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From the Editor

"When you are a Bear of Very Little Brain, and you Think of Things, you find sometimes that a Thing which seemed very Thingish inside you is quite different when it gets out into the open and has other people looking at it."

Ah, the wisdom of Winnie the Pooh (or A. A. Milne). It applies to our psychotherapy practices. When thoughts are exposed there is a therapeutic effect. When a patient says something aloud, it becomes more real and they can start the process of evaluation or grief. Sometimes when things are out in the open it becomes apparent how foolish they are. Darkness is revealed by the light, shadows exposed.

Winnie's wisdom also applies to the written word, including this journal. (To be clear, I am not suggesting our authors are of Very Little Brain.) As a reminder, the purpose of the *GP Psychotherapist* is to "provide readers with educational articles to enhance their knowledge and skill in the practice of psychotherapy, primary care psychiatry and the neurosciences." This allows other people to look at Things inside someone else's brain. When we write about our experience and expertise, knowledge is consolidated, new ideas emerge, and new conversations are begun. When we read what others have written, not only are we educated and challenged, but community is built.

Once again, this is apparent in this issue of the *GP Psychotherapist*. Howard Schneider, in his regular Psychopharmacology Corner, discusses treatment options for delusional disorder. This mental illness is perhaps an extreme example of how "things" inside can appear different on the outside. In the section on clinical approaches, John Yaphe shares his experiences in using e-counselling to help those with chronic illnesses. Using written communication in therapy has different challenges. The "things" that come out are more tangible. Psychiatrist Barry Dolin discusses "Psychotherapy and Reflective Writing" and how it can be used with medical students. We are encouraged to reflect on how a story affects us personally and how it might affect us in the future. One of his quotes sounds remarkably like Winnie the Pooh: "Writing becomes a way that

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From the Editor (cont'd)

one reflects on one's experience. It is as if that which is experienced has somehow 'gotten outside' of the person so that it can be apprehended and then comprehended."

Another purpose of the *GP Psychotherapist* is to "facilitate communication from Board members, Committees, and other representatives to members of the Association." Accordingly, in a two-part article on their regular series, Standards in Psychotherapy, Michael Paré and colleagues discuss the difficult legal issues around committing patients, review common misconceptions, and provide practical tips on completing the Form 1 (Application for Psychiatric Assessment). Catherine Low reports on GPPA board activities, including the recent retreat for which there are some accompanying photographs. Finally, as winter weather surrounds us, Josée Labrosse's poem, "See-side," and her delightful photographs provide a pleasant diversion and an opportunity for reflection.

In editing the *GP Psychotherapist*, I have observed that sometimes the "thingish things" that emerge when we write defy categorization. Our journal sections typically include science, art, clinical approaches and GPPA interests. However, there is always much overlap. Although a poem is clearly an "art," pharmacotherapy can also have an artistic component. In addition, legal matters apply to both the art and science of psychotherapy, and clinical approaches can be addressed using the scientific method (as John Yaphe does). In a society where science is often idolized, we would not want to imply that pharmacotherapy is superior to psychotherapy. In sum, our current journal categories are somewhat artificial—stay tuned and consult the on-line "Author's Guidelines" for possible future changes. A category we are introducing for the next issue helps fulfill another purpose of the *GP Psychotherapist*: to "provide readers with information about resources." We are looking for short non-scholarly articles in which GPPA members share their clinical tips, recommended resources or favourite books.

So here it is—the first issue of the *GP Psychotherapist,* Volume 23. Out in the open for everyone to see. Once again, a reflection of the diversity of GPPA interests. And hopefully a stimulus for self-reflection.

Grace and peace,

Janet Warren

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SCIENTIFIC PSYCHOTHERAPY

Psychopharmacology

Delusional Disorder

Howard Schneider, MD, CGPP, CCFP

ABSTRACT

Delusional Disorder generally consists of non-bizarre delusions without simultaneous hallucinations, disorganized speech, or negative symptoms. Functioning is generally not markedly impaired, and behaviour is not grossly odd or bizarre. Delusional Disorder, unlike schizophrenia, is often not diagnosed until patients are in their forties. Delusional Disorder may be resistant to psychopharmacology, but psychotherapy may help patients to function better.

As medical psychotherapists, whether we prescribe or not, we are expected to be familiar with current psychopharmacotherapy. Psychopharmacologist Stephen M. Stahl, of the University of California San Diego, trained in Internal Medicine, Neurology, and Psychiatry, as well as obtaining a PhD in Pharmacology. In 2011, Stahl released a case book of patients he has treated. In this column, I will examine one of his cases and highlight the important lessons.

Stahl's rationale for his series of cases is that knowing the science of psychopharmacology is not sufficient to deliver the best care. Many, if not most, patients would not meet the stringent (and, arguably, artificial) criteria of randomized controlled trials and the guidelines that arise from these trials. Thus, as clinicians, we need to become skilled in the *art* of psychopharmacology. To quote Stahl (2011, p. xvii), this requires us "to listen, educate, destigmatize, mix psychotherapy with medications and use intuition to select and combine medications."

In this issue, we will consider Stahl's sixteenth case, "the computer analyst who thought the government would choke him to death." The patient is a 38-year-old married man, without children, who is an unemployed (for several months) computer analyst.

Past Psychiatric History:

- As a teenager (exact years not specified) the patient would have sexual thoughts when he "looked people in the eye." These thoughts were not specified beyond being "disturbing." As a result he tried to avoid eye contact with people (age, sex not specified).
- treated with an unspecified SSRI with limited improvement.
- also started showing unstable moods and was diagnosed at times with bipolar disorder and schizoaffective disorder.
- main treatment the patient received between ages 19 and 27 was psychotherapy (type not specified), which he believed was very effective.
- No history of drug or alcohol abuse.

Intake Psychotropic Medications:

- Topiramate 300 mg/d
- Bupropion SR 300 mg/d
- Buspirone 60 mg/d
- Paroxetine 60 mg/d
- Aripiprazole 40 mg/d
- Risperidone 8 mg/d

Past Medical History and other Intake Medications:

- Smoker

Physical and Lab Intake:

- Obese (exact BMI not specified)

Personal History:

The patient graduated university and started working for the government as a computer analyst very successfully for 15 years, until recently quitting his work.

Family Psychiatric History:

- Sister: schizophrenia
- Paternal aunt: schizophrenia

Chief Complaint: "*The government is out to get me and there is a grand conspiracy against me*."

History of Present Illness and Mental Status Examination:

The patient quit his government job a few months ago due to fear that his employer would physically choke him to death. He strongly believes that the government is after him, wanting to harm him. However, he understands that no one else, including his wife, believes this. At present the patient is fearful of police cars, believing when he sees one that it is after him.

Stahl notes that the patient's mood is not depressed although somewhat flat. No other delusions are noted. No hallucinations are noted.

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Delusional Disorder (cont'd)

In the DSM-V (APA, 2013) diagnostic criteria for schizophrenia, hallucinations are not required. Rather there must be at least one of the following: delusions and/or hallucinations and/or disorganized speech with at least two criteria in total also including grossly disorganized behaviour and/or negative symptoms (i.e., diminished emotional expression). In the ICD-10 category of F20.6 there is the diagnosis of "Simple Schizophrenia," which is characterized by lack of hallucinations and includes a loss of drive and interests, gradual appearance and worsening of negative symptoms, and marked decline in social, scholastic, or occupational performance. Stahl notes that there is not much functional decline in the patient, and so this makes simple schizophrenia, at this point, unlikely.

However, Stahl thinks that perhaps this might be an early Obsessive Compulsive Disorder (OCD) which is becoming paranoia, but of more a delusional nature than a paranoid schizophrenia nature. Stahl notes that the patient seems to be taking perhaps more medications than justified, and that they are not proving effective in controlling the patient's delusion about the government being after him. Stahl recommends replacing the bupropion SR and the paroxetine with fluvoxamine, cross-tapering the switch.

Fluvoxamine is a selective serotonin reuptake inhibitor (SSRI) that also has sigma-1 agonist properties. The sigma-1 receptor modulates calcium signaling. Fluvoxamine can help in OCD as well as delusional/psychotic depression.

Thus medications at this point, prescribed and followed up by the patient's local psychiatrist are:

- Topiramate 300 mg/d
- Buspirone 60 mg/d
- Aripiprazole 40 mg/d
- Risperidone 8 mg/d
- Fluvoxamine 200 mg/d

Stahl saw the patient 12 weeks later. The response to treatment is not well documented but Stahl notes that the response to SSRIs can sometimes be slow and so he wants to continue the fluvoxamine for a few more months. With regard to the other medications, Stahl considers that aripiprazole has a higher affinity for the D2 dopamine receptor than risperidone does, and aripiprazole is a partial agonist, so perhaps it is interfering with the effect of the risperidone. Thus the aripiprazole should be stopped. (Aripiprazole itself plus its active metabolite have long half-lives and so, while it can be tapered, it actually can be stopped at once since in effect it tapers itself.)

Thus medications at this point, prescribed and followed up by the patient's local psychiatrist are:

- Topiramate 300 mg/d
- Buspirone 60mg/d
- Risperidone 8mg/d
- Fluvoxamine 200mg/d

Stahl saw the patient 12 weeks later at the 24 week mark (i.e., 24 weeks since seeing the patient for the first time). The patient is moderately improved, but there is no dramatic improvement as had been hoped for. Stahl recommends that the same medications be continued and the patient observed, or possibly a higher dose of risperidone can be continued. Stahl ends the case here.

Stahl notes that the patient is a first-degree relative of two other family members with schizophrenia. Delusional disorder, DSM-V category 297.1 (APA, 2013), consists of delusion(s) that have lasted for more than a month, the criteria for schizophrenia have not been met, nor can it better be explained by other disorders such as obsessive-compulsive disorder. Delusional disorder has been thought to have a significant familial relationship with schizophrenia, although work by Kendler and colleagues (1985) does not support this. Stahl notes that while schizophrenia typically has an early onset, delusional disorder is often not diagnosed until the forties. Stahl considers that perhaps the patient's condition is indeed best categorized as delusional disorder. Stahl notes that delusional disorder can be resistant to treatment by both psychotherapy and by psychopharmacology. However, Stahl writes that psychotherapy has helped this patient greatly in the past, and rather than using it to "challenge the delusion," using psychotherapy might be used best to help the patient learn how to live with the delusion—for example, not talking about the delusion in the workplace or in particular social settings.

While the prevalence of schizophrenia is over 1%, and the prevalence of OCD is over 2% (Goodman, 2014), the prevalence of delusional disorder is much lower, at approximately 0.03%; hence, Stahl's initial consideration in this patient's case of an OCD evolving into paranoia, and a consideration of non-hallucinatory forms of schizophrenia.

Recently, Vicens and colleagues (2015) performed neuroimaging (structural as well as functional) on 22 patients with a diagnosis of delusional disorder compared to 44 matched healthy controls. The delusional disorder patients showed grey matter reductions in the medial anterior cingulate cortex and bilateral insula on structural neuroimaging. Functional neuroimaging in the patients with delusional disorder showed abnormalities in the medial anterior cin-

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Delusional Disorder (cont'd)

gulate cortex and in the bilateral insula. Thus these regions may play an important role in the pathogenesis of delusional disorder.

Recently, Skelton and colleagues (2015) conducted a Cochrane review in order to evaluate the effectiveness of medications (antipsychotics, antidepressants, and mood stabilizers) and psychotherapy versus placebo in the treatment of delusional disorder. However, they were only able to find one eligible trial in which to evaluate the effectiveness of treatments. This was a small study of 17 patients comparing cognitive behavioural therapy (CBT) to supportive psychotherapy. Most patients were already taking medication, which was continued during the trial. There was no data on global outcomes in this study. However, a positive effect for the patients receiving CBT was found on the Social Self-Esteem Inventory. Skelton and colleagues concluded that there is insufficient data in the literature by which to make evidence-based recommendations for treatments of any type for delusional disorder.

Generic Name	**Trade Name**
	(common, Canadian names where possible)
topiramate	Topamax
bupropion SR	Wellbutrin SR
buspirone	generic *in Canada (Buspar in USA)*
paroxetine	Paxil
aripiprazole	Abilify
risperidone	Risperdal
fluvoxamine	Luvox

Conflict of Interest: None

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Howard Schneider started his career performing psychiatric consultations and short -term follow-up care in the emergency department in Laval, Québec. For the last 16 years he has taken care of psychiatry and psychotherapy patients in the community in the Toronto area.

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CLINICAL APPROACHES

Electronic Counselling for Patients Facing Chronic Disease: A Text Analysis of E-Counselling Letters

John Yaphe, MD, CM, MClSc

ABSTRACT

Electronic counselling is increasing in importance as a means of supporting patients especially in the care of chronic diseases. The case files of one electronic counsellor were searched for elements of care of chronic disease. Text analysis revealed patient needs for emotional support, information, specific instructions, resource management and ongoing care. Physician skills required include active listening, validation, support, advice giving, resource management and long-term availability. These findings may have implications for the training of physicians involved in chronic care management and for the planning of services.

Introduction

In an aging population, chronic disease management has become increasingly important for family doctors and their patients. In order to meet growing needs, family doctors require special knowledge, skills and attitudes. Counselling skills play an important role in chronic care. Although office-based consultation remains the most common tool, electronic counselling is increasing in importance as an accessible medium. E-counselling has been described in this journal (Yaphe, 2014). The role of this phenomenon in chronic disease management deserves study.

The literature on communication with patients facing chronic disease has identified several behaviours that can promote good outcomes. These include enhancing the patient's knowledge of the condition and its treatment, negotiation on agreed self-management plans, shared decision making, patient management of symptoms, exploration of the impact of the condition on physical, emotional, and social functioning, and helping the patient to adopt health promoting behaviours (Battersby, 2015).

However, direct observations of chronic care consultations show that many doctors give explanations of the rationale for change without goal setting or follow up visits as effective methods to promote change (Russell, 1993). Doctors may support sharing decision making with patients in theory, but this is not always clear (Pollard, 2015). It is useful where there are many different treatment options; where there is no published evidence to support the options; or where patient preferences and patient oriented outcomes matter.

Internet coaching on good communication skills is helpful in empowering patients to get the most out of chronic care visits (Allen 2008). Electronic counselling presents new possibilities for chronic patients. The objective of this article is to describe clinical experience using e-counselling for patients with chronic disease. By examining the text of letters to the counsellor, it attempts to determine patients' needs for care and the training needs of physicians.

Materials and Methods

The e-counselling case records (n=1842) of the author were searched electronically using the search terms: chronic disease, hypertension, diabetes, cancer, bronchitis, asthma, arthritis, and colitis. These terms were chosen as the chronic conditions most frequently seen in general practice. The files appearing in the search were reviewed to look for quotes relating to patient needs for care and their reasons for requesting counselling. These quotes were grouped in themes and given descriptive titles under the heading Patients' Needs. The letters were then searched for the physician's response to these needs. These responses were grouped into themes under the heading Physician's Skills Required. For the purposes of this article, some clinical details have been modified to preserve patient anonymity.

Results

The analysis of the letters selected by the search procedure produced a list of 11 patient needs and 11 physician responses required to address them. This is summarized in Table 1. Selected quotations for the letters are presented to illustrate these points.

Patients first presented their need to *express their emotions*. They also hoped to find constructive ways to deal with their feelings. A 60 year-old patient with pulmonary fibrosis expressed it this way:

> *I am feeling anxious and scared and need help dealing with my emotions and my family. I am hoping to learn how not to dwell on the fact that I may die sooner than expected* (Case 1).

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Electronic Counselling (cont'd)

In response the counsellor may provide *validation* and help the patient by reassuring them that their feelings are legitimate. They can experience them and express them fully. The counsellor may ask: "How would you like to feel?" and explore ways to move towards the desired emotional state.

Patients are often aware of the behavioural changes that need to occur to improve their health but often complain of a lack of *will to make the changes*. A 40 year-old man with morbid obesity and diabetes wrote:

> *I have problems with depression and anxiety. I eat fast food 5-6 times a week and sometimes on weekends I eat out for all 3 meals. I feel I could have a heart attack or stroke if I don't correct this problem but I have no energy to even try to start* (Case 2).

The counsellor can help the patient with techniques of *motivational interviewing* by asking: "What will your life be like when you make the required changes? What will you do then? How will you feel?" This may help the patient establish their personal motivating goals of treatment.

Patients also expressed their *information* needs. We can help empower them to ask the questions they want to get the information they need. The same diabetic patient explained it this way:

> *I was diagnosed with diabetes ten years ago but didn't have a family doctor. I was seeing a specialist who would give me check-ups and prescriptions but never gave me much information on it. I was more or less left to figure it out on my own* (Case 2).

Patients can also see their struggle as a journey and we have a role to play walking beside them as a guide. This patient also presents his *explanatory model* of the mental block he sees standing in his way. The block begins to crumble when he sees that there are ways to get past it.

> *I am going to see my GP today to ask about lap band surgery. I feel as though a page has been turned in my book but I feel that it is a very long book. One of the things I've had trouble dealing with is the feeling of being overwhelmed and taking it step by step. I do feel at least I have started the journey, slow as it may be* (Case 2).

Patients are aware of the association between stressful life events and the control of chronic disease giving importance to *knowing the life story*. A woman coping with diabetes described the important events of her life this way.

> *I am the youngest of 4 girls and my mother and my sisters have diabetes. They also have high cholesterol and high blood pressure. A few years ago, I lost 3 immediate family members in less than 6 months. It started a chain reaction, with the end of a long-term relationship, depression, and trying to get my life back on track* (Case 3).

The families of patients also require information and support to help them cope with a family member living with chronic disease. The daughter of a patient with both diabetes and bipolar disorder requested *family support* when both conditions appeared to be going out of control.

> *My father has been admitted to the hospital to stabilize his mood. They changed his medication for his bipolar disorder. The medication was affecting his blood sugar* (Case 4).

Parents of children with chronic illness also require *social support*. In addition to expressing concern for their child's wellbeing, there may also be financial and social consequences to caring for a child with chronic disease. One mother expressed it this way:

> *A few months ago my daughter was diagnosed with diabetes. Without insulin she will die. This has caused feelings of anxiety, stress, and now depression. I am overwhelmed with the grief they are causing on top of the constant worry about my fragile daughter. I have gone into debt by not being able to work in the past few months* (Case 5).

By using *knowledge of community resources*, the family doctor may provide help to the patient and/or family in negotiating the complex requirements of insurance systems. However when the desire for secondary gain seems out of proportion to the clinical reality, the doctor can also play a role in providing *education* regarding what the family can realistically expect from care.

Emotional support and reorientation are also required when anxiety about chronic disease is a disabling symptom. The following patient presented health concerns that appeared to interfere with her enjoyment of life and normal function.

> *I feel nervous all the time about my health. I have aches and pains that I want to get rid of. I want to be tested for thyroid disease, lactose intolerance, gluten allergy, diabetes, and high blood pressure. I want to know that I'm healthy but my biggest fear is that they will find something. It would be a relief to finally know my diagnosis but I'm scared to know. What if something is wrong? How will I cope? How will my family manage* (Case 6)?

Attention to the patient's *life story* and current social context can be keys in unlocking this mystery.

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Electronic Counselling (cont'd)

Chronic illness in more than one generation at the same time can complicate matters. A patient coping with diabetes and facing alcoholism in her father wrote:

> *I have Type 1 diabetes and my father is an alcoholic who refuses to seek help or change. He was recently arrested and hospitalized, adding to my stress. My mother is still with him despite emotional and financial abuse. I feel like I have to be the strong one and the one that everyone in the family depends on for support. I don't feel strong anymore. I'm not sure what to do* (Case 7).

The family doctor can also help to *coordinate care* for other family members with indirect beneficial effects on the control of chronic disease in the identified patient.

Often patients with chronic illness are hard on themselves because that is the message being transmitted by doctors and others. Patients may need to show self-compassion in order to promote *self–efficacy*. This patient expresses how she wants to be cared for.

> *I had an appointment with my endocrinologist today but I was terrified to go. I'm harder on myself than I need to be I suppose. My A1C wasn't nearly as bad as I thought. My endo told me that I was doing great and to not be so hard on myself but it's so terrifying thinking of the potential complications of poor control. Sometimes I wish someone could control it for me* (Case 7).

Care is also often depicted as a fight or a struggle (as in "the war on cancer"). Here is how one 42 year-old patient sees it.

> *I have recently started to fight with three diseases: diabetes, high blood pressure and a recent heart attack. Do you have any advice on how to counter the thought of fighting three diseases at age of 42! I believe since this is the first time in my life that I had to come across fighting chronic diseases, it has come as a shock to me. I think that it may take some time before I accept this fact and live the new "modified" life* (Case 8).

The physician may need to find a way to reframe and rephrase this for the patient so that it is less a fight and a shock.

Adjustment to chronic disease also requires adjustments by others in the patient's environment. This 28 year-old woman with inflammatory bowel disease was admitted to hospital for management of a bowel obstruction. When she failed to reach her performance targets at work, she experienced emotional distress.

> *I have Crohn's disease. My manager is aware of my disease and that I've had complications. As a member of a large team, there are productivity expectations, which I should be meeting. But I am not always able to perform to the same degree as my team members. My manager hasn't adjusted her expectations of me in light of my health* (Case 9).

Further exploration revealed a recurring pattern of emotions arising from failing to meet her father's expectations of her. The manager triggered a similar response with his reaction to her illness. Sorting out her feelings and working on transference issues helped her to move forward dealing with her illness and her work. Arranging accommodations in the workplace may also be helpful.

Counselling by the family doctor can be a springboard to other forms of counselling. Patients may show readiness for counselling or therapy at different times in the course of their illness. A supportive word regarding a *referral for therapy* can have positive effects as shown in this example.

> *I have MS. I have had depression for quite a while. I am overwhelmed by many events in my life. My physio said I should see a counsellor. The appointment was very hard on me. It is time to see what I can overcome in my life and what I can't* (Case 10).

Counselling by the family doctor can help prepare the patient for other forms of counselling or therapy. This can reinforce notions of *self-efficacy for self-care.* As this patient says

> *the answers are in me. Anyways, I get it that things have to come from me, that the answers are in me. I guess I was just looking for ideas from you* (Case 10).

Discussion

The cases have illustrated the varying needs of patients with different chronic diseases. What they have in common is the need for good communication about the disease with the doctor, emotional support, support for self-care, continuing care, coordination with community resources and specialist care, and careful attention to the life story and context of the patient. While not all physicians will use the written medium to communicate with patients, this medium has proven to be effective. It can teach us effective strategies to help patients with chronic disease to manage their conditions.

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Electronic Counselling (cont'd)

Patients' Needs	Physicians' Skills Required
Express emotions (fear, sadness, hope)	Listening, validation
Will to make behavioural changes	Motivational interviewing
Information	Education
Finding meaning	Exploring explanatory model
A witness	Discovering the life story
Timely referrals	Coordinating care
Family support	Involve the family
Community support	Knowledge of community resources
On-going support	Continuity of care
A plan	Providing written plans
Self-efficacy	Empowering others

Table 1: Patients' needs and the skills required by the family doctors in counselling patients with chronic disease

Conflict of Interest: The author has done e-counselling for an EFAP company since 2004 but has no financial interest in the publication of this article.

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John Yaphe is a family physician with a special interest in counselling. He is currently associate professor in community health in the School of Health Sciences of the University of Minho in Portugal. He has been an active on-line counsellor since 2004. He has contributed to the development of the theory and practice of online counselling and the training and supervision of new E-counsellors.

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Psychotherapy and Reflective Writing

Barry Dollin, MDCM, FRCP (C)

Advocates of different educational approaches and of various psychotherapeutic methods believe that reflection plays an important part in life-long learning. Reflecting on our actions allows us to move beyond mindless reflex and habit to actions based on conscious intention and choice. It is generally agreed that medical training requires doctors to develop skills of creative reflection. To that end, some clinical teachers have been looking at how reflective writing can be used in the education of medical students.

Medicine is an Art as much as it is a Science. While it is important to present students with information from scientific research, it is also important to promote the development of skills that inform scientific research and that allow practitioners to evolve through their own experience. Observation, analysis and creative hypothesis generation are all promoted by reflecting on experience. Contemporary medical educators are exploring ways to "precept humanism" with reflective process. Psychotherapists have been working with the process of reflection since the early development of Freud's psychoanalytic method. This essay explores how current debate over fostering and evaluating reflective capacity in medical students provides an interesting perspective on the processes of both education and psychotherapy. It also shows how psychotherapeutic process can contribute to the understanding and the development of reflective capacity.

Initial work with medical students at Brown University in the United States (Reis et al, 2010) formalized a process that used reflective writing (RW) assignments to encourage a deeper understanding of clinical experience. Students were asked to make "field notes" on their patients. The notes were structured and assessed with a specific method. Assignment prompts were used to focus the student on specific elements of the clinical encounter. The mentors then analyzed the field notes. They were also advised to follow an outline that structured their close reading of the student's notes, and their associated analysis. The process, entitled the Brown Educational Guide to Analysis of Narrative (BEGAN) framework was designed to promote more authentic and effective clinical encounters. The aim was to facilitate and promote desirable professional development.

Further work by members of that group (Wald et al, 2012) outlined a method that used a tool, called the Reflection Evaluation for Learners Enhanced Competencies Tool (REFLECT), to grade the essays of medical students as they learned in clinical practice. That tool took the form of a quantitative rubric. The authors claimed that the measurements could be used both as a summative method to evaluate the quality of reflection and as a formative method to teach pedagogical aims. Their hypothesis was that when we can delineate preferred goals of RW then we can promote the movement of students in that direction. This is how they described their intention:

> Fostering reflective capacity within medical education helps develop critical thinking skills, inform clinical reasoning and enhance professionalism among trainees. Reflection—the expertise enhancing, metacognitive, tacit process whereby personal experience informs practice—is integral to core professional practice competencies.

The teachers using this method focused on what they saw as a reflective moment and reinforced that behaviour in their students.

> Mentors who skillfully support and challenge learners through noticing the reflective moment, making sense of the experience (including emotional responses), tolerating uncertainty (or messiness of clinical practice at the heart of professional expertise) and using new insights, are an essential component to developing reflective capacity.

The REFLECT rubric assessed different writing criteria to delineate four hierarchical levels of reflection. The lowest form of reflection was habitual action (non-reflective). Next were thoughtful action or introspection, reflection, and finally, critical reflection. The last category had two forms: one leads to transformative reflection and learning and the second to confirmatory learning. This research satisfied the demands for quantitative research and also presented a definable curriculum that could guide teaching.

Another group of inquirers studying the importance of reflective process in education takes a completely different perspective. These authors, led by Rita Charon, suggest that the instrumentalization of RW is contrary to the very nature of the reflective process. They describe a reciprocal model of "writing as discovery," suggesting that the writing itself is what teaches the skills of reflection. In a paper titled *Commentary: A Sense of Story, or Why Teach Reflective Writing*, Charon (2012) describes how developing a sense of story is by itself the process by which we learn to understand our lives and come to terms with

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Reflective Writing (cont'd)

our existence. Her understanding of the nature of reflective process and her approach to teaching reflection is quite different.

> Writing is used to attain the state of reflection. Writing is not about the reporting, it is about discovering. It unlocks reservoirs of thought or knowledge otherwise inaccessible to the writer. Representing one's experience in language is perhaps the most forceful means by which one can render it visible and, hence, comprehensible. Writing becomes a way that one reflects on one's experience. It is as if that which is experienced has somehow "gotten outside" of the person so that it can be apprehended and then comprehended.

Her associates express concern that the attempts mentioned above impose quantified markers of student achievement. They suggest that the only way to respond to a reflective piece (to RW) is with more reflective writing. She concludes her study with these lines:

> [The medical student] may represent that clinical encounter in language, not in order to fulfill an assignment but, rather, to undergo and, hence, to understand what has happened in his or her brush with this patient... Our deepening sense of story will open us to the vastness, the lostness, the uncertainty, and the meanings that unite all who are ill and all of us who do our best to care for them.

Group psychotherapy is a unique form of medical intervention in which the patient both receives and administers treatment. It allows the boundary between doctor and patient to become permeable and brings to light the fact that we all have within us an experience of dis-ease, recovery and healing. In a group other people can help us to reflect on our experience. This allows us to approach the reflective process and RW in a different way. The Narrative Therapy developed by Michael White (1995), an Australian social work pioneer, describes a group ritual that he called the "Reflecting Team." That process illustrates how reflection can be experienced in a clinical group. At different points in the course of a therapy group, some members can be assigned to a reflecting team subgroup. They are asked to be "outsider witnesses." From that structured role they are invited to comment on events that have recently transpired in the group. Their reflection may or may not be in the form of writing. In my group therapy experience, the reflections can take on many forms. Depending on the circumstance, some forms of reflection have been found to be more desirable than others. Reflecting teams enlarge the number of perspectives on issues that emerge in a group. White (1995) has applied postmodern philosophical insights to create guidelines for the way that outsider-witnesses reflect on their experiences in group. He proposes that there are particularly beneficial ways to reflect on experiences in a group. Those guidelines for reflection in a group seem to integrate the two opposing methodologies mentioned above.

I have modified White's classical Reflecting Team method and use four questions that can be addressed to enrich the reflection process. When we consider reflecting upon a specific story, experience, or quandary, the following lines of inquiry can be followed:

1) First, we ask the general and non-specific question: What was stirred in you by the story?
2) Second, we ask about a connection to the personal and subjective life of the reflector: How does the story relate to your personal life?
3) Then we address the naming of the issues elicited by the first two questions. We ask, what are the terms used to describe the experiences that you have been discussing, and how has cultural wisdom dealt with that issue?
4) Finally, we look at the transformational potential of the experience: Where and how would you hope that the story might move you in your future life?

Like the BEGAN framework and the REFLECT rubric, this method with its four lines of focused reflection has the ability to support pedagogical advancement towards what Wald calls "critical reflection." The Outsider-Witness method does not involve the rating of reflective process but it does structure and "externalize" the process. At the same time, by virtue of its experiential nature, it holds the mystery of an unfolding creative process as advocated by Charon. Practically, there is some benefit in asking the questions in the order outlined above because the information revealed in earlier reflections allows for a meaningful building of knowledge and a promise of deeper authenticity, communication, and ethical action.

The educational intention of promoting the development of wisdom in student physicians or in clinical patients is challenging. In my opinion, wisdom can only grow through slow, spontaneous, organic methods. No support or incentive can be used to grow ethical imagination. It grows from individual freedom. It is unpredictable in the way that it evolves. We need to exercise caution in situations where we have doctors growing and learning to be more able physicians. We must balance the expectations of a training program with the student's personal nature and awareness. The best motivator for the development of

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THE ART OF PSYCHOTHERAPY

SEE-SIDE

Josée Labrosse, MD, MEd

Ocean merges with muscle and bone from the good swim.
Now sitting with shade
Waves heave inside, rise and fall
Like breath itself.
Closed eyes see crests roll
And hear the gentle thunder,
The intense turquoise and indigo
that explode then stretch and yawn toward the crag of shore.
Eyes closed but In mind's eye
A starburst of hibiscus forms
Set against the perfect sky
Itself an azure ocean dotted with white moist cotton.
The breeze is a-salted, carrying a hint of false coconut.
The real is surreal.
Nothing can replicate.
Nothing can capture.
The body can absorb.
It will remember.

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Reflective Writing (cont'd)

ethical physicians is a concern for both the well-being of their patients and for the values of their culture. Individual human experience and culture are constantly changing and cannot be predetermined. They must be wrestled with, reflected upon and reconciled. With both patient and Doctor, the fundamental incentive for the development of wisdom is the living experience of creating a good life for oneself and for others.

Conflict of Interest: none

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GPPA INTERESTS

Standards for Psychotherapy: The Form 1—Application by Physician for Psychiatric Assessment, Part 1

Michael Paré, MD, MEd, MSc, Laura A. Dawson, BA, Joshua Kim, MD, MSc

Introduction

The clinical area of Primary Care Mental Health provided in a community non-emergency setting (i.e., general practice psychotherapy) does not usually necessitate emergency interventions. However, the exception is the determination whether or not to place a patient on a Form 1 (Service Ontario E-laws, 1990). This decision is often a very difficult, heart-wrenching—and indeed, mind-wrenching—clinical judgement call. The use of a Form 1: Application by Physician for Psychiatric Assessment pertains mostly to physicians in Ontario. This is primarily due to the fact that the Form 1 falls under the Ontario Mental Health Act (Service Ontario E-laws, 1990, amended 2010). Each province will have somewhat different standards, policies, guidelines, and forms regarding the precise process of civil commitment.

A judge of the Ontario Superior Court of Justice recently stated that there is no generally accepted standard of care for primary care physicians concerning the determination of when, specifically, a Form 1 should or should not be filled out, and that the final decision typically rests upon the physician's judgement call (Court File No.: 08-2778). Therefore, this article is not purporting to define a precise standard, but rather is seeking to understand and explore ideas that will help the ultimate development of that standard of care.

In attempting to understand the processes and requirements for properly utilizing and filling out a Form 1, we have found that, in our experiences, there has been a lot of misunderstanding communicated through the literature. This has resulted in a surprisingly high number of Form 1s being rejected and discarded, requiring recompletion by the attending physician in the Emergency Department in order to appropriately detain the patient for a needed psychiatric assessment.

The Form 1 must include contact information for the physician who filled out the form, and the address of the patient (to help law enforcement personnel locate the patient if necessary). In order for the Form 1 to be properly completed, the physician who fills out the Form 1 must personally examine the patient. However, this examination does not need to be a full or comprehensive examination, yet neither should it be a cursory "eyeballing" of the patient. The examination must be long enough for the physician to determine whether or not the patient appears as though he/she may cause harm or injury to him/herself, or appears to be incapable of caring for him/herself due to a mental illness. The aforementioned risk of harm does not need to be "imminent" (which will be discussed in further detail in the section entitled "Canada, Mental Health, and the Law"), and the patient does not actually have to be "threatening" anyone to be placed on a Form 1. (See Cavanagh [n.d.] for more information.)

In addition, the examining physician does not have to witness the patient engaging in risky behaviour. The physician, however, must describe the behaviours or statements of the patient that lead the physician to believe that the patient is at risk of engaging in the aforementioned harmful behaviours. The physician must, therefore, carefully observe the patient, and consider his or her observations in conjunction with any facts communicated to the physician by other parties. The examining physician must also describe the psychiatric symptoms of the patient that led the physician to conclude that a Form 1 is the most appropriate course of action to take in order to address the safety of the patient and society.

Misconceptions and Corrections

It has repeatedly been taught by many authorities that there is "no precedent of a physician having successful legal action brought against them for the use of a Form 1," or for incorrectly completing a Form 1, if the physician felt that he or she had sufficient cause to do so (Court File No.: 08-2778). Yet this is simply not the case. There is a possibility that the physician's behaviour will be seen as unprofessional and/or unlawful according to the law or according to professional regulation. Inappropriately placing a patient on a Form 1 can be seen as constituting unlawful detainment of the patient, and is therefore illegal. One example that we have encountered is a case in which a physician's decision to place a patient on a

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Standards for Psychotherapy, Part 1 (cont'd)

Form 1 was successfully challenged in court by the patient. The physician's decision to "form" the patient was deemed inappropriate due to a number of issues (Court File No.: 08-2778). The details of this decision are beyond the scope of this paper; however, the overall message of the decision is quite clear: correctly completing a Form 1 is an essential skill of our clinical work as physicians practising psychotherapy. Unfortunately, errors in completing a Form 1 can potentially result in a ruling of professional incompetence, and/or can result in a successful lawsuit against the physician, in favour of the patient. Therefore, it is important for a physician to understand the correct process of correctly completing a Form 1 for the best interest of the patient and for the safety of society, and to reflect positively upon the physician's professionalism.

Another misconception is that the implementation of a Form 1 always makes it necessary for police to escort the patient to the hospital for further assessment. While this is a commonly recognized and reasonably utilized option, it is also permissible for a friend, a relative, or another individual to escort the patient to the hospital to receive further psychiatric assessment. Some physicians incorrectly believe that a patient is being *arrested* or *committed* by a Form 1. However, this is not the case. A patient is rather being apprehended and detained for the purposes of clinical examination and a determination of the patient's psychiatric mental status and state. The patient can then be involuntarily committed to a hospital if necessary (for the safety of the patient and of society).

Primary care physicians, even when focusing their practices on psychotherapy, are not often called upon to place a patient on a Form 1, and certainly do not relish doing so. Many physicians, when asked, cannot even recall the full correct name of the Form 1, which is an "Application by Physician for Psychiatric Assessment." This decision is not to be taken lightly, and certainly does not always need to be decided at a moment's notice (although, at times, a physician may need to do so). Seven days are permitted between the time a physician has assessed a patient and when the physician finally decides whether or not to place the patient on a Form 1. Similarly, the police are given seven days to detain and transport the patient to a Schedule 1 facility.

The conditions under which a patient may be placed on a Form 1 are far from precise and at times need to be "based upon a judgement call when there is no obvious solution" (Ontario College of Family Physicians, 2012). The placement of a patient on a Form 1 could also severely disrupt the essential therapeutic relationship between the primary care doctor and the patient. This is especially of concern for a primary care physician practising psychotherapy since the psychotherapeutic relationship forms the core of the healing effect of psychotherapy. Placing a patient on a Form 1 could also cause "stigma or emotional trauma to the patient from the restriction of freedom" (Argintaru & Fairbairn, 2012).

Nevertheless, any and all "licensed physicians" (typically community physicians, including general practitioners, family practitioners, and psychiatrists) may be required to place a patient on a Form 1 when necessary (Argintaru & Fairbairn, 2012). This is a difficult decision as physicians are required to discern between two delicate pathways: an overuse—and thus potential abuse—of this power, and an underuse of this power, with possible subsequent danger to patients and/or society.

Another problem that primary care physicians often face is that they need to relearn, and re-familiarize themselves with, how to complete a Form 1 properly and adequately each time it is needed (as it is required very infrequently). Nevertheless, the completion of a Form 1 is clearly an extremely important medical-legal responsibility which each physician should take pains to complete correctly. For this reason, although it can be somewhat time consuming, it is important for physicians to learn how to complete the Form 1 correctly. The following guidelines published here and in the next article will help physicians appropriately complete a Form 1.

Here are some sample case studies that explore this difficult and complex issue:

Case 1: When to Use a Form 1

A 41-year-old man who has suffered from schizophrenia for the previous twenty years enters his physician's office, appearing obviously disturbed and frightened. When his physician psychotherapist asks him how he is feeling, the patient resentfully exclaims: "Are you kidding? How would you feel if your sister was trying to poison you!" The patient then proceeds to huddle in a corner of the room, muttering nervously to himself (and apparently to other unseen individuals as well). When the physician steps forward to attempt to engage and calm down the patient, the man yells, "You better not come any closer, or else!" The patient then backs further into the corner, looking miserable.

The physician recalls that this patient had exhibited similarly distrustful and paranoid symptoms ten years earlier when he had ceased taking his medications, subsequently stating that they were tainted drugs purposefully given to him to control his mind.

What should the physician do next?

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Standards for Psychotherapy, Part 1 (cont'd)

Of course, we cannot give a definitive answer to this question as there are many subtleties entwined in these types of cases, necessitating that the decision be based upon a physician's judgement call. However, we can provide some direction to help each physician determine an appropriate answer to this question. We must primarily determine what information has been provided by the case, and what information is still needed to make an informed decision. For example, it is clear that the patient is suffering from a serious mental disorder that has the potential to cause this patient to threaten or harm himself or others, and/or make him unable to care for himself. These facts indicate that this patient may be acceptably placed on a Form 1. However, is this the right decision?

The case also indicates that this patient had suffered a similar episode in the past when he had ceased taking his medications. It would be prudent, therefore, for the physician to determine how the situation was handled in the past and whether the method chosen was effective.

Here is a second case that explores possible, more subtle, options during the process of implementing a Form 1:

Case 2: Options Prior to Form 1
A patient who has been diagnosed with bipolar disorder presents to her physician psychotherapist's office in a highly agitated state. She begins to sob heavily, while pacing around the room and talks about how she can't stand living with her illness any longer and is going to find a way to "make it all end!"

The physician psychotherapist determines that this patient is in need of potential further psychiatric help, or at least an assessment, in order to prevent her from hurting herself. Rather than simply forming the patient, the physician (with the patient's agreement) calls her boyfriend to have him pick her up and drive her to the hospital.

When the patient's boyfriend arrives, he begins challenging the physician, saying that the patient doesn't need to go to the hospital and that she is coming home "right now!" The physician psychotherapist insists that she be psychiatrically assessed in the hospital. The patient's boyfriend, again, unreasonably refuses. However, it is the doctor's responsibility to control the situation.

Therefore, the physician warns the patient's boyfriend that the police might need to be called in order to escort the patient to hospital, and that the police might also detain him for interfering with this important legal/medical process. The boyfriend then becomes immediately compliant. The physician, however, does not trust that the boyfriend will act appropriately by bringing the patient to the hospital in a timely manner. Therefore, the physician calls the patient's mother to come and pick her up and help escort her to the hospital. The mother is calm and reasonable, and does not object to the doctor's plans; in fact, she even states, "I've done this before." In this instance, the physician is able to stop the patient's boyfriend from interfering, and is able to get someone more reliable to take the patient to the hospital.

What action could the physician psychotherapist take in order to protect this patient while still doing his professional duty?

One possible course of action could be that the physician permits the patient to leave with her mother, with the added provision that the mother must take the patient immediately to the hospital. With patients who meet the requirement of Form 1, it could be potentially dangerous for the physician psychotherapist to attempt to detain these patients. Of course, the physician psychotherapist must also consider whether or not it could be dangerous if the patient were escorted by a family member or friend instead of by the police. In this particular case, as the patient has not been expressing any dangerous intent toward anyone but herself, it may not be excessively risky for this patient to leave with her mother.

As a final determination whether or not to issue a Form 1, the physician can judge the behaviours of the patient and the patient's friend or relative who is transporting the patient to the hospital. For example, in the case above, if the patient's mother does not present the patient to the emergency department in a reasonable amount of time, the physician psychotherapist could place the patient on a Form 1. Then the physician psychotherapist could also add to the patient's medical record that the patient (and her mother) did not comply with the necessary and agreed-upon course of action in order to preserve the patient's safety. Therefore, the physician's subsequent assessment of the patient's increased risk could lead to the placement of this patient on a Form 1.

Case 3: Patient Placed on a Form 2
Dr. Smith's patient, Gerry, suffers from fairly new-onset bipolar disorder. Over the previous two weeks, Gerry's siblings have noticed a drastic change in Gerry's behaviour. He has begun to mutter threats toward them and has even exhibited some violent behaviour (e.g., throwing his large dog across the room). Gerry's siblings are concerned about his mental health, and also about their own safety. They have attempted to get Gerry to come to the hospital for an assessment, but he refuses to go.

Gerry's siblings contact Dr. Smith and ask him to "force" their sibling to go to the hospital. Dr. Smith indicates that he has not examined Gerry in the previous seven days,

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Standards for Psychotherapy, Part 1 (cont'd)

and so he has no legal/professional ability to do so. Alternatively, Dr. Smith suggests that they instead request a Form 2 from the Justice of the Peace (or call the police, as a last resort).

Gerry's sibling, Cynthia, goes to the Justice of the Peace and gives testimony, under oath, that Gerry suffers from bi-polar disorder, has threatened to cause bodily harm to his siblings, and has caused his siblings to fear bodily harm from him. The Justice of the Peace then issues a Form 2, allowing the police to detain Gerry and bring him to a Schedule 1 facility for a psychiatric assessment.

The Form 2 allows the patient to be detained at the hospital only long enough to be assessed by a physician, in contrast to the 72 hours granted by a Form 1. Alternatively, police also have the right to detain and transport an individual whom they believe to be mentally ill, and who is exhibiting risky behaviours, to a Schedule 1 hospital for a psychiatric assessment without requiring either a Form 1 or a Form 2.

Once a patient has been brought to the Schedule 1 facility and has been assessed by a psychiatrist, the attending Emergency physician (or a psychiatrist) will determine whether or not to accept, reject, or re-do the form. It is then—and not before—that the patient receives a Form 42: Notice of Application for Psychiatric Assessment… (see glossary for additional information). The Form 42 must be given to the patient by the Schedule 1 Facility where the patient has been transported for assessment (Cavanagh, n.d.). The patient can then be subsequently committed to the hospital by a psychiatrist who will place the patient on a Form 3: Certificate of Involuntary Admission, if necessary. It is at this point that the patient would become an involuntary patient at the hospital. (The Form 3, however, must not be filled out by the same physician who filled out the Form 1.)

History

The concept of involuntary commitment has been utilized throughout various stages in history, and especially during the nineteenth and twentieth centuries, often without just cause. For example, one psychiatrist authored the following report:

> I worked with a patient who in the 1960s had been brought to the hospital by her husband. The chief complaint listed on the admitting record was: "Patient does not do her housework." I think she did actually have recurrent depression, a symptom of which was her inability to care for herself and her home, but there was obviously a large overlap conceptually between mental illness and not functioning in a proscribed social role (Curtis, 2001).

In 1874, a reform movement lobbied for the first commitment law to be passed in Maine, which protected individuals "against wrongful commitment" (Curtis, 2001). Over the following years, this law became successfully adapted and enacted in other parts of North America, including Canada.

Many additional social movements also positively impacted the development of laws and policies regarding involuntary commitment. For example, "the patients' rights movement;…the changing role of psychiatric hospitals; the greater interest in the subject of the patient rights by the legal profession;…the increased emphasis on the quality of life…[and even] the 'anti-psychiatry' movement" have all played substantial roles in advancing the development of more ethical processes and policies concerning involuntary commitment (Cahn, 1981). We do not ignore the fact that there have been significant problems with regard to the profession of psychiatry occasionally employing its powers in an excessive manner throughout history. Yet this is not much different than in many other social institutions, such as the medical profession as a whole, the church, the courts, etc. Additionally, the profession of psychiatry can be somewhat compared to a police force: some (a small minority) in the field have at times clearly abused their powers; however, it is a much-needed institution that is in the line-of-fire when its professional obligations entail intrinsically difficult and controversial decisions.

These critical social movements should be taken very seriously, considering their instrumental roles in developing our current standards for involuntary commitment. The concerns raised and objections posed by these movements have shaped our current policies and continue to assist physicians greatly in determining the most constructive and objective ways we can make reasonable decisions regarding our patients' conditions. As one author aptly stated, "Only those rights or freedoms necessary to maintain safety should be removed [I would suggest 'suspended'] to ensure clinical and personal progress" (Simpson, 2015).

Some patients' mental conditions are exceedingly complicated—commonly, patients want to stay out of the hospital, even when they are at times seriously and possibly dangerously mentally ill. It is our duty to examine and weigh the complex balance of the rights of the individual against the safety of society. Patients who are placed on a Form 1 may continue to hold bitter feelings toward their physician psychotherapist. The forming of a patient also has the potential to cause serious damage to the psychotherapeutic relationship between the patient and the physician.

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Standards for Psychotherapy, Part 1 (cont'd)

Another important factor to consider is the possibility that placing a patient on a Form 1 could impact the patient's ability to travel for work, family visits, or vacations. When a patient is detained by police, there is a possibility that the patient's health information relating to that incident will be uploaded to the Canadian Police Information Centre, which is a database system which has been shared with United States federal agencies. United States Customs and Border Protection has detained and/or prevented a number of patients who have experienced severe mental health crises from being able to cross the border into the United States (Gregoire, 2014). The number of these detainments has decreased over the past few years due to changes in policy. However, the possibility of detainment and/or denial of entry still exists for a notable number of patients. The reasoning given for these detainments (and/or preventions) is often described as a precaution against possible harm the patient could inflict upon others. However, this information may be out of date. "Information from this database, including mental health reports, may also appear in background searches conducted by TPS [Toronto Police Service] for an individual's application for employment, education, volunteer positions, or other purposes" (Gregoire, 2014). Evidently, there are many potentially compounding considerations that should be taken into account before a physician places a patient on a Form 1. However, ultimately, we must make an appropriate determination regarding whether or not the patient should be placed on a Form 1 in spite of, and yet considering, these and other potential side effects.

Canada, Mental Health, and the Law

In 2000, the Ontario government amended the Mental Health Act to address the frequent and recurring admittance of mentally ill patients in crises to hospitals and emergency departments. These revisions introduced new requirements for civil commitments (involuntary commitments), including the provision for "substantial mental or physical deterioration that would likely arise if the person were not treated… now known as the 'Box B' criteria" of the Form 1 utilized in Ontario (Byrick & Walker-Renshaw, 2012). Typically, Box B is rarely, if ever, used by a physician practising general practice psychotherapy.

Also in 2000, the Mental Health Legislative Reform implemented *Brian's Law*, which removed the term "imminent" from being applied to instances of danger in the Mental Health Act. This change was implemented following the tragic case of a sportscaster, Brian Smith, who was shot and killed by an individual suffering from a serious mental illness ("Brian's Law," 2000). After some debate, the term "imminent" was subsequently removed from the Mental Health Act due to a number of substantial issues, such as the lack of a generally accepted definition of the term, and the difficulty the term posed by sometimes preventing mentally ill individuals from receiving beneficial treatments earlier in their illnesses (Ontario College of Family Physicians, 2000).

Medicine is moving away from its historically paternalistic stance toward individuals with mental health issues. A Form 1 could be misused, thus unfortunately perpetuating this stance. Nevertheless, the true purpose of a Form 1 is to protect patients and society by promptly assisting patients in receiving the care they need, with the goal of helping patients who suffer from serious mental illnesses return to living safely within society.

Practical Exercise

Case 4: A Physician's Judgement Call

At his psychotherapy session, a patient with bipolar disorder yells angrily and bitterly about his wife. Through tears, he states that just that morning he learned that his wife had been having an affair with his neighbour. The patient proceeds to call his wife all sorts of names, and mutters "I could just kill her right now!" The physician psychotherapist asks the patient what he means by that statement and the man says, "Oh, nothing really. I'm more mad at my neighbour." The patient then proceeds to tell the physician psychotherapist all the things he hates about his neighbour, and concludes by saying, "Now, if he picked a fight with me, I'd sure give him what-for!" The physician psychotherapist notes that the patient appears to be in a manic state.

Should the physician psychotherapist involuntarily commit this patient?

To find out possible courses of action, please read the next article in this series, entitled "The Form 1: Application by Physician for Psychiatric Assessment, Part 2."

Disclaimer: This article is directed toward family and general practice physicians and should in no way be taken as legal advice. The opinions expressed are those solely of the authors. This article is meant as a guideline only and does not purport to supply detailed step-by-step instructions or information regarding civic commitments or forming procedures for physicians.

Conflict of Interest: none

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Standards for Psychotherapy—Part 1 (cont'd)

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Glossary

Administrative Tribunal: A general term applied to a board or agency that exists separately from the provincial government, and that settles disagreements between "the Province of Ontario and its citizens" (Ontario Ministry of the Attorney General, 2010). For example, the Ontario Consent and Capacity Board is one administrative tribunal that typically manages cases pertaining to involuntary commitment, among many other issues. (For additional information, see Dhir, 2008.)

Civil Commitment: The process of involuntarily apprehending, detaining, and transporting a patient to a Schedule 1 facility in order to determine whether or not the patient suffers from a mental disorder which is believed to be the cause of the patient's inability to care for him/herself, or is likely the cause of the patient's violent behaviour or threats toward him/herself or others. The criteria for civil commitment varies by province (see "Legalities" heading above for additional information).

Form 1: Application by Physician for Psychiatric Assessment. This form is filled out by a physician who has examined a patient within the previous seven days and believes that, as a result of a mental disorder, there is a serious possibility that the patient is in danger of harming him/herself or others, or the patient is incapable of caring for him/herself. A Form 1 allows the patient to be detained by police, family, or friends in order to transport the patient to a Schedule 1 facility where the patient will receive a psychiatric assessment. The form allows the patient to be detained at the Schedule 1 facility for 72 hours. *It should be noted that, in certain cases, it might be ill-advised for a patient to be transported by his or her family or friends if the patient is extremely disturbed and may present a danger to him/herself or those transporting the patient. From an ethical and legal point of view we, as physicians, are required to make this judgement call.

Form 2: Order for Examination by the Justice of the Peace. This form is filled out by a Justice of the Peace and may be requested by anyone, including a physician, who brings convincing information before the Justice of the Peace regarding the patient's mental state and safety concerns. The form is similar to a Form 1 in that it permits the detainment of the patient, by police, in order to have the patient transported to a Schedule 1 facility to receive a psychiatric assessment. However, this form differs from a Form 1 in that the detainment of the patient lasts only long enough for the patient to be assessed at the Schedule 1 facility (and not the full 72 hours permitted by the Form 1).

Form 3: Certificate of Involuntary Admission. A Form 3 can be filled out by a psychiatrist at a Schedule 1 facility once a patient has been placed on a Form 1 and has received a psychiatric assessment by the psychiatrist. This form allows the involuntary commitment of the patient to the Schedule 1 facility for 14 calendar days.

Form 42: This form is a notice that informs the patient that he or she is being held in a Schedule 1 facility (typically a major, general hospital), and the reasons for this decision. It also outlines the patient's right to contact a lawyer or rights advisor without delay, and indicates the responsibility of the hospital to aid the patient in that process (Argintaru & Fairbairn, 2012).

Mental Health Act: A set of laws established in Ontario that regulate and protect the involuntary admission of patients into Schedule 1 facilities.

Schedule 1 Hospital: Typically a large, general hospital that staffs psychiatrists as well as emergency physicians, thus providing a suitable environment for a patient to receive a psychiatric assessment if needed.

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Standards for Psychotherapy—Part 1 (cont'd)

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Annual General Meeting Notice

The Annual General Meeting of the

General Practice Psychotherapy Association

will be held in conjunction with the

2016 Annual Conference

on Friday May 27, 2016

at the Doubletree by Hilton, Toronto Downtown

from 12 noon to 1:30 pm.

Standards for Psychotherapy: The Form 1—Application by Physician for Psychiatric Assessment, Part 2

Michael Paré, MD, MEd, MSc, Laura A. Dawson, BA, Joshua Kim, MD, MSc

Introduction

As a continuation of our previous article, the following information will seek to expand upon, and provide clinical case studies pertaining to the use of a Form 1: Application by Physician for Psychiatric Assessment in Ontario.

To review: the primary purposes of a Form 1 are to protect the safety of both the patient and society. The Form 1 puts into place a dramatic and extensive process of apprehending, detaining, and transporting patients sometimes against their will to receive a needed psychiatric assessment. There is a substantial subjective element to this process due to the fact that many complex and intertwined issues may influence a physician's decision to utilize a Form 1. In many ways it seems as though it is a "lose-lose" situation to place a patient on a Form 1, and yet it is a legal, professional, and societal requirement of the physician to make this difficult determination. Alternatively, however, an appropriately completed Form 1 can, at times, genuinely be a "win-win-win" situation for the patient, the physician, and society; as discussed in Part 1 of this article.

When Should I Place a Patient on a Form 1?

According to Gandy (2004), several factors must be considered when completing a Form 1. These include, "the severity and intensity of [suicidal and/or homicidal] thoughts, the patient's expressed [suicidal and/or homicidal] plans, their access to lethal means, the level and competency of interpersonal supervision and the patient's willingness to contract for safety." Therefore, the exact conditions under which a Form 1 should be completed may vary between patients and physicians. Fortunately, the criteria outlined in Part 1 of this article, along with multiple case studies and guidelines provided below, should provide some clarity with regard to this important aspect of risk management in patient care.

To reiterate: in certain situations, clinicians are required to consider the use of a Form 1. There is no way around this responsibility. To deny this responsibility would be negligent and could lead to legal ramifications. Realistically, physicians should carefully assess the situation as best they can, and complete the Form 1 as accurately as possible. The following case study is a continuation of the question regarding "a physician's judgement call," posed to our readers at the end of Part 1 of this two-part article: Should the physician psychotherapist place this patient on a Form 1?

Answer A:

Yes. This patient has indicated that he "may be causing another person to fear bodily harm from him," which is one of the criteria of a Form 1. Also, as indicated, this patient "is suffering from a mental disorder" which has the potential to result in "serious bodily harm to another person." In addition, this patient has indicated threats toward a specific person. However, it is not entirely clear whether or not the patient's mental disorder "will likely" cause the individual to initiate serious bodily harm toward another person. The physician, therefore, should conduct a mental status assessment of the patient, taking into account the patient's mental state and past psychiatric history as well as the patient's compliance with and response to treatments for his current disorder. In cases such as this, additional collateral information and/or a second opinion may be useful.

Answer B:

No. This patient has indicated that his exclamation, "I could just kill her right now," was an expression of his frustration and hurt, rather than an actual intent to harm his wife. Also, this patient has indicated that if his neighbour picked a fight with him, he would respond. The patient does not, however, indicate that he intends to provoke or initiate a fight with his neighbour. Therefore, it is not clear whether or not this patient's motives are sufficient to place this patient on a Form 1. The physician should conduct an assessment of the patient, taking into account the patient's compliance with, and response to, treatments for his current disorder as well as any previous history of violent behaviour, etc. Of course, getting the patient to state his actual intentions of violence toward his wife or neighbour would also help the physician decide in favour of placing the patient on a Form 1.

This case is a good example of how difficult it is to determine whether a patient should (or should not) be placed on a Form 1. The physician's subjective judgement of the patient's condition plays a significant role in determining the outcome of this decision. We are not going to claim that one particular action is the "right" course of action with regard to the above scenario. Our own judgement and conclusion may not be any more accurate than another physician's judgement call. Evidently, this

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Standards for Psychotherapy, Part 2 (cont'd)

process is not a linear, step-by-step, logical deduction. The reality is that the decision to place a patient on a Form 1, or not to do so, must ultimately be determined by a combination of the physician's intuitions, knowledge of the patient, facts of the case, and other factors, such as the patient's level of impulsivity, his/her tendency to exaggerate or use hyperbole, his/her actual intentions, and his/her past propensity to violence.

It is important to note that the Mental Health Act states that, when completing a Form 1, a physician must have "made careful inquiry into all of the facts necessary for him or her to form his or her opinion as to the nature and quality of the mental disorder of the person" (Service Ontario E-laws, 1990, amended 2010). Based on this requirement, one judge has determined that collateral evidence given to the physician by others should be investigated, recorded, and contemplated by the physician when identifying whether the evidence can be utilized as support for the physician's decision (Court File No.: 08-2778). This is likely meant to minimize the hasty attitude of some physicians who may attempt to place a patient on a Form 1 for insufficient reasons; e.g., simply because the patient has a serious mental disorder and might be at some risk. However, it is only fair to point out that the resolution to place a patient on a Form 1 can be highly ambiguous and must be ultimately determined by a physician's clinical judgement.

There are many complex considerations a physician must weigh and judge regarding these risks before determining whether or not a patient should be placed on a Form 1. Sometimes the final decision is not readily apparent or uniform between physicians. The following guidelines, established by the Mental Health Act, will shed some additional light on the assessment process physicians must undertake before arriving at the decision to place, or not place, a patient on a Form 1.

Determining Eligibility for a Form 1

The Mental Health Act states the following regarding the implementation of a Form 1 in Section 15 of the Act: "A physician must personally examine the patient and carefully consider the facts concerning whether the person:

- has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
- has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
- has shown or is showing a lack of competence to care for himself or herself." (Service Ontario E-laws, 1990, amended 2010)

Below, we have illustrated an example of a patient who has been placed on a Form 1 due to the likelihood of the patient's risk to self:

Case 1: Patient Poses a Serious Risk of Harm to Herself

A patient who has been previously diagnosed with Major Depressive Disorder arrives at her physician's office in a highly distressed state. She sobs while relating how her mother found and removed the noose the patient had hidden in her room. In a shaky voice, the patient says, "I can't believe my own mother doesn't even care if I kill myself!" (This is somewhat characteristically illogical since the patient's mother does, care; that is why she removed the rope.)

The physician does a suicidal assessment of the patient. He learns that the patient has been having ongoing suicidal thoughts for the past two weeks, and still has a clearly articulated suicidal plan (hanging herself in her room from a rafter).

The patient states firmly, "I'll show her! She can't control me. I'm in charge of my own life. Let's see how she likes it when I'm gone." Upon further questioning, the physician learns that the patient plans to commit suicide immediately following the session in order to get even with her mother.

The physician psychotherapist, concerned for the patient's safety, consults with the patient's mother, who is also very concerned and is, in fact, terrified of what might happen to her daughter. The doctor determines that this patient should be placed on a Form 1.

The physician carefully completes the Form 1 using his own observations, the past psychiatric diagnosis, and a consideration of the collateral information collected from the patient's mother.

The physician must also determine whether the patient is suffering from a mental disorder "of a nature or quality" which will likely result in:

- serious bodily harm to the person
- serious bodily harm to another person; or
- serious physical impairment of the person (Service Ontario E-laws, 1990, amended 2010)

At least one of these criteria must be met, in conjunction with the patient's observed and/or assumed mental illness that is having a direct impact on the patient's mental state and/or behaviour for a Form 1 to be legally necessary and valid (Gandy, 2004). In addition, all other reasonable and less intensive management options should be considered before a Form 1 is utilized. For example, the physician should assess whether or not the patient will agree to attend the emergency department voluntarily for a psychiatric assessment.

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Standards for Psychotherapy—Part 2 (cont'd)

If the physician determines that the above factors are present and thus warrant serious medical intervention, the physician may "make application in the prescribed form for a psychiatric assessment of the person" (Service Ontario E-laws, 1990, amended 2010). This application must:

- [include] the facts upon which he or she formed his or her opinion as to the nature and quality of the mental disorder;
- distinguish…between the facts observed by him or her and the facts communicated to him or her by others; and
- [include] the date on which he or she examined the person who is the subject of the application…(Service Ontario E-laws, 1990, amended 2010).

The Form 1 application will be void unless the physician who completes the form properly completes, signs, dates, and charts the form within seven days of examining the patient. If a physician encounters a problem while filling out the Form 1 (i.e., makes a mistake), he/she should complete a new form (Naidoo, 2015). This process will be highlighted in greater detail in the following section.

Application Process

On the Form 1, physicians must select one of two components: Box A—Serious Harm Test *or* Box B—Patients who are Incapable of Consenting to Treatment and Meet Specified Criteria. Box A focuses on past, present, and future risks of harm, while Box B hinges on two factors: (1) a patient has an established mental disorder and has improved with treatment, (2) the patient has not continued to comply with this treatment and, without treatment, poses a serious risk to themself or to others; and is therefore considered to be incapable of consenting to treatment. For the purposes of this paper, we will focus on Box A. Box B is primarily of concern to psychiatrists who work with patients who are on Community Treatment Orders—which is beyond the scope of this article.

Once the Form 1 has been completed, the patient will be apprehended and detained for the purposes of:

1) obtaining an expert psychiatric assessment to determine the diagnosis of the patient,
2) determining the patient's safety and the subsequent safety of society, and
3) potentially treating the patient's mental illness.

It is only at this point, and not before, that the patient must receive a Form 42, providing an explanation regarding his or her detainment.

A person who has been placed on a Form 1 under Box A is still permitted to refuse treatment completely, barring emergency situations. The patient must undergo psychiatric assessment within 72 hours of the submission of the Form 1, and there must be a determination of whether or not there is a need for "Certification" and involuntary commitment to a Schedule 1 facility, properly identified as a Form 3 (Certificate of Involuntary Admission). If at the end of the 72 hours of detainment via the Form 1 the patient is not deemed certifiable by a Form 3, the patient must be informed of this fact and, if deemed capable to consent to treatment, be advised of his/her options, which include:

1. staying voluntarily in the hospital
2. being discharged forthwith
3. being allowed to sign out of the hospital Against Medical Advice (Naidoo, 2015).

For additional direction in this matter, see Patricia Cavanagh's (n.d.) excellent guide.

Application versus Acceptance

The completion of a Form 1 is simply an *application* by any licensed physician for a psychiatric assessment of a patient. This process allows a general or family physician, or community psychiatrist to defer to the expertise of an emergency physician and especially, finally, to a hospital psychiatrist. Usually the emergency physician conducts a brief psychiatric history and mental status examination of the patient. If the patient is not found to have the necessary criteria to be transferred over to a Form 3 (Certificate of Involuntary Admission), the hospital physician may choose not to "approve" or "accept" the original Form 1 application, and can freely release the patient. The patient may be discharged *or* the patient may agree to stay at the hospital as a voluntary patient at this time. (Rarely is this an option because of a shortage of beds.) To clarify, there are, in a sense, two phases of a Form 1:

> Phase 1: writing/issuing the Form 1 (usually completed by the community physician), and
>
> Phase 2: receiving/accepting the Form 1 (usually received by the hospital physician: either the emergency physician or a hospital psychiatrist).

The first phase of the process of writing or issuing a Form 1 consists of the actual "Application by a Physician for Psychiatric Assessment," whereas the second phase of a Form 1 entails receiving or accepting the Form 1, resulting in the further detainment of the patient for psychiatric assessment at a medical facility. At this point in the process, if the Form 1 is accepted, the attending emergency physician must also give the patient a completed Form 42, which outlines the patient's legal right to appeal

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Standards for Psychotherapy—Part 2 (cont'd)

the decision (entitled, Notice to Persons under Subsection 38.1 of the Act of Application for Psychiatric Assessment under Section 15 or an Order under Section 32 of the Mental Health Act). Form 42 provides an explanation to the patient regarding his or her detainment.

There should be a reasonably low index of suspicion in issuing a Form 1 that is needed to attempt to secure both the patient's and the public's safety. The complexity of this determination (whether or not to place a patient on a Form 1) will account for some potential disagreement between the physician submitting the Form 1 and the hospital physician making his or her own examination of the patient's (or society's) current safety, as well as a determination of the patient's mental health status. Of course, the patient's true mental state (or expressed mental state) may change substantially between the patient's attendance at his or her physician's office and his or her arrival at the Emergency Department.

The following cases illustrate one potential instance in which a Form 1 application is "accepted" (Case 1 Continued); and one potential instance in which a Form 1 application is "not accepted" by a hospital physician (Case 2).

Case 1 Continued: Form 1 Application is Accepted

The patient (described above in Case 1), now irate at having been detained and escorted by police, is clearly hysterical and demands to be released at once so she can kill herself (and demands that this is one of her basic human rights). The emergency physician conducts a psychiatric assessment of the patient and considers her obviously compromised mental status.

The results of the psychiatric assessment indicate that the patient is, indeed, at risk of committing suicide if she is released. For this reason, the hospital physician places the patient on a Form 3 (Certificate of Involuntary Admission), and gives the patient a Form 42. The patient is then involuntarily admitted to the hospital, and is placed under observation by the hospital staff every hour (the patient can still refuse all treatment except under emergency conditions).

Case 2: Form 1 Application is Not Accepted

A physician places a patient, previously diagnosed with bipolar disorder, on a Form 1 after hearing the agitated patient adamantly and repeatedly state that he is going to kill his boss.

Upon arrival at the hospital, the patient is assessed by the hospital physician. The physician learns that the patient was denied his yearly bonus, earlier in the day, because the company was undergoing a "restructuring" process. The patient was relying heavily on this additional income. The patient, now quite calm, openly admits that he certainly overreacted and promises to "apologize to my boss for yelling at him (if I still have a job, that is)." There is no evidence of mania or risk of violence.

Through the process of a brief (yet sufficient) psychiatric history and mental status examination, the physician determines that the patient does not require further hospitalization and agrees to release the patient.

Common Misconceptions of Form 1

There is a lot of misinformation and misunderstanding regarding the proper implementation of a Form 1 by physicians. These errors are even found within the government's own informational materials (see Part 1 of this article for details). For example, the Psychiatric Patient Advocate Office (2008) states that "[t]he reason that the doctor is holding you [the patient] on the Form 1 will be given to you on a Form 42. You have the right to receive the Form 42 immediately." Similarly, according to the Emergency Psychiatry Services (2002) at St. Joseph's Healthcare Centre, Hamilton, "The physician completing the Form 1 needs to complete the Form 42 and hand it to the patient"; and the Community Legal Education Ontario (2009) organization indicates that "[t]he law says that soon after a doctor signs a Form 1, you [the patient] must be given a Form 42." All three of these statements, made by prominent organizations and individuals, are somewhat incorrect.

A primary care physician (or community psychiatrist) is not required to provide a patient with a Form 42. Rather, when a patient arrives at the hospital, a Form 42 must then be completed if the patient is detained in order for the Form 1 to be valid. Indeed, the Form 1 itself states, "Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42." The *Osgoode* Certificate in Mental Health Law course states this requirement by indicating, "When '*detention*' in *psychiatric facility* starts, provide Form 42 (Notice to Patient) and chart" (Naidoo, 2015).

As for another misunderstanding, some primary care physicians mistakenly refer to the Form 1 process as "certification" or as "involuntary commitment," and yet these terms are also incorrect. Certification and/or psychiatric commitment is the process by which a *psychiatrist* identifies a patient as having a mental illness, considers the patient to be in significant danger of hurting him/herself or others, and subsequently places the patient on a Form 3 (Certificate of Involuntary Admission). See Figure 1, below, for an outline of the differences and similarities between the Form 1 and the Form 3.

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Standards of Psychotherapy—Part 2 (cont'd)

	Form 1: Application by Physician for Psychiatric Assessment		Form 3: Certificate of Involuntary Admission
	Phase 1: Issuing a Form 1	**Phase 2: Accepting, Rejecting, or Redoing a Form 1**	
Physician who completes the form	A licensed physician (typically a general practitioner, family practitioner, or sometimes a community psychiatrist) whose patient meets the criteria for a Form 1 (the physician is not required to detain the patient or stop him/her from leaving)	The emergency physician either accepts, rejects, or recompletes the Form 1 after personally examining the patient	A psychiatrist at a Schedule 1 facility (cannot be the same physician who completed the Form 1)
Involvement of a rights advisor	Patient does not have the right to ask for a rights advisor at this time (no Form 42 needed)	The patient must be given a Form 42 as soon as his or her detention begins in the Schedule 1 facility, and must be given a rights advisor at this time	The patient may appeal to the Consent and Capacity Board to request a re-examination of the decision to detain him/her
Personally conducted examination of the patient by the physician	Always required: the physician has up to seven days, after examining the patient, to submit a Form 1; the examination does not need to be a lengthy or full assessment	The emergency physician must examine the patient and either accept, reject, or redo the Form 1 (the latter often occurs)	Always required by a psychiatrist; at this point it is often better to complete a more comprehensive history and mental status examination of the patient

[1] We have added the titles "Phase 1" and "Phase 2" for clarification purposes only. These are not, as far as the authors are aware, legal or professional terms utilized to distinguish the above steps in the process of completing and submitting a Form 1. Nevertheless, these steps will help to clarify the process. Physicians in primary care typically need only focus on Phase 1, as Phase 2 becomes the responsibility of the emergency physicians and psychiatrists at the Schedule 1 facility.

Conclusion

In my (Michael Paré) experience testifying as an Expert Witness for the Court it was determined by a Judge of the Ontario Superior Court of Justice on one occasion concerning the Form 1 that:

> there is no respectable body of opinion on either side of this standard of care issue…relating, for example, to the required length of a personal examination or as to any specific questions that must form part of the examination…generally, deference should be accorded to a doctor considering a Form I application as to what information is necessary to give reasonable cause for belief, and for an opinion under the Past/Present and Future tests respectively. In other words, there is virtually no accepted standard of care within the profession (Court File No.: 08-2778).

This quote emphasizes the fact that no exact formula or complete set of guidelines can be used or followed when filling out a Form 1 because of the need for physicians to make judgement calls regarding the criteria surrounding this important decision.

The use of a Form 1 is a regrettable but sometimes necessary instrument utilized within the complex social, psychological, interpersonal, and psychiatric landscape that patients and doctors share. Placing a patient on a Form 1 mainly asks the question "Is this person in need of certification?" It is not primarily an answer. Additional assessments, potential treatments, and possibly extended involuntary commitments or voluntary status at a hospital may be necessary in order to provide patients with sufficient and appropriate mental health care.

Conflict of Interest: none

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SEE AUTHOR BIOGRAPHIES ON P 18

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Standards of Psychotherapy—Part 2 (cont'd)

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Report from the GPPA Board

Catherine Low, MD, CGPP

GPPA

This year's conference will be held in Toronto at the Hilton Doubletree Hotel (Chestnut Street) on Friday, May 27 and Saturday, May 28, 2016. The title and theme of the conference is "Frontiers of Brain Science."

The Fourth Annual GPPA Retreat

The fourth annual GPPA Retreat took place on the weekend of October 23–25, 2015 at the YMCA's Geneva Park facilities in Orillia. The retreat was led by Harry Zeit, MD, CGPP, and Amy Alexander, MD, MHSc, CCFPA. The weekend was a perfect balance of didactic and experiential learning. An introduction to Internal Family Systems included videos, a practice session and a very powerful piece of art therapy. The Trauma Releasing Exercises, guided meditations and two sessions of Integrative Rest were novel and exciting. The retreat was sold out even before the expiry of the early bird deadline and the organizers were approached about the idea of offering it twice a year in the future.

Outreach Activities

The GPPA was well represented at the Family Medicine Forum (November 12–14, 2015) in Toronto. The booth there offered pamphlets, handouts, and a promotional video to show to prospective new members. Chris Toplack, as the GPPA representative on the College of Family Physicians Mental Health Program Committee, and Vicki Winterton, as a representative of GPPs, prepared and delivered two workshops each at the FMF. They also hosted a GPP interest group breakfast during the conference.

Approval of Online Courses for Group CE Credits

The Board has recently approved the use of certain online courses for the purpose of earning Group CE credits.

Minimum components or elements in order for the activity to be approved as an online CE activity are as follows:

1) There is a didactic online teaching session for each module.
2) There is a videotaped actual or simulated session as a teaching tool for each module (such sessions are now commonly used as teaching tools in the Psychiatry residency programs).
3) There is an interactive component for each module. (The interactive component could include the "virtual therapist" [as used in PtER], the posting of online comments, or other interactive activities.)
4) A self-assessment activity (quiz or test) at the end of each module.

Information is to be completed in the web program for online activities.

The GPPA member will be required to submit the following information *for each module* (as the member may decide to complete some or all of the modules in a given on-line course).

- Name of the online course
- Website of the online course
- Organization sponsoring/providing the course
- Name of the module completed
- Date the module was completed (to determine the CPD cycle in which the activity should be included).

GoToMeeting APP

The GPPA has purchased a one-year subscription to this web-based meeting application. This application facilitates video conferencing and the display of documents for drafting and editing during meetings. It can also be used to deliver distance education for groups of up to 25 participants. Requests to use this application must go through Carol Ford who will determine the availability of the app and send out email invitations with a link to the site prior to the meeting to all those who will be participating. The app GoTomeeting must be downloaded onto the participant's computer or tablet prior to the first time it is used. There is no charge to the participants for the use of this service.

Conflict of Interest: none

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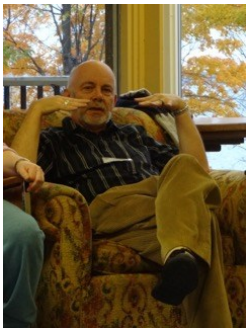
Catherine Low, the current chair of the board, has been a member of the GPPA since 1996 and involved in committee work since 2007. Her medical practice began in Scarborough with an interest in women's health, and continued in Ottawa where work with immigrant women led to her interest in psychotherapy. She currently practices in Belleville.

GPPA 2015 Fall Retreat Photos - *Courtesy of Louis Girard*



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Whom to Contact at the GPPA

Journal – to submit an article or comments,
e-mail Janet Warren at journal@gppaonline.ca

To Contact a Member - Search the Membership Directory or contact the GPPA Office.

Listserv
Clinical, Clinical CPSO/CPD, Certificant and Mentor Members may e-mail the GPPA Office to join.

Questions about submitting educational credits – CE/CCI Reporting , or Website CE/CCI System - for submitting CE/CCI credits,
contact Muriel J. van Lierop at vanlierop@rogers.com
or call 416-229-1993

Reasons to Contact the GPPA Office
1. To join the GPPA.
2. Notification of change of address, telephone, fax, or email address.
3. To register for an educational event.
4. To put an ad in the Journal.
5. To request application forms in order to apply for Certificant or Mentor Status.

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