that they are the most important patients' advocate. Instead they reported that the patient was his/her own best advocate (see Table 6). The nurse and family were of equal import, and were ranked second on advocacy ratings, followed by the psychiatrist, the nursing supervisor, and finally, the hospital Ombudsman. The finding that the patient is thought to be his/her own "most important" advocate clearly indicates the need to provide the patient with information.

Summary and Conclusions

The results of this study show that: (1) The general duty psychiatric nurse is, at present, ill-prepared to act as the primary source of information about patients' rights, (2) education, via continuing education and/or curriculum inclusion, is not necessarily a satisfactory solution to the current lack of knowledge about patients' legal rights, (3) general duty nurses (and their supervisors) favour the introduction of a compendium of psychiatric patients' rights, (4) the patient is believed to be his/her own best advocate. It is concluded that continuing education, and curriculum inclusion of materials relating to psychiatric patients' rights, are important, but these will not fulfill the need for proper advocacy services. Such advocacy services, offered by trained individuals, are especially important in the province of Manitoba where currently there is no program for periodic review of the status of psychiatric patients. Even when the new section of the Manitoba Mental Health Act (Am., S.M. 1980, c. 62, s. 26), which provides for such a "review", is proclaimed (becomes law), and a "review board" is activated, psychiatric patients will still be in need of advocacy services. It is recommended (1) that, advocacy services in Manitoba should be improved to include a patients' rights advocate who is specifically trained to fulfill the needs of the psychiatric patient, and (2) that psychiatric patients be given a written summary of rights when admitted to a psychiatric facility.

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Appendix A: Tables 1 - 6

Table 1

Frequency of Types of Psychiatric Nurse in the Present Sample and Approximate Total in the Parent Population

	Type of Nurse[1]				
	BN	RN	RPN	RN+RPN BN+RPN	RN or RPN with BA
Sample	4	31	31	6	9
Approximate Total	7	66	81	11	10

1. See footnote 6 for explanation of "Type of Nurse."

Table 2

Frequency of Score Attained Out of

a Possible Score of Twenty-one

Score	Psychiatric Nurses (n=81)	Non-psychiatric Nurses (n=43)
1	0	0
2	1	1
3	1	5
4	1	3
5	8	13
6	13	9
7	9	5
8	16	5
9	16	2
10	3	0
11	5	0
12	4	0
13	3	0
14	1	0
15+	0	0

Table 3

ANOVA Summary of the Comparison Between Psychiatric RNs (n=31), RPNs (n=31), and Non-psychiatric RNs (n=40) on the "Knowledge" Measure

Source of Variation	Sum of Squares	DF	Mean Square	F	Significance of F
Covariates	45.95	2	22.97	5.43	.006
Area Months	33.72	1	33.72	7.97	.006
Months Total	44.55	1	44.55	10.53	.002
Main Effects	188.76	2	94.38	22.31	.000
(Group Membership)	188.76	2	94.38	22.31	.000
Explained	234.70	4	58.68	13.87	.000
Residual	410.31	97	4.23		
Total	645.01	101	6.39		

Table 4

Frequency of Correct Responses Among Psychiatric Nurses (n=81) in the Sample

Item No.	BN (n=4)	RN (n=31	RPN (n=31)	RN or RPN with BA (n=6)	BN+RPN RN+RPN (n=9)	Total (n=81)
1	0	3	8	1	3	15
2	1	13	18	2	1	35
3	2	15	16	4	7	44
4	1	2	3	3	3	12
5	0	6	8	0	1	15
6	0	0	4	0	0	4
7	0	3	1	1	0	5
8	0	1	0	0	1	5
9	1	14	25	1	4	45
10	1	7	18	5	4	35
11	0	11	7	3	4	25
12	0	1	2	0	1	4
13	4	29	28	5	8	74
14	2	19	18	2	7	48
15	0	7	10	1	3	21
16	3	20	25	5	7	60
17	1	25	25	6	7	64
18	3	12	14	2	2	33
19	2	13	18	2	3	38
20	0	6	6	1	0	13
21	3	16	23	6	6	54

Note. Mean = 8.0; Variance = 5.7; Kuder-Richardson r = .81; Standard error of measurement = 2.0 (95% confidence).

Table 5

Frequency of Correct Responses Among Non-psychiatric Nurses (n=43) in the Control Sample

Item Number	Total (All Types of Nurse Combined)
1	11
2	21
3	25
4	3
5	2
6	0
7	5
8	10
9	7
10	4
11	4
12	4
13	20
14	18
15	2
16	26
17	35
18	5
19	6
20	9
21	28

Note. Mean = 5.6; Variance = 3.0; Kuder-Richardson $\bar{r}$ = .66; Standard error of measurement = 1.9 (95% confidence).

Table 6

Frequency of Psychiatric Nurses' (n=79)[1] Ratings of Various Individuals in Order of Importance as Patients' Advocate

Rating[2]	Category					
	Patient	Psychi-atrist	Super-visor	Nurse	Family	Ombuds-man
1	42	12	1	16	5	3
2	11	15	5	20	21	7
3	7	17	4	19	23	9
4	5	24	11	13	19	7
5	6	7	38	8	7	13
6	8	4	20	3	4	40

1. Two of the 81 participating psychiatric nurses did not complete the advocacy rating.

2. Rating: 1 = most important; 6 = least important.

Appendix B: A Summary of Psychiatric Patients' Rights

INFORMATION ABOUT PATIENTS' RIGHTS: THE MENTAL HEALTH ACT

The following outline is a basic representation of the 1980 edition of the Manitoba Mental Health Act (Am. S.M. 1980, c. 62). The intent of this outline is to provide patients in psychiatric facilities with a basic understanding of what their rights are and of what rights have been abdicated.

MEDICAL EXAMINATION: As a newly admitted patient you have the right to a medical examination, by a physician, within 48 hours of the time you were admitted.

OBJECTION TO TREATMENT: If you are a non-compulsory patient you have the right to refuse any treatment you object to.

PERIOD OF CONFINEMENT: Forty-eight hours from the time you are admitted, if you are admitted as a non-compulsory patient, you may give WRITTEN notice requesting discharge (ask your nurse about the necessary materials and be sure to include the date and time on the request). Unless a "medical certificate" is issued within 24 hours of submitting your request you will be discharged. If a medical certificate is issued you can be detained, against your will, for a period not to exceed 21 days from the day the certificate was issued. (Reversion to non-compulsory status, or discharge, can be accomplished at any time by your physician.) After 21 days has passed the medical officer in charge can apply to a provincial judge who, after reviewing your case, can grant an order extending your period of detention for such further period as may be necessary (usually not more than three months). If an "open-ended extension" is granted it may be in your best interest to seek professional legal advice.

NOTIFICATION OF NEXT-OF-KIN: The medical officer in charge, where possible, is required to notify your next-of-kin of any changes in your legal status as a patient, e.g., from non-compulsory to compulsory.

CONFIDENTIALITY: Other than members of the hospital staff who are involved in assessing or treating you, no person shall disclose, transmit, or examine your clinical record ("chart") without your consent unless you are under 18 years old or mentally not competent enough to decide to disclose the information. If you are under age, your parents or legal guardian will make the decision. If you are not mentally competent, the Public Trustee's office will assume this responsibility. (A medical certificate does not constitute mental incompetence.)

Your clinical record can also be examined by order of a court. However, if you feel that disclosure may result in either physical or mental injury to another person, your psychiatrist may request (in writing) that your records be examined in a hearing from which the public is excluded, before any public disclosure is made.

Current statutes do not make your "chart" available to you to examine, but should you wish to examine your records, ask your physician to issue a written order allowing you access.

INFORMATION ABOUT PATIENTS' RIGHTS

THE REVIEW BOARD: The psychiatric facility is required to provide you with a written communication outlining the functions of the review board, and the manner in which you could appeal your legal status.

Note: At the time this summary was written, the section of the mental health statute providing for the Review Board had not yet been enacted.

APPEALS: As a psychiatric patient under the current statute, if you are unsatisfied with your legal status, you or your relatives may appeal to a judge of the County Court. To accomplish this, professional legal advice should be sought. If you launch an appeal, unless the Appeals Court otherwise orders, you shall not be required to deposit any money as security for the cost of the appeal, or to furnish the evidence upon which you have been detained. However, should you decide to launch an appeal, request SPECIFIC information from your attorney about the cost of such an undertaking.

Also, if you feel you are being detained unjustly, you may write to your Member of the Legislative Assembly (M.L.A.), Member of Parliament (M.P.), the Chief Provincial Psychiatrist (Assistant Deputy Minister of Health), or the Provincial Ombudsman, and request their assistance.

If the "Review Board" is operational (ask your nurse), you, or any person known to you, may request a hearing before the board to determine whether or not you should remain in the facility or be discharged. Unless otherwise allowed by the Minister of Health, the board must hold a hearing within 30 days of your WRITTEN APPLICATION, and is further required to give you its decision not later than 28 days after the hearing. If you are unsatisfied with the decision of the board you may appeal to a court as above.

COMMUNICATION: All patients have the right to send and receive mail to and from: a. your attorney; b. any member of the Executive Council or Assembly (see telephone directory under "Government of Manitoba"); c. any person appointed to inspect the facility; d. the Provincial Ombudsman; e. the Review Board (see ADDRESSES). The Psychiatric facility is required to provide you with the materials necessary for these communications. All other communications, either written by or sent to you, may be examined, censored, or withheld at the discretion of the medical officer in charge of the facility.

Use of the telephone is a privilege, not a right.

FUNDS FOR DISCHARGED PATIENTS: If you are soon to be discharged, and you have insufficient clothing and/or money, you have the right to be provided with clothing and funds sufficient for sustenance and travel to your place of residence. To accomplish this, ask your nurse to assist you in making an appointment with a Social Worker. Plan several days in advance--do not wait until the last minute!

UNAUTHORIZED ABSENCE: Where a patient in a psychiatric facility is absent without permission, the medical officer in charge of the facility may issue a warrant to detain and return the person to the facility. The warrant may be executed by hospital staff or by any peace officer in the province.

ESTATE: If matters of estate (property or money) are referred to a court, where it appears to the court that your "mental disorder" is temporary, the court may appoint a person, and give that person access to your funds in such an amount as it deems proper to allow for the maintenance of your estate and persons dependent upon you. The person appointed is accountable for money spent. In the event that your "mental disorder" is challenged as being "other than temporary," the court has several options which may provide for the administration of your estate. Where matters of property or money become complicated to the point where you become concerned, it may be in your best interest to seek professional legal advice.

* * * * * * *

PROCEDURE TO FOLLOW IF YOU HAVE QUESTIONS--OR WISH TO APPEAL YOUR STATUS

1. First, inform the following individuals, in the order given, of your question or complaint: a. your physician; b. the nurse assigned to you; c. the nursing supervisor of the unit you are on; d. the hospital's Ombudsman/Patients' Advocate (see below); e. the medical officer in charge of the facility.

2. Once you have followed the above procedure and are still unsatisfied, you may communicate with any of the following individuals: a. an attorney (see lawyer referral below); b. your M.L.A. and/or M.P. (see Appeals,above); c. the Chief Provincial Psychiatrist, Assistant Deputy Minister of Health; the Minister of Health; e. the Provincial Ombudsman.

ADDRESSES:

Hospital Ombudsman, or
Patients' Advocate
Phone_____ - _____

Assistant Deputy Minister
of Health and Chief
Provincial Psychiatrist
Room 315
Legislative Building
Winnipeg, Manitoba R3C OV8

Provincial Ombudsman
Mall Centre R(509)
491 Portage Avenue
Winnipeg, Manitoba R3B 2E4
Phone: 774-4491

Minister of Health
Room 301
Legislative Building
Winnipeg, Manitoba R3C OV8

HOW TO GET THE ADDRESS OF YOUR M.L.A. OR M.P.:

1. Your M.P.'s name and address--phone Citizens Inquiry at 944-3744.
2. Your M.L.A.'s name and address--phone the Elections Office at 944-3225.

LEGAL SERVICES:

1. Law Society phone-in lawyer referral service--toll free 1-800-262-8800 (24 hour service).
2. Legal Aid, Manitoba--phone 947-6501 (9 a.m. to 5 p.m., Monday to Friday).

Appendix C: The Survey Instrument

A STUDY CONCERNING MENTAL HEALTH PROFESSIONALS'

AWARENESS OF

PSYCHIATRIC PATIENTS' RIGHTS

Please note: The information obtained in this study will be used to: 1) identify potential needs for inservice training for mental health professionals employed in psychiatric facilities in Manitoba; and 2) evaluate attitudes toward introducing a standard summary of psychiatric patients' rights to psychiatric patients either at the time they are admitted or shortly thereafter.

Rest assured that there is NO way that any individual, unit, or facility, can be identified by this procedure. INFORMATION OBTAINED WILL BE ABSOLUTELY CONFIDENTIAL.

Thank you for volunteering to participate. You may choose to withdraw your cooperation at any time.

Terms:

INVOLUNTARY = COMPULSORY: A patient in a psychiatric facility who is under medical certificate, or an extension of the original certificate.

VOLUNTARY = NON-COMPULSORY: A patient in a psychiatric facility who is there of her/his own "free will," and is not certified.

MEDICAL CERTIFICATE: A legal document issued for the purpose of detaining a patient as a compulsory patient.

MENTAL HEALTH STATUTE: Refers to the Manitoba Mental Health Act.

Note: Assume that all items herein refer to the general case and not to the extreme or unusual exception.

Instructions: Circle and/or fill in the blank.

* * * * * * * * * * * *

#1. I am (a/an):

a) R.N.--A registered nurse whose basic preparation in nursing is graduation from a diploma program and who has not acquired a baccalaureate degree.

b) B.N.--A registered nurse whose basic preparation in nursing has been a baccalaureate degree in nursing.

c) R.P.N.--A registered psychiatric nurse whose basic preparation in nursing has been graduation from a diploma psychiatric nursing program and who has not acquired a baccalaureate degree.

d) R.N., B.A., or R.P.N., B.A.--An R.N. or an R.P.N. who has acquired a baccalaureate degree in an area other than nursing.

e) "OTHER"--A nurse who has completed any combination of choices a, b, and c (above), e.g., R.P.N. and B.N.

#2. Other than as a student in a school of nursing, I have not worked in psychiatry.

a) true b) false

#3. I have been employed as a nurse in (_____) for (_____) years, and (_____) months.

#4. I have been employed as a nurse for a total of (_____) years, and (_____) months. (Note: If you have worked part-time, estimate full-time equivalent.)

Note. Demographic information for non-psychiatric nurses.

Instructions: Circle and/or fill in the blank.

* * * * * * * * * *

#1. I am (a/an):

a) R.N.--A registered nurse whose basic preparation in nursing is graduation from a diploma program and who has not acquired a baccalaureate degree.

b) B.N.--A registered nurse whose basic preparation in nursing has been a baccalaureate degree in nursing.

c) R.P.N.--A registered psychiatric nurse whose basic preparation in nursing has been graduation from a diploma psychiatric nursing program and who has not acquired a baccalaureate degree.

d) R.N., B.A., or R.P.N., B.A.--An R.N. or an R.P.N. who has acquired a baccalaureate degree in an area other than nursing.

e) "OTHER"--A nurse who has completed any combination of choices a, b, and c (above), e.g., R.P.N. and B.N.

#2. I have been employed as a nurse in an inpatient psychiatric unit for (_____) years, and (_____) months.

#3. I have been employed as a nurse for a total of (_____) years, and (_____) months. (Note: if you have worked part-time, estimate full-time equivalent.)

#4. Have you read the section of the Manitoba Mental Health Act that pertains to psychiatric patients?

a) yes b) no

#5. Have you had any formal training on the provisions of the Manitoba Mental Health Act, either

a) while you were in nursing school (yes no). If yes--how long ago? (_____ years, _____ months);

b) or as "inservice training"? (yes no). If yes--how long ago? (_____ years, _____ months; other _____).

* * ** OPINIONNAIRE ** * *

#6. Would you be in favour of providing each patient with a basic three-page summary of psychiatric patients' rights, including specific information about these rights?

a) no b) on occasion c) as a regular procedure

#7. Please rank the following persons from MOST to LEAST important as patients' advocate (most important=1; least important=6).

( ) the patient

( ) the psychiatrist

( ) the nursing supervisor

( ) the general duty nurse

( ) the family

( ) the hospital ombudsman/advocate

Note. These items were administered only to psychiatric nurses.

INSTRUCTIONS: Circle the letter corresponding to your choice, or fill in the blank.

* * * * * * * * * *

#1. Does the mental health statute require that before a medical certificate can be issued, a patient must in all cases, be either a danger to himself or to others?

a) not sure b) no c) yes

#2. A medical certificate which has been issued but NOT served is valid _____ (for how long?)

a) until served b) for 14 days c) for 21 days

#3. According to the mental health statute, can a compulsory patient refuse treatment?

a) yes b) sometimes c) no

#4. A patient is under medical certificate. She asks you whether or not the mental health statute protects her from involuntary psychosurgery. Does it?

a) don't know b) yes c) no

#5. A newly certified patient on your ward wishes to appeal the "certificate." According to the mental health statute, who can be contacted to this end? (Please identify two agents other than an attorney.)

1. _____

2. _____

#6. Does the voluntary patient have the right to uncensored written communication to and from family members?

a) yes b) don't know c) no

#7. A compulsory patient on your unit demands that you allow him to phone his attorney. Does the mental health statute require you to allow him to make the call?

a) don't know b) no c) yes

#8. Are you required under the mental health statute to provide the patient with the materials necessary for written communication?

a) no b) sometimes c) yes

#9. Once a voluntary patient has submitted a written request for discharge, the person must wait _____ (hours) before she/he is free to leave the psychiatric facility (assuming no medical certificate is issued)?

a) can leave immediately b) 24 hours c) 48 hours

* * * * *

#10. How many hours must a newly admitted non-compulsory patient wait before submitting written request for discharge?

a) 24 hours b) 48 hours c) 72 hours

#11. Following admission to a psychiatric facility as a voluntary patient, according to the mental health statute, a medical examination is required_____(how soon after admission?).

a) immediately b) within 24 hours c) within 48 hours

#12. Neither voluntary or involuntary psychiatric patients have the right to periodic review of their mental status.

a) true b) don't know c) false

#13. Once the initial medical certificate is issued and served, the maximum number of days a person can be detained under that certificate is _____?

a) 14 days b) 21 days c) indefinitely

#14. A compulsory patient's period of detention, established under the original medical certificate, can be extended without applying to a judge:

a) definitely is a law b) don't know c) definitely not a law

#15. A person has been a non-compulsory patient on your ward for 24 hours. He suddenly informs you that he is leaving the hospital "against medical advice." Can you forcibly detain him?

a) yes b) no c) don't know

#16. Psychiatric patients, whether voluntary or compulsory, do not have the right to vote in provincial elections:

a) definitely is a law b) don't know c) definitely not a law

#17. The psychiatric facility is obligated to assure that each psychiatric patient is advised of his/her rights:

a) definitely is a law b) don't know c) definitely not a law

#18. An individual may be committed upon certification of one physician of any specialty:

a) definitely is a law b) don't know c) definitely not a law

* * * * *

#19. An involuntary patient may, without permission of the court, be placed on probation for a _____ month period:

a) 3 month(s) b) 6 month(s) c) 12 month(s)

#20. Once the initial probationary period expires, can it be extended without permission of the court?

a) no b) yes c) don't know

#21. A subpoena has been issued which requires disclosure of a patient's clinical record. Can the psychiatric facility refuse to honour the subpoena?

a) no b) don't know c) yes

THANK YOU!!! If you wish to receive a summary of the results of this study, DETACH and complete the form on the next page. Send the completed form to the address indicated, along with a self-addressed, stamped envelope. It is expected that results of the experiment proper will be available in August, 1982.

Appendix D: The Debriefing Request

TO: Paul J. Lewis, Researcher
Faculty of Arts
Dept. of Psychology
University of Manitoba

RE: Debriefing.

Please send a summary of the results of your study entitled, "Winnipeg Psychiatric Nurses: Opinions and Awareness of Psychiatric Patients' Rights," to the following address:

NAME: _____

ADDRESS: _____

_____

Postal Code: ___ ___

(Note to sender: PLEASE INCLUDE SELF-ADDRESSED STAMPED ENVELOPE!)

Appendix E: The Introductory Letters

Paul J. Lewis, Researcher
Faculty of Arts
Dept. of Psychology
University of Manitoba
Winnipeg, Manitoba R3T 2N2

June 1982

General Duty Psychiatric Nurses
Winnipeg, Manitoba

Dear Ms./Sir:

During the past year I have worked to design a study which has two objectives: 1. To promote awareness, among mental health professionals, of the legal rights of psychiatric patients; and 2. to gather information concerning the potential need for "in-service training" for psychiatric professionals and/or distribution of current information about psychiatric patients' rights. Pursuant to these goals I am submitting to you the enclosed materials for your consideration. Should you decide to respond (completion time averages about 18 minutes) your participation will be greatly appreciated!

I would add that there are no hidden incitements, i.e.; this project is not designed to promote a legalistic environment in Winnipeg's psychiatric facilities.

Please do not discuss responses with your peers, and do not research items prior to responding. If you would like a summary of psychiatric patients' rights (as provided in Manitoba) submit the enclosed request for debriefing. Return completed materials via the stamped envelope provided.

Thank you,

Paul J. Lewis

July, 1982

Paul J. Lewis
Faculty of Arts
Dept. of Psychology
University of Manitoba
Winnipeg, Manitoba R3T 2N2

Nurses (RNs and RNs)

Dear Mam/Sir:

As part of a study, directed at assessing various mental health professionals' familiarity with psychiatric patients' rights, the enclosed materials are being submitted for your consideration. As you probably know, in a study of this type, it is necessary to acquire data from a select group of subjects whose familiarity with the subject matter is incidental, i.e., a "control" group. This procedure allows a comparison between the "experimental" group (in this case, nurses employed on inpatient psychiatric wards) and the "control" group (nurses employed in areas other than psychiatry), and therefore provides a means by which some experimental variable (awareness of psychiatric patients' rights) can be evaluated. By examining the magnitude of the difference between the two groups ("experimental" and "control") the researcher can more accurately define the effect of the variable being investigated. In the present study one of the questions being asked is, "Do "Psychiatric nurses" know more about psychiatric patients' rights than do "non-Psychiatric nurses"?

The unit on which you are employed has been selected, via a random sampling procedure, as a "control" unit for the study entitled, "Winnipeg's Psychiatric Nurses' Opinions and Awareness of Psychiatric Patients' Rights." Your participation would be GREATLY APPRECIATED! Where you encounter items that you are unfamiliar with (which is to be expected) Please guess.

Your participation is strictly voluntary. There is no possible way that either you or the facility/unit at which you are employed can be identified, i.e., YOUR RESPONSES ARE ABSOLUTELY CONFIDENTIAL! Should you decide to participate Please return the materials via the stamped envelope enclosed.

Yours respectfully,

Paul J. Lewis

Appendix F: The Consent Form

To: General duty nurses.

From: Paul J. Lewis, Psychology
University of Manitoba

PLEASE NOTE.

The information obtained in this study will be used to (1) identify potential needs for "inservice education" for mental health professionals employed in psychiatric facilities in Manitoba; and (2) to evaluate attitudes towards introducing a standard summary of psychiatric patients' rights to psychiatric patients either at the time that they are admitted to hospital or shortly thereafter.

Raw data will be treated as privileged communication. (There is no way to identify either participants or their place of employment, and no comparison will be made between facilities.)

Signed consent forms will be placed in a sealed envelope and filed in a secure location, and will eventually be destroyed.

Participation is strictly voluntary.

To whom it concerns:

Having read the above, I understand that my participation in the study entitled, "Winnipeg's Psychiatric Nurses: Opinions and Awareness of Psychiatric Patients' Rights," is voluntary, and that the results may be published.

Signed:_____ date_____ 1982