PSYCHIATRIC FACILITIES REVIEW BOARD

ANNUAL REPORT APRIL 1, 1998 - MARCH 31, 1999

The Psychiatric Facilities Review Board is appointed under the mental health provisions of the Hospitals Act of Nova Scotia. Its primary responsibilities are to review the decision of the treating psychiatrist that a person in a psychiatric facility should be held under 'formal' status and that a person is not capable of consenting to treatment. A person is held under formal status if a psychiatrist has certified that the person (a) suffers from a psychiatric disorder and (b) is a danger either to their own safety or to the safety of others. The Board is also authorized to review competency to administer a patient's estate, where necessary, and to make recommendations as to the treatment, care, or placement of a patient.

These responsibilities and powers are formidable, since they can operate to deprive the individual of the right to make decisions concerning oneself, and authorize detention and treatment against one's wishes even in situations in which no criminal act has been committed. Outside the areas of criminal law and child protection, this power to interfere with individual autonomy is unprecedented. Therefore the Board carries a weighty onus to ensure to the extent possible that its decisions, both in terms of substance and of procedure, are reached in judicious manner within the context of the utmost respect for the rights of the individual whose interests are at stake.

This annual report is presented in four parts. Part I lays out the statistics as to the Board's operation. Part II is an analysis of trends indicated by the statistics. In Part III we discuss recent changes made in the functioning of the Board in attempting to improve its openness, accountability, and quality of decision-making in response to the recommendations of the Law Reform Commission of Nova Scotia. Finally, Part IV identifies issues of serious concern to the Board of which we believe

the legislature should take note: in particular, the decline in provision of resources in the area of community services for people with mental health problems. It is hoped that this report will stimulate discussion and eventual redress of these concerns to better serve mental health consumers, professionals, and Nova Scotian society overall.

PART 1 - STATISTICS

During its twentieth year of operation, April 1, 1998 to March 31, 1999, the Board conducted three automatic reviews under section 64 of the Hospitals Act. In each case the patient's formal status was continued. A fourth automatic review was cancelled because the patient was made informal prior to the hearing.

The Board received 64 requests for review under section 65 of the Hospitals Act. Of the 64, 61 were requested by the patient and 3 by the hospital administration. The Board also initiated one review as authorized under Hospitals Act section 64, resulting in a total of 65 non-automatic reviews..

Of these 65, 23 of the patients were made informal prior to review and 10 requests were withdrawn, resulting in 32 requested or Board-initiated reviews being conducted. Of these, 4 patients were made informal as a result of the review and 28 were continued under formal status. This means that excluding automatic reviews, 14% of patients had their formal status revoked following review.

There were no hearings held under section 60 to determine whether there had been compliance with the requirements for psychosurgery to be performed.

PART 2 - TRENDS

A. Automatic Reviews

Under Hospitals Act section 64, whether or not there has been a request for a hearing, the Board must review the status of each patient held under formal status every six months for the first two years and once per year thereafter. This year three automatic reviews were held, the number being identical to last year. As well, as noted above, a fourth was scheduled but the patient's status was changed to informal prior to the hearing. The number of automatic review hearings has dropped dramatically in recent years. For instance, in its first four years of operation, the Board held an average of forty automatic reviews per year, and as recently as 1991-92, fourteen automatic reviews were held. Overall, the decline to three automatic reviews per year in the past two years means that far fewer patients are now involuntarily hospitalized in psychiatric institutions for long terms, i.e. greater than six months, than in the 1980s and early 1990s.

B. Requested and Board-Initiated Reviews

Non-automatic reviews are commenced primarily by two methods: requests from patients or from hospital administrators. As well, the Board initiated one review in this past year pursuant to s. 64 of the Hospitals Act. Three requests were made by hospital administrators, a reduction from the eight received in the previous year. Patient requests for review increased sharply, from thirty-five in the previous year to sixty-one in the past year (an increase of 74%). As noted in Part I, this resulted in thirty-two hearings being conducted, an increase from twenty-three hearings held in the previous year (an increase of 39% - see chart attached as Appendix 1). Replicating the pattern of previous years, following approximately half of all requests, a hearing was held. The remainder were cancelled due to the patient's status being switched to informal prior to review (in 23 cases) or the request

being withdrawn (in 10 cases). The patient's status was changed to informal in four instances following review. This is similar to the five changes made in the previous year.

The average number of days from the date a request for hearing was received to the date the hearing was conducted was 15.0, down slightly from 16.2 days on average in 1997-98.

How does one account for the marked increase in the number of patient requests for review, and hence the number of hearings conducted? An analysis of statistics collected over the past two years on formalization throughout the province, while performed with caution and acknowledged as speculative in nature, may provide some indication of developing trends. There appear to be two major reasons for the increase: a rise in use of formalization by two of the smaller institutions, and an increase in awareness of patient rights.

The statistics reveal a 15% increase in number of formalizations by psychiatric institutions in 1998-99 as compared to 1997-98. In most of the psychiatric facilities, the number of patients placed under formal status remained relatively constant. Two of the smaller hospitals showed an increase in their use of formalization. Thirteen requests in total originated in those hospitals, up from seven in the previous year. This resulted in eight non-automatic hearings being held at these two hospitals, as compared to none in the previous year.

While an increase of eight is significant, this is not the whole answer. Another important causative agent appears to be an increase in awareness by mental health consumers of their rights. Every institution has a duty outlined in section 70(8) of the Hospitals Act to inform the patient of her/his right to review and to provide assistance to a patient who wishes to apply for review. However, the Act does not specify what actions are required to fulfil this duty. One hospital may consider the posting and distribution of pamphlets discussing these issues as sufficient, whereas

another might have its staff engage in regular discussions with the patient as to the meaning and implications of formalization and the availability of review. The latter approach may be far more effective in raising patient awareness of rights and hence number of requests for review, especially since one's ability to comprehend may ebb and flow along with one's fluctuating mental health.

One indication that rights awareness may be a significant operative factor is that there is a dramatic difference between institutions throughout the province in the number of patient requests for review following formalization. Excluding hospitals that had only one or two formal patients last year, the rate of patient requests for review ranged from approximately twelve to forty-eight percent. In other words, in some hospitals, 12% of formal patients requested a hearing in the past year, whereas in one major psychiatric institution, the Nova Scotia Hospital, 48% of the formal patients requested review. The Nova Scotia Hospital patient review request rate the previous year had been 23%. The identifiable change from one year to the next was the hiring of a new patient representative who appears to have taken a more assertive role than previous representatives in providing patients with information and regular direct contact.

C. Psychosurgery

As in the previous seventeen years, there were no hearings held to determine whether there had been compliance with the requirements for psychosurgery.

PART III - CHANGES

The Board has taken seriously the recommendations of the Law Reform Commission of Nova Scotia in their Final Report on Reform of the Administrative Justice System in Nova Scotia. The Commission recommends that the administrative justice system should be "...impartial, accessible,

expert, efficient and accountable" (Final Report at iv). We have attempted to refine and, where necessary, revise our functioning in response to these proposed requirements, particularly in the areas of appointment of Board members, training, procedure, and communication.

A. The Appointments Process

In our understanding, historically the process of selection of members of the Psychiatric Facilities Review Board was largely private and ad hoc. The Law Reform Commission recommended that a 'transparent' process of appointment to agencies, boards and commissions be established in order to improve public trust in the quality of appointees. The Board and the Mental Health Services Division of the Department of Health have now jointly established a process of advertising for candidates, including selection criteria in the advertisement, as proposed by the Commission. This was followed by the shortlisting and interviewing of candidates by a committee consisting of the Programme Planning Consultant for Mental Health Services and the Chair and Vice-Chair of the Board. The resulting recommendations were then presented to the Minister of Health. This process of selection has not been entirely respected in the past year, but now that its development has been drawn to the attention of the Minister of Health, we have no doubt that it will be strictly adhered to in the interests of justice and accountability.

It is also worthy of note that there have been inordinately lengthy delays in the approval of appointments by the Human Resources Committee. Appointments and re-appointments have been in abeyance for a number of months at a time. This has caused considerable inconvenience and has at times hampered the Board's ability to function effectively. For example, for a period of more than two months the Board had no lay representation and was forced to function with panels exclusively composed of psychiatrists and lawyers. Lay representation is especially important as a majority of

these appointments are now held by mental health consumers.

B. Training of Members

The Department of Justice has developed a two-day seminar programme in response to the Law Reform Commission's suggestion that training be provided as to appointees' roles and responsibilities. All Board members have been invited and encouraged to participate in this programme, and the costs of the seminar have been covered. To date, six members have participated, including the Vice-Chair, Chair, and all those who write decisions on behalf of the Board (it should be noted that one of our Board members teaches a segment of the course). Remaining members will be urged to attend in the near future, and attendance may well become a precondition to service on the Board.

C. Board Procedures

The past year has witnessed further improvements in the quality of decision writing. As noted in last year's report, the Board has evolved from the historical practice of providing no reasons to specifying the reasons for decision. Since that time, review of the evidence leading to the decision has become more elaborate. Further work remains to be done to provide for lay participants, particularly the patients involved, an explanation as to the basics of the process within the decision.

Also in the area of education as to procedures, a set of documents is being prepared for distribution to mental health consumers and to psychiatrists and hospital administrators to inform them of the Board's statutory mandate and its procedures. This will respond to the following suggestion of the Law Reform Commission in regard to its proposed Administrative Justice Act:

> The Act requires that administrative tribunals develop procedures and rules consistent with the minimum procedures in the Act which must be communicated to the people involved in a hearing. This will ensure that the administrative tribunal develops rules

> which address these issues and it will also help ensure that people are informed about the process they will encounter (at iii).

By circulating information in advance as to the roles and procedures of the Board, all parties can be better prepared and hopefully less anxious about appearing at a hearing.

D. Communication

In the past year there has been increased communication between the Board and the Director and Programme Planning Consultant of Mental Health Services regarding issues of concern to individual patients. The Board is authorized under Hospitals Act s. 63(e) to make recommendations respecting the treatment or care of a patient, and under s. 63(f) to advise the administrator of psychiatric mental health services where it believes it is in the best interests of a patient to be transferred to another facility. Some examples of recommendations the Board has made in the past year include the following requests: intervention to facilitate the availability of a bed for a patient in a community care setting; placement of a patient in a different psychiatric institution, pursuant to her wishes; creation of a specialized care facility for two long-term patients with serious and chronic mental health problems, as well as in the interim providing them with dedicated staff.

In the area of education, the Chair of the Board gave a seminar presentation to psychiatric residents at the QEII Health Sciences Centre on issues regarding civil commitment, capacity, and competency. The talk was warmly received, and it is anticipated that the educative function of the Board will continue to expand.

PART IV - REFLECTIONS ON TRENDS

The patterns identified in this report, and the observations of the Board while visiting the various psychiatric institutions across the province, lead to the following reflections on trends. The first two are commendations as to review of the Hospitals Act and increased efforts at patient rights awareness. The latter four are areas of concern in which work is needed, i.e., legal representation, patient transfer, liberty of formal patients, and most importantly, decline in the provision of community services.

1. The annual reports of this Board for the past two years have identified the need for review of the Hospitals Act in light of the Canadian Charter of Rights and Freedoms. The Board is gratified to note that the Minister of Justice, on recommendation of the Minister of Health, has referred the matter of reform of mental health legislation to the Law Reform Commission of Nova Scotia, and a review is presently underway. It is hoped that new and improved legislation will result that deals specifically with mental health issues.

2. Earlier in this report we identified that a likely causative factor in the increased number of requests for review in this past year was the increased dissemination of information on patient rights. We also identified, in the introduction, the sweeping interference with autonomy that accompanies civil commitment under the provisions of the Hospitals Act. It would appear that one of the concomitant obligations of the hospital that accompanies this extensive power is the need to ensure that the patient is informed frequently and in meaningful fashion of his/her rights, including the right to review of the detention. Staff at the Nova Scotia Hospital should be commended for their endeavours in this area. Other psychiatric institutions should strive to match this standard.

3. An issue raised in the previous two reports is the lack of provision of legal aid services for

those indigent mental health consumers held under formal status. It would appear that some legal aid lawyers do from time to time receive approval to represent such patients, but the practice is infrequent and inconsistent throughout the province. It is the position of the Board that legal aid should be provided for all patients detained under civil commitment who qualify under the financial criteria for legal aid. It is hoped that this issue will be addressed in conjunction with the review of mental health legislation, as discussed above.

4. An additional area of concern that has come to the attention of the Board in the past year is that of patient transfer. The Board has encountered situations wherein a patient being treated on an outpatient basis at a particular psychiatric institution is then sent to another institution when inpatient services are required. It is our position that this interferes with continuity of care and can be disruptive for patients whose lives may already be in turmoil. Furthermore, having differing catchment boundaries for outpatients than for inpatients does not make intuitive sense. This problem needs to be addressed.

5. Another issue we have identified is the degree of freedom granted to patients detained under civil commitment. There is wide variation from institution to institution, such that in one hospital, the patient is never allowed to leave the ward, and in another, one patient leaves unsupervised for up to three days at a time. It is appropriate that the least restrictive alternative required by the individual patient in the particular circumstances be utilized, and the Board makes no comment as to whether unsupervised leaves can be appropriate. Rather, the critique being offered is that there is dramatic and inexplicable inconsistency in policy between the various institutions. This would seem to be an appropriate area for departmental consultation and province-wide guidelines to be developed.

6. Finally, in the past year an issue has come to be seen by the Board as being of critical and

over-riding importance. We are growing extremely concerned about an apparent lack of resources in the area of community services. There would appear to have been a notable and serious decline as compared to previous years in the availability of appropriate community living placements. On numerous occasions the Board has been confronted with situations wherein, on the evidence of the treating psychiatrist, the patient is being held in a psychiatric facility because adequate provision for support in the community does not exist. For example, we have reviewed patients who do not need to be in a psychiatric facility but for the fact that the evidence indicates that they will be likely to deteriorate inordinately rapidly in the absence of supervision of medication, and an appropriate small options group home or other supervised living situation is not available.

This problem is particularly acute for patients taking the newer atypical antipsychotic medications such as clozapine. Abrupt discontinuation of these medications can lead to rapid decompensation and the need for doses of up to three times the former strength in order to reinstate therapeutic levels. For some particularly refractory individuals, such medications may be the sole remaining treatment option. For these individuals, appropriately supervised living situations are required but are not sufficiently available.

This phenomenon has disturbing ramifications in the areas of acute care and adult protection. Because of an inability to place patients in the appropriate least restrictive living environment, the few long-term care wards are filled to capacity and patients that should be in those wards are being retained, at times for many months, in acute care settings. Acute care wards are designed to stabilize the acutely ill patient initially, but do not provide the therapeutic services necessary for successful treatment and rehabilitation of the seriously ill. The presence of long-term patients in acute care wards is non-therapeutic both for the long-term patients and for other patients that do require acute

care services. Furthermore, the overlap and crowding is problematic for the staff. It also means that fewer beds are available for the intended purpose, i.e., care of the acutely mentally ill.

Rather than keeping these individuals in psychiatric facilities, some psychiatrists are seeking adult protection orders. These orders place the patient squarely under the rubric of the Department of Community Services and, it is hoped, ensure that suitable accommodation will then be provided. However, these orders also have the potential of broad and sweeping interference with freedom of the individual. It would appear to be an infringement of rights and a misuse of resources if they are being sought and granted in situations in which they would not be required if the proper community services were being provided.

It is clear that for the situation of mental health consumers to improve overall, increased funding for the Department of Community Services is required. In recognition of fundamental human rights, including the freedom, dignity, and security of the person, each person is entitled (within the requisite parameters) to the least restrictive living situation possible. It is Community Services, and not the Department of Health, that provides the facilities to optimize the degree of independent living possible. However, Community Services appears not to have the resources necessary to meet the needs for these facilities. It is our contention that the government has a responsibility to ensure quality living conditions for the most vulnerable in society, a category which patently includes those with serious mental health problems. This responsibility is not being adequately met.

What is needed to address these concerns? The Department of Community Services must expand its network of small options settings, and the living options offered must be tailored to meet the differing needs of individual mental health consumers. If Community Services requires increased funding in order to provide such services, it is imperative that the funding be provided. There should

also be increased co-operation between the Departments of Health and Community Services to ensure that patients are not caught in a gap between the two departments. Programmes such as the Nova Scotia Hospital SCOT team (Supportive Community Outreach Team), which provides voluntary services to individuals with severe mental health problems who are living in the community, should be developed and expanded throughout the province.

In conclusion, in the view of the Board, there have been some positive and negative developments in the area of provision of mental health services in the past year. It is sincerely hoped that the major and pressing concern raised in this report as to the decline in community services will be addressed forthwith. Consumers of mental health services are suffering in the interim. And to the extent to which our most vulnerable are made to suffer inordinately due to government inaction, we are all as a society thereby impoverished.

PSYCHIATRIC FACILITIES REVIEW BOARD
COMPARISON OF REVIEWS DONE
FROM 1993/94 TO 1998/99