PSYCHIATRIC FACILITIES REVIEW BOARD

ANNUAL REPORT APRIL 1, 2000 - MARCH 31, 2001

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 three parts. Part I presents the statistics as to the Board's operation in the period from April 1, 2000 to March 31, 2001. Part II is an analysis of trends indicated by the statistics. In Part III we bring to the attention of the Legislature issues of note, in particular a serious concern regarding lack of availability of community resources for persons with mental disorder.

PART 1 - STATISTICS

During its twenty-second year of operation, April 1, 2000 to March 31, 2001, the Board scheduled 10 automatic reviews under section 64 of the Hospitals Act. Of these, 1 was cancelled because the patient was made informal prior to the hearing. Of the 9 automatic reviews held, 8 of the patients were continued under formal status and 1 patient's status was changed to informal.

The Board received 65 requests for review under section 65 of the Hospitals Act. All were requested by the patient. There were also 2 Board-ordered reviews. Of these 67, 20 of the patients were made informal prior to review and 13 requests were withdrawn, resulting in 34 requested or Board-ordered reviews being conducted. Of the 34 hearings held to review formal status, 7 patients were made informal as a result of the review and 27 were continued under formal status. This means that excluding automatic reviews, 21% 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. In the year 2000-01 ten automatic reviews were scheduled, of which one was cancelled because the patient was made informal prior to hearing. In 1999-2000, in contrast, twelve were scheduled, of which four were cancelled prior to the hearing. In 1998-99, four automatic reviews were scheduled and three conducted, and in 1997-98, three were scheduled

and conducted. Looking back historically, in its first four years of operation, the Board held an average of forty automatic reviews per year. While recent figures do not come close to these levels, it is of note that in 1999-2000 there was a dramatic increase in the number of automatic reviews in comparison to the previous two years. This year the number has decreased moderately, but is still high compared to recent figures up to two years ago. The implication is that there has been an increase in the length of term of hospitalization for some severely ill patients, such that a number of patients are detained for six months or more.

B. Requested Reviews

Non-automatic reviews are commenced primarily by requests from patients and on occasion from hospital administrators. No requests were made by hospital administrators in the past year. Two reviews were ordered by the Board so that the patient's status could be reviewed prior to the 6-month automatic review. When total number of requests from patients, administrators, and board-ordered requests are combined, there were 67 this year, 64 in 1999-2000, 65 in 1998-99, and only 43 in 1997-98. (The number of patient requests for review rose somewhat; 65 were received this year compared to 62 in 1999-2000, 61 in 1998-99 and only 35 in 1997-98.) As noted in Part I, this resulted in 34 hearings being conducted, an increase from 29 in 1999-2000, 32 in 1998-99, and only 20 in 1997-98.[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 20 cases, as compared to 29 last year) or the request being withdrawn (in 13 cases, as compared to 6 last year). There has been a major increase in number of

[1] Note that the Annual Reports for 1998-99 and 1999-2000 incorrectly listed the number of requested hearings conducted in 1997-98 as being 23. The correct figure is 20; the number of 23 included both requested and automatic hearings.

times requests are withdrawn. The Board is monitoring this by requiring the patient to complete a statement giving reasons for withdrawal of the request. If the Board is unsatisfied with the reason provided, e.g. if it appears there may have been undue influence on the patient or the explanation supplied doesn't make sense, the review proceeds regardless.

The patient's status was changed to informal in 7 instances following review (i.e., in 21% of requested reviews). Last year the patient's status was changed in 7 cases (26%); in 1998-99, in 4 cases (14%), and in 1997-98, in 5 cases (20%).

When the statistics for automatic and requested reviews are combined, the total number of reviews in 2000-01 was 43, a noticeable increase from 1999-2000 (37 reviews). In 1998-99 there were 35 reviews in total and in 1997-98, 23.

For the first time this year, the Board had access to statistics showing the total number of times formal status is invoked at any of the psychiatric institutions throughout the province. In 2000-01, there were 358 formalizations; in 1999-2000, 381; in 1998-99, 353; and in 1997-98, 387. When these statistics are matched with those of number of reviews in a given year, oddly, there is no discernable correlation. One can surmise that the number of times formalization is invoked does not correspond with the length of term of each formalization. It may also be that a greater percentage of patients held under formal status now request review.

The Act provides for a maximum period of one month from the date of request to the date of hearing. In this year, the average number of days from the date a request for hearing was received to the date the hearing was conducted was 14.8, identical to 1999-2000. The comparable figure for 1998-99 was 15.0 and in 1997-98, 16.2 days on average.

It should be noted that although the Hospitals Act provides that the Board has 14 days in

which to issue its decision following a hearing, we routinely do so, with reasons, within three to four working days.

C. Psychosurgery

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

PART 3 - COMMENTS

(a) Lack of Community Resources: As outlined above, the statistics for the last four years show a major increase in the numbers of automatic reviews scheduled, from a low of three to twelve last year and ten this year. The number of requests for review went from a low of 20 to a present high of 67. It does not appear that patients are being formalized more frequently, but that they are being kept longer, resulting in the need for review. There are a number of factors potentially contributing to this phenomenon. Throughout the health care system, the decline in number of hospital beds available and the inclination to keep people in the community as much as possible result in a higher average acuity (level of illness) for patients admitted to hospital. Therefore their need for intensive hospital care and longer term treatment may be increased once admitted.

A clear causative factor, and one of intense concern to the Board, is the decline in availability of resources in the community. This causes acute problems throughout the system for the severely mentally ill. Many of the hospitalizations that occur may well have been prevented if proper care and support had been available in the community. At the other end of the spectrum, when placement is sought in the community for hospitalized patients

ready for gradual reintegration via the group home and/or small option placement setting, severe problems are encountered. This problem was identified and discussed in Board annual reports in 1998-99 and 1999-2000. The issue was also analysed in detail in the review of mental health services in Nova Scotia commissioned by the present government and prepared by Drs. Roger Bland and Brian Dufton, entitled "Mental Health: A Time for Action", released on May 31, 2000. Specifically, the reviewers recommended that the Department of Health develop a housing programme for those with severe and persistent mental illness as well as small regional intensive care residences.

Running parallel to this review, in the spring of 2000 the Nova Scotia Department of Community Services commissioned an independent review of its Community Based Options(CBO) system. The resulting report, entitled, "An Evaluation of the Nova Scotia Community Based Options Community Residential Service System", was prepared by Dr. Michael Kendrick and released in February 2001. It specifically addresses CBOs for persons with mental disorders. The report identifies a pronounced lack of Nova Scotian investment in CBOs in general for a prolonged period of time, and a particular problem for persons with mental disorders caused by the split jurisdiction over community mental health services between the Departments of Community Services and of Health which has persisted for decades. It recommends the creation within two years of a single community system to serve persons with mental disorders. In the interim, the report recommends that a mandated working party established jointly between the two Departments work on implementing this single community system.

To its credit, the Department of Health recently announced the formation of a steering

committee to develop an implementation plan resulting from the Bland/Dufton Report. However, close to a year has passed since the release of the Kendrick Report, yet there has been no evidence of the creation of a single community system, nor even to our knowledge the establishment of a working party by the Departments of Community Services and Health. And the Psychiatric Facilities Review Board has yet to receive a response by the government to its recommendation, repeated now for three years, that this issue be addressed. Meanwhile, the problem intensifies. What will prompt the government to wrestle seriously with this issue?

It should also be noted that the Board has been recommending in the specific instance of two patients in one of the psychiatric units that a long term care facility be established wherein they can receive a high quality of personalized care whilst maintaining their formal status. Both of these individuals suffer from a combination of organic brain disorder and psychiatric illness, and have been institutionalized for their entire adult lives, in one instance for 46 years. They are both maintained on an acute psychiatric care unit in order to keep them close to family and because there is no community facility that will accept them, given their unique needs. It is the understanding of the Board that both the regional hospital where they are presently housed and Mental Health Services support and have developed a detailed plan for the creation of a dedicated facility to provide the best and most humane care possible for these individuals. However, the funds for this project were not allocated in the most recent Health budget. We urge that the government respond by creating this facility.

Other issues fade in comparison to the lack of adequate community resources for those with mental disorder. The government is enjoined to respond to the plea in the

independent reviews of Kendrick and Bland/Dufton and in our series of annual reports.

(b) Appointments to the Board: The ability of the Board to provide quality services to its constituents depends on the ability of persons appointed to the Board to comprehend and be proficient in the specialized nature of its tasks. The Chair in conjunction with the Senior Co-ordinator for Adult Mental Health Services developed a process by which quality appointments would be ensured. This consists of dedicated advertising with qualifications for the position identified, shortlisting, interviewing, and recommending to the Minister those candidates most suitable for appointment. This process was previously described in the Board's 1998-99 Annual Report. At times this process is followed to the letter, and at times it appears to be circumvented. Given the important and onerous responsibilities vested in Board appointees, it is vital that candidates be selected purely on the basis of expertise in the area, and that the process be free from the taint of political interference. The Chair has been advised by the Executive Assistant to the Minister that the present government is interested in high turnover on Agencies, Boards and Commissions to provide the opportunity for large numbers of individuals to serve. While this may be a laudable goal, it should not be given precedence such that it overshadows other important factors of expertise, continuity, and knowledge acquired from service on this specialized Board.

(c) Community Treatment Orders: The Chair of the Board sat on the Advisory Group for the Law Reform Commission for its review of the mental health provisions of the Hospitals Act. Subsequently, the Law Reform Commission released a Discussion Paper recommending numerous revisions to the Hospitals Act. Many of the recommendations are beyond the scope of this Report, but discussion is warranted regarding the Discussion Paper's

tentative endorsement of community treatment orders or leave certificates. These orders provide for the compulsory treatment of a psychiatric patient, who is allowed to live in the community provided that he/she complies with the terms of the order/certificate.

At the operating level, the Board questions the necessity for such orders/certificates. Many of the psychiatric units throughout the province have policies that permit selective gradual degrees of supervised release for the formal patient. In situations where gradual reintegration and testing of one's ability to function without harming oneself or others is desirable and appropriate, the formal patient may leave the institution under supervision for up to three or four days at a time. This permits flexibility without intruding in the longer term on the individual's liberties to which he/she is entitled. While the Nova Scotian government has deemed that in certain circumstances, detention and/or forced treatment of the acutely ill psychiatric patient is in the interests of the individual and/or society, we question the extension of the long arm of the law into the longer term community setting once a patient is released. These orders may be unnecessarily detrimental to the autonomy rights enshrined in the Canadian Charter of Rights and Freedoms.

(d) Provision of Legal Representation at Hearings: The Board has previously recommended that the Legal Aid Commission of Nova Scotia provide counsel for those patients subject to review who meet the requirements on the basis of financial need and who desire legal representation. This would provide a degree of safeguard of the rights of patients. Legal representation for those under civil commitment is routine in a number of provinces, including Ontario. The Hospitals Act already provides that patients be advised of their right to counsel; such right is relatively hollow for most patients, who tend to be impecunious and

can only have legal representation if funded by the Legal Aid Commission.

Conclusion

In this Report, the Psychiatric Facilities Review Board has advised the Legislature of an increase in the number of automatic and requested reviews in the last two years as compared to the previous two. We have attempted to alert those concerned of a serious problem with the lack of resources available in the community, particularly in the area of housing for those with severe mental illness. This problem has been flagged as major not only by the Board in three consecutive annual reports but also in two separate reviews commissioned by the present government. Needless to say, the time for reflection or further review is long gone. It is now, to repeat the subtitle of one of these reviews, "A Time for Action".