Report of the Independent Panel to Review the *Involuntary Psychiatric Treatment Act* and Community Treatment Orders

Submitted July 10, 2013

to the Minister of Health and Wellness, Nova Scotia

Reviewers

Honourable Justice Gérard V La Forest, Chair

William Lahey

Research and Project Director

Leah Hutt

July 10, 2013

Minister David Wilson
Nova Scotia Department of Health and Wellness
Barrington Tower
1894 Barrington Street
PO Box 488
Halifax, NS B3J 2R8

Via Hand-delivery and Email: health.minister@gov.ns.ca

Dear Minister Wilson,

Re Report of the Independent Panel to Review the *Involuntary Psychiatric Treatment Act* and Community Treatment Orders

The Department of Health and Wellness appointed us to conduct the Independent Review pursuant to sections 59 and 84 of the *Involuntary Psychiatric Treatment Act.*

We are pleased to enclose our final Report in fulfillment of the terms of our appointment. Our mandate required us to provide advice to you that is reasonable and able to be implemented within the current fiscal reality on matters related to the objectives and functioning of the Act and the changes that should be made to the Act or associated legislation, or their administration, to improve or strengthen the Act's functioning relative to: its proper objectives, patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives. In our Report we outline the issues relevant to these matters and provide our analysis and conclusions on them. Based on our analysis and conclusions, we make 101 recommendations for the Department's consideration.

The Act contemplates the Independent Review would take place over the course of the full year starting July 3, 2012. As you know, we were appointed in early October. We were not able to start the review in earnest until January 2013, but we have done our best to complete as thorough and as complete a review as we could in the time available to us.

We would be pleased to meet with you to present the Report and answer any questions.

Yours sincerely,

Gérard V. La Forest
Chair

William Lahey

Table of Contents

Acknowledgements.....v

Executive Summary.....vii

Part 1: Background

1. Introduction.....1
   - 1.1. Background.....1
   - 1.2. Overview of Report Structure.....3
2. Process
   - 2.1. Attention to Previous Work.....5
   - 2.2. Engagement of the Nova Scotia Health Research Foundation.....6
   - 2.3. Establishment of the Technical Reference Group.....6
   - 2.4. Documentary Research.....7
   - 2.5. Input Regarding Human Rights Issues.....7
   - 2.6. Public and Stakeholder Consultation
     - 2.6.1. Webpage Materials.....8
     - 2.6.2. Meetings.....9
     - 2.6.3. Public Meetings.....9
     - 2.6.4. Targeted Stakeholder Meetings.....10
     - 2.6.5. District Health Authority Meetings.....11
     - 2.6.6. Focus Groups.....11
   - 2.7. Data Review
     - 2.7.1. Qualitative Data.....12
     - 2.7.2. Quantitative Data.....12

Part 2: Issues, Analysis, Conclusions

1. Introduction.....14
2. Review Under Section 84 16
   - 2.1. Objectives of *IPTA*.....16
     - 2.1.1. Guiding Principles.....17
     - 2.1.2. The Protection of the Rights of Patients Under Involuntary Evaluation, Assessment, and Treatment.....21
     - 2.1.3. Should the Objectives of *IPTA* be Expanded to Address Mental Health More Generally? 25
     - 2.1.4. Should the Objectives of *IPTA* be Expanded to Address Provincial Aspects of *IPTA*'s Implementation? 28
   - 2.2. The Functioning of *IPTA*
     - 2.2.1. Introduction.....33

2.2.2. The Overall Functioning of *IPTA*.....34
2.2.2.1. The Overall Functioning of the Act Relative to Its Objectives.....34
2.2.2.1.1. What We heard from Stakeholders.....34
2.2.2.1.2. What We Learned From the Quantitative Data.....40
2.2.2.1.2.1. Introduction. 40
2.2.2.1.2.2. Available Data.....40
2.2.2.1.2.3. Conclusions on the Data.....43
2.2.2.1.2.4. Conclusions About the Data That Should be Tracked in the Future.....50
2.2.2.1.2.5. Conclusions About the Role of Quantitative Data Tracking in the Functioning of the Act.....51
2.2.2.2. The Overall Functioning of the Act Relative to Patient Well-Being.....53
2.2.2.3. The Overall Functioning of the Act Relative to Applicable Human Rights Principles
2.2.2.3.1. Introduction.....57
2.2.2.3.2. The *Charter of Rights and Freedoms*.....58
2.2.2.3.2.1. Section 7 of the *Charter of Rights and Freedoms*.....59
2.2.2.3.2.2. Section 15 of the *Charter of Rights and Freedoms*.....63
2.2.2.3.2.3. Section 1 of the *Charter of Rights and Freedoms*.....65
2.2.2.3.3. The *Convention on the Rights of Persons with Disabilities*.....66
2.2.2.3.4. The Functioning of the Review Board.....69
2.2.2.3.4.1. Administrative Functioning.....70
2.2.2.3.4.2. The Board's Adjudicative Process.....73
2.2.2.3.5. Other Legislation Affecting Persons with Mental Illness.....75
2.2.2.4. The Overall Functioning of the Act Relative to the Importance of Mental Health and the Mental Health System.....76
2.2.2.5. The Overall Functioning of the Act Relative to Nova Scotia's Mental Health Policy Objectives as Articulated in Nova Scotia's Mental Health and Addictions Strategy.....78
2.2.3. The Functioning of Specific Sections or of Related Sections
2.2.3.1. Introduction.....81
2.2.3.2. The Title of the Act.....81
2.2.3.3. Section 3: Interpretation
2.2.3.3.1. Overview.....82
2.2.3.3.2. Issues.....83
2.2.3.3.3. Conclusions.....83
2.2.3.4. Section 4-7: Voluntary Admission
2.2.3.4.1. Overview.....84
2.2.3.4.2. Issues.....84
2.2.3.4.3. Conclusions.....85
2.2.3.5. Section 8-16: Medical Examination and Involuntary Psychiatric Assessment
2.2.3.5.1. Overview.....86

2.2.3.5.2. Issues ……..88
2.2.3.5.3. Conclusions……91
2.2.3.6. Section 13: Judicial Order for Examination
2.2.3.6.1. Overview……93
2.2.3.6.2. Issues……94
2.2.3.6.3. Conclusions……95
2.2.3.7. Section 14: Powers and Responsibilities of Police
2.2.3.7.1. Overview……95
2.2.3.7.2. Issues……96
2.2.3.7.3. Conclusions……97
2.2.3.8. Sections 38-42: Substitute Decision-Making
2.2.3.8.1. Overview……98
2.2.3.8.2. Issues……98
2.2.3.8.3. Conclusions……100
2.2.3.9. Section 43-46: Certificates of Leave
2.2.3.9.1. Overview……101
2.2.3.9.2. Issues……102
2.2.3.9.3. Conclusions……102
2.2.3.10. Sections 60-64: Patient Advisor Service and Patient Rights
2.2.3.10.1. Overview……102
2.2.3.10.2. Issues……103
2.2.3.10.3. Conclusions……104
2.2.3.11. Section 82(1): Privacy and Confidentiality
2.2.3.11.1. Overview……105
2.2.3.11.2. Issues……106
2.2.3.11.3. Conclusions……108
2.2.3.12. The Forms
2.2.3.12.1. Overview……109
2.2.3.12.2. Issues……110
2.2.3.12.3. Conclusions……110
2.3. Future Reviews of *IPTA*……111
3. Review of the Functioning of *IPTA* Under Section 59 (Community Treatment Orders)
3.1. Introduction……113
3.2. Section 59 of *IPTA*……114
3.3. The Objectives of *IPTA* Relative to CTOs……114
3.4. Use of CTOs……117
3.5. Effectiveness of CTOs……118
3.6. Methods Used to Evaluate the Outcome of Treatment Under CTOs……122
3.7. Other Issues Relating to CTOs……124

Part 3: Recommendations

1. Introduction……129
2. Recommendations Pertaining to the Objectives of *IPTA*……129
   - 2.1. Recommendations on Guiding Principles……129
   - 2.2. Recommendations on Rights of Patients under Involuntary Evaluation, Assessment, and Treatment……130
   - 2.3. Recommendations on the Expansion of *IPTA* to Deal with Mental Health More Generally……130
3. Recommendations Pertaining to the Functioning of *IPTA*……131
   - 3.1. Recommendations Relating to the Overall Functioning of the Act……131
     - 3.1.1. Recommendations on Overall Functioning of the Act Relative to Patient Well-Being……134
     - 3.1.2. Recommendations on the Overall Functioning of the Act Relative to Applicable Human Rights Principles……136
     - 3.1.3. Recommendations on the Overall Functioning of the Act Relative to the Mental Health System……140
   - 3.2. Recommendations Relating to Specific Sections or to Related Sections……141
     - 3.2.1. Recommendations on the Title of the Act……141
     - 3.2.2. Recommendations on Interpretation……141
     - 3.2.3. Recommendations on Voluntary Patients……141
     - 3.2.4. Recommendations on Medical Examination and Involuntary Psychiatric Assessment……141
     - 3.2.5. Recommendations on Judicial Orders for Examination……143
     - 3.2.6. Recommendations on Powers and Responsibilities of Police……143
     - 3.2.7. Recommendations on Substitute Decision-Makers……144
     - 3.2.8. Recommendations on Certificates of Leave……145
     - 3.2.9. Recommendations on Patient Advisor Service and Patient Rights……145
     - 3.2.10. Recommendations on Privacy and Confidentiality……146
     - 3.2.11. Recommendation on Forms……146
4. Recommendations on Future Reviews……146
5. Recommendations on Functioning of *IPTA* Under Section 59 (Community Treatment Orders)……147

Selected References……149

Appendices

Acknowledgments

It has been an honour to have the opportunity to conduct this review and to contribute to the continuing process of improving mental health legislation and mental health in Nova Scotia. We would like to begin these acknowledgements by thanking Minister David Wilson and Deputy Minister Kevin McNamara for that opportunity and for their support and the support of the Department of Health and Wellness throughout the process.

We were very fortunate to have been assisted in the process by our Research and Project Director, Leah Hutt. We simply could not have completed the review in the time-frame set for the work without Leah's incredibly efficient management of the process. She was instrumental to the production of our consultation documents, to the planning of our consultations, and to our research efforts. The very positive and constructive discussions we had with over 350 Nova Scotians are due to Leah's organizational skills as well as to her considerable interpersonal skills. Her wise counsel, broad knowledge of health law, and insightfulness are reflected on every page of this Report, although we, of course, are solely responsible for whatever we may have got wrong. Above all, we benefited day in and day out from Leah's unwavering commitment to, and enthusiasm for the work and her optimistic disposition.

Along with Leah, Professor Elaine Gibson supported Justice La Forest in providing advice to the Department on the process for conducting the review, advice that was largely accepted by the Department and incorporated into our mandate. The process proved effective and efficient in identifying the issues requiring our consideration and the range of ideas available across Nova Scotia for improving *IPTA* and its functioning. This is due in no small measure to the sound advice provided by Professor Gibson in the earlier stage of the work.

In the process, we heard from many of Nova Scotia's experts in mental health, particularly as it relates to mental health legislation. We acknowledge the contribution of all of these experts, some of whom work in universities and hospitals, while others have the expertise of lived experience. In the latter connection, we want to acknowledge our deep indebtedness and gratitude to those who taught us from First Voice and family member perspectives what *IPTA* means to those who live with mental illness in Nova Scotia.

From among the experts who helped us, we want to particularly acknowledge the contributions of Professor Hugh Kindred of the Schulich School of Law, Dalhousie University, and of Professor Peter Carver of the Faculty of Law, University of Alberta. By helping us put what we were reading and hearing about the human rights dimensions of *IPTA* into the broader context of International and Canadian constitutional law, they admirably compensated for the larger staff we sometimes wished we had to thoroughly review the complex and contentious issues that mental health legislation raises.

The mental health directors of Nova Scotia's ten health districts were, without exception, warm and gracious hosts as we travelled around the province seeking the views of Nova Scotians. We are also grateful to them for the advice they provided to us and for the advice we received from those they invited to the meetings they arranged on our behalf with patients, families, doctors, mental health

professionals, police, and other community partners. Without exaggeration, we could not have completed this Report without this series of meetings and what it taught us. The same goes for the assistance and input we received from our Technical Reference Group.

We acknowledge the staff of the Department of Health and Wellness for their responsiveness to every request we made to them for administrative assistance during the process. Lynn Cheek and Dean Hirtle were very accommodating project patrons. Dean's predecessor, Dennis Holland, expertly steered the planning for the review through its developmental stages before leaving the Department in 2012. We want to particularly acknowledge and thank Ken Scott, Director of Mental Health, and Maureen Aucoin, Manager of Business Intelligence and Analytics. Both went beyond what any job description could require in doing what they could do to ensure our work was supported.

Nancy Carter of the Nova Scotia Health Research Foundation was a superb collaborator in helping us get the most of the hundreds of pages of notes we took from our meetings with Nova Scotians. Wayne Marsh helped us organize and expertly facilitated two focus groups that were very helpful in testing our sense of what we had heard in our consultation process. We owe our thanks to Victoria Apold, for her research assistance in putting *IPTA* into the context of the debates that took place when it was proposed in 2004 and the various reports and documents that have been produced in Nova Scotia or in Canada in recent years on mental health legislation. We also owe our thanks to the three law students, all studying at the Schulich School of Law, who helped with information gathering and sundry other important tasks as we approached the end of our mandate: David Dhillon, Noelle Yhard, and Emma Baasch. Emma's additional contribution in assisting us with the production of a large and complex report requires particular acknowledgement, as it was absolutely essential to the completion of our mandate.

Executive Summary

Introduction

The *Involuntary Psychiatric Treatment Act* (*IPTA*) is a critical piece of legislation for individuals with mental illness and their families, as well as health care, judicial, and law enforcement professionals. It governs the provision of psychiatric treatment on an involuntary basis and voluntary treatment, when in hospital.

The legislation, in force since July 2, 2007, requires a review of both the Act in its entirety and under section 59, which pertains specifically to community treatment orders (CTOs). This Report provides both. It encompasses a review of the:

(1) direct functioning of the legislative provisions;

(2) contextual factors that may affect the operation of the Act; and

(3) impact of significant developments in provincial, national and international law and policy as related to mental health.

The broad mandate of this review was to provide advice to the Minister of Health and Wellness on the objectives of *IPTA*, on whether the legislation is meeting its appropriate objectives, and on whether amendments should be made to the Act or associated legislation or whether administrative changes are required to *IPTA* or related legislation.

This Report does that. It is important, however, to understand the context in which the 101 recommendations in this Report are being made. There are four important foundations.

First, by a significant margin, most of those who participated in the review spoke positively about *IPTA*, its objectives, and its importance. This view was expressed with particular conviction by the family members of those who have been treated under the Act, many of who favourably compared their experiences under *IPTA* with their experience under the provisions of the *Hospitals Act* that *IPTA* replaced.

Not everyone supported the legislation. Some First Voice participants raised fundamental objections to involuntary psychiatric treatment and expressed deep concerns about the pervasive vulnerability they feel once diagnosed with a mental illness that can result in involuntary treatment. We are respectful of those concerns.

We also heard from others, including experts in mental health law, who feel strongly that the legislation is wrong in principle because of its almost exclusive focus on involuntary psychiatric treatment and because of the breadth of authority it provides for that kind of treatment. In addition, it has always to be kept in mind that *IPTA* deals with the rights of the individual that our society has recognized as our fundamental rights. As the mandate of this review recognized, such legislation must conform to those rights independently of whether or not the majority of people who choose to participate in a review process think it is beneficial legislation.

Yet overall, what we heard about *IPTA* was strongly positive. This leads us to conclude that stakeholders want the conversation on mental health legislation to move forward by concentrating on making the legislation better, not by revisiting the debates that took place when it was proposed. This is what we have tried to do in writing this Report.

Second, we also learned from our consultations that it takes the health care system time to adjust to new mental health legislation. Indeed, we learned that this process of adjustment continues and that it is at variable stages across the district health authorities. This may be because the implementation of *IPTA* has not been given sufficient priority: accordingly, we make specific recommendations to address that possibility. But we think it also reflects the inherent complications of transitioning a complex integrated system of care from one legislative framework to another. This is an additional reason to focus attention on the things that can be done to improve *IPTA* and its operation, rather than on reconsideration of the debates that took place in the past.

Third, the approach that *IPTA* takes to involuntary psychiatric treatment is highly consistent with the approach taken in mental health legislation in most of Canada. This approach is commonly called the human needs approach to mental health legislation because of its emphasis on the benefits that involuntary psychiatric treatment can provide. It is an approach that is sharply criticized by those who think that the purpose of legislation in this area is to protect people against unwarranted involuntary treatment. Nevertheless, it has become the predominant approach in Canada and in many comparable countries. Moreover, for those who favour the human needs approach, one of the strengths of *IPTA* is the level of concern and protection it provides to individual rights.

Fourth, legislation built on a human needs model is necessarily legislation that places greater confidence and trust in physician decision-making. This is because it defines physician authority in broader and more discretionary terms than legislation written on other models. In our view, the protections against abuse and inconsistency that are built into all legislation that authorizes involuntary treatment become all the more important under such legislation. Indeed, we think such legislation calls for more than protection of individual rights and equal treatment through after-the-fact review of individual decisions. It calls for proactive, preventive measures of a systemic nature to ensure that the legislation is interpreted and applied in a consistent fashion within defensible parameters.

Review Under Section 84

Objectives of *IPTA*

At a high level, the objectives of *IPTA* are unmistakable: unlike mental health legislation in other provinces, the Act is exclusively concerned with psychiatric treatment and primarily with involuntary psychiatric treatment. Beyond that, the objectives as regards psychiatric treatment become debatable.

Some would say that the objectives are to enable involuntary psychiatric treatment at the expense of the liberty and autonomy of people with mental illness. They point to the breadth of the harm criterion for involuntary admission found in *IPTA* compared to the harm criteria of the provisions in the *Hospitals* Act. They point to the addition to the criteria for involuntary admission of the "serious deterioration"

criterion. They also point to the introduction of community treatment orders and certificates of leave, under which *IPTA* authorizes involuntary psychiatric treatment outside of hospitals.

Others contend that the objectives of *IPTA* are to combine access to involuntary treatment with protection of individual rights. They point to the exclusion from involuntary admission under *IPTA* of those who have capacity and those who would not benefit from psychiatric treatment. They also point to section 2 of the Act, which says that the purpose of *IPTA* is to ensure that issues dealing with mental health are dealt with in accordance with eight guiding principles, all of which encompass aspects of respect for individual rights. They might also point to the patient advisor service that *IPTA* authorized and that has been established. They also stress the positive contributions that involuntary psychiatric treatment provided under the Act can make to the lives of those who receive it.

The first interpretation of the objectives of *IPTA* would be consistent with an understanding that the purpose of legislation on psychiatric treatment should be to protect people from being subjected to such treatment to the greatest extent possible. The second interpretation would correspond to the human needs understanding of the purpose of such legislation, which places greater emphasis on the benefits involuntary psychiatric treatment can provide to those who are determined to need it.

In our view, it is the second interpretation of the objectives of *IPTA* that best accords with the provisions of the Act. It also accords with the explanation of the policy objectives of the Act that were given when it was considered in the House of Assembly. It accords as well with the understanding of the objectives articulated in this review by the majority of those who participated. It follows that the overall objective of *IPTA* is to institute a version of the human needs approach to the law on involuntary psychiatric treatment in Nova Scotia.

So understood, it was clear to us that the current objectives of *IPTA* were overwhelmingly supported by those who participated in the review. It was also clear to us that the major provisions of *IPTA* are closely and directly related to its objectives. A significant change to the major provisions of the Act would require a complete rethinking of the basic core objectives. Although this review has identified a rationale for a number of significant amendments, it has not revealed a rationale for legislative restructuring on that scale. We would also be concerned that the resources required for such an undertaking and the associated adjustments it would necessitate in the mental health system could be better utilized by ensuring that good care is provided and individual rights are protected under the legislative framework now provided by *IPTA*.

Guiding Principles

Section 2 directly addresses the objectives and purpose of the Act: to ensure that issues dealing with mental health are dealt with in accordance with eight guiding principles. Those principles are:

(a) persons of all ages with mental disorders are entitled to be treated with dignity and respect;

(b) each person has the right to make treatment decisions to the extent of the person's capacity to do so;

(c) treatment and related services are to be offered in the least-restrictive manner and environment with the goal of having the person continue to live in the community or return to the person's home surroundings at the earliest possible time;

(d) the primary mode of admission to a psychiatric facility shall be as a voluntary patient wherever possible;

(e) treatment and related services, where possible, should promote the person's self-determination and self-reliance;

(f) the person has the right to a treatment plan that maximizes the person's potential and is based on the principles of evidence-based best practice;

(g) persons with mental disorders should have access to mental health services as close to the person's home as practicable; and

(h) any declaration of involuntary admission or declaration of incapacity is made on the basis of evidence.

The guiding principles call for a patient-centred approach that includes a strong emphasis on patient rights. Overall, they emphasize that involuntary treatment is to be the exception.

More is required, however. In our view, the guiding principles should be expanded to include a statement on cultural safety and one on equality between people with mental and physical health issues and between people with different mental health issues. We also agree that the *Convention on the Rights of Persons with Disabilities* should be referenced in the Act*,* but recommend that this be done in a separate provision confirming that *IPTA* is to be read and applied consistently with Canada's accepted obligations under the Convention.

There are two other changes of a more specific nature that we propose for section 2. The first relates to the opening language. We recommend it be rewritten to read: "The purpose of the Act is to ensure that issues dealing with mental health, *including the interpretation and administration of this Act*, are dealt with in accordance with the following guiding principles." The second specific change relates to the final guiding principle. We recommend it should read: "*Any certificate for involuntary psychiatric assessment*, declaration of involuntary admission, declaration of incapacity *or community treatment order*, is made on the basis of evidence."

Protection of the Rights of Patients Under Involuntary Evaluation, Assessment, and Treatment

Much of the focus in debates on legislation that authorizes involuntary psychiatric treatment is on the criteria and processes that are prescribed for evaluating, assessing, and treating patients involuntarily. In other words, the debate often focuses on how the legislation protects the right of the patient not to be subject to involuntary evaluation, assessment, and treatment.

Legislation such as *IPTA* also typically provides protection to a closely related but distinct set of patient rights: those to be treated properly during the process of involuntary evaluation, assessment, admission, and treatment. We heard, however, that *IPTA* was not as strong or as clear in offering protection to these rights as it should be.

We are in general agreement that the objectives of *IPTA* should be amended to provide additional explicit protection to the rights of patients who are being involuntarily evaluated, assessed, admitted, or treated under the Act.

We are also influenced by several other considerations. Legislative protection for these kinds of patient rights is common in Canadian mental health legislation. Such protection would not be in tension with the larger objectives of *IPTA*. Indeed, it would advance these objectives. Finally, greater legislative protection for the rights of patients in care would not be a new thing in Nova Scotia: the provisions of the *Hospitals Act* that *IPTA* replaced gave more explicit protection than *IPTA* does to a number of in-patient rights.

Should the Objectives of *IPTA* be Expanded to Address Mental Health More Generally?

Some submitted that Nova Scotia should have legislation that is broader than *IPTA* to address mental health more generally. The issues that might be addressed in broader mental health legislation, such as access to the broader spectrum of mental health services and the broader social determinants of mental health, were of significant concern for many who participated in the review, even if they did not connect these issues to broader mental health legislation. Some linked certain of these issues to Nova Scotia's Mental Health Strategy, "Together We Can," which the review was mandated to consider. Most participants were optimistic about what the strategy might accomplish, particularly in light of the steps that have already been taken. There was, however, scepticism expressed as to whether the strategy would be fully and effectively implemented in the longer term.

We have not heard enough in this review nor had sufficient opportunity to research the issue to provide firm advice on the question of whether Nova Scotia should have a broader legislative framework on mental health than is provided by *IPTA*. We have, however, heard enough to conclude that the question should be explored in more depth. We put it this way: the objectives of *IPTA* are suitable for what *IPTA* does, but there is a question as to whether they are sufficient for the broader mental health system within which *IPTA* operates.

We conclude that a possible approach would be broader mental health legislation that complements *IPTA* and the *Health Authorities Act* by providing a statutory framework for mental health planning at the provincial level, building on the release of Nova Scotia's first mental health and addictions care strategy in 2012. We recommend that Nova Scotia consider the adoption of a "Mental Health and Addictions Care Planning Act" and outline some of its potential functions, elements, and benefits.

Should the Objectives Address the Provincial Aspects of *IPTA*'s Implementation?

Like other legislation of its kind, *IPTA* is largely legislation about a process of individualised clinical decision-making. It is legislation that is primarily implemented through decision-making by doctors and in particular by doctors who work in emergency rooms and psychiatrists who work in the mental health units of hospitals.

We understand that physicians carry out their roles under *IPTA* in a broader institutional context as members of multi-disciplinary mental health care teams. Their work is subject to a broad range of contextual factors, including the resources made available to mental health within the priorities of the broader health care system and the chosen approach of each district to mental health program design and delivery.

Yet overall, *IPTA* says very little about the broader system of psychiatric care within which individual physicians carry out the roles that only they can play. In particular, there is very little in the Act about the broader administrative and governance responsibilities of the Department of Health and Wellness in relation to the overall functioning of the Act across the province.

Based on the totality of what we have heard about the functioning of *IPTA*, we think that the silence of the Act in these broader respects is problematic. Although each district must be responsible for implementing *IPTA*, the implementation of *IPTA* cannot be left to each district. This is, however, what *IPTA*, as currently written, implies.

Throughout this Report we reach a number of conclusions and make associated recommendations about the broad areas of responsibility we think *IPTA* should assign to the Department of Health and Wellness. We do not do so because we have found that there are things that the Department should have been doing under *IPTA* that it has not done. Instead, we do so because we find that *IPTA* does not currently provide a statutory framework for the work that has to be done at the system level if *IPTA* is to be optimally implemented at the district level and for each patient and family. While many of these responsibilities or functions are responsibilities or functions that could be carried out without explicit legislative authority, some are not. Moreover, we have concluded that authority to carry them out should be added to the Act so that everyone, including the Department, has a clear expectation from this point on that the Department has a critical role to play in system leadership.

In our view, a shift in this direction is particularly appropriate under legislation built, as *IPTA* is, on the human needs approach to legislation on involuntary treatment for mental illness. As mentioned above, the hallmark of such legislation is the greater weight it places on the need of certain patients for treatment and the benefits treatment can provide. The mechanism is criteria for involuntary admission and treatment, which give broader clinical discretion to physicians than legislation on other models. The system must accept responsibility for ensuring this broader authority is consistently used to benefit patients in ways that protects individual rights.

The Functioning of *IPTA*

The Overall Functioning of *IPTA*

What We Learned from Stakeholders

Most participants in the review were positive or largely positive about the effectiveness of *IPTA* in meeting its broad objectives. Although there were dissenting views strongly expressed to us, the general view was that the Act enabled psychiatrists and, therefore, the health care system to be

responsive to the care needs of individuals who were unable, due to their illness, to understand or appreciate their need for care.

Concerns were expressed that *IPTA* was being applied too infrequently and concerns expressed that it is open to being applied too frequently. Based on what we heard, the concern that we have is one of potential inconsistency in how the Act is interpreted and applied. In other words, we are concerned that differences in interpretation may be causing too much variation in how the Act is being applied to similarly situated persons.

Differences among stakeholders' understandings of *IPTA*, including those who work in mental health, were manifested in our consultations. Some of these differences related to the understanding of key substantive concepts, such as deterioration, which are open to different interpretations. But others related to more mechanical issues on which common understanding should be easier to achieve, such as whether an involuntary psychiatric assessment can be performed in a hospital that does not have an in-patient psychiatric unit.

Legislation such as *IPTA* should be guided in its administration by a comprehensive and continuous effort to ensure that it is interpreted and applied within acceptable parameters. Although the Review Board plays a critical role in this regard, other mechanisms of a more proactive and systemic nature are also available. Because the stakes are so high for all concerned in decision-making under *IPTA*, greater use should be made of these additional tools. This includes on-going education about the Act and training where appropriate for providers, health administrators, police, judges, partners in the community services sector, substitute decision-makers, patients, and the broader public. Of particular importance is the need for decision-support tools, monitoring, and evaluation to ensure key concepts, such as risk of serious deterioration and capacity, are consistently understood and applied across the province.

To enable and facilitate these and other changes, the Act should be amended to define more explicitly and extensively the mandate of the Minister of Health and Wellness with respect to the overall functioning of the legislation. This provision needs to be written in alignment with the division of functions and responsibilities between the Minister and the district health authorities as set out in the *Health Authorities Act*.

What We Learned From the Quantitative Data

Based on the quantitative data at our disposal and the time we had to devote to its analysis, we offer the following conclusions on the functioning of *IPTA*. Additional conclusions are included in the full Report.

1. In any given year, there are between 2,400 and 2,800 people receiving mental health care on an inpatient basis in Nova Scotia hospitals. The number of involuntary admissions, including admissions for the purpose of involuntary assessment, is between 1,000 and 1,300 in any given year.

2. The data suggests the level of involuntary admission has increased significantly under *IPTA* while the number of in-patients remained relatively stable. In 2006, the last full year of the operation of the *Hospitals Act* provisions on mental health, there were 885 patients held for observation. Of these, there were 373 admissions for up to one month or longer. In comparison, in 2008, the first full year of *IPTA*'s operation, there were 1,076 involuntary psychiatric assessments. These resulted in 800 involuntary admissions for up to one month or longer.

3. The data indicates that the operation of *IPTA* has been fairly stable and consistent on all key metrics from 2008 through to and including 2011, both at a provincial and district health authority level.

4. The data reveals variation between districts on key metrics such as percentage of assessed patients who are involuntarily admitted, percentage of patients admitted as voluntary or as involuntary, median length of in-patient stay, and median number of days spent as a voluntary or involuntary patient for patients who spent days in hospital as both a voluntary and involuntary patient.

5. The identified variations between districts may be consistent with what we heard from some stakeholders about unwarranted differences in practice patterns. The variation among districts warrants inquiry to determine what the causes are and specifically to determine if they reflect differences in practice that should be addressed. The variations, therefore, illustrate the role that continuous monitoring of data on the operation of the Act could play in ensuring that the Act is being interpreted and applied within acceptable parameters.

Conclusions About the Data that Should be Tracked in the Future

Our analysis suggests that there is information relevant to understanding the functioning of the Act not currently being tracked in a systematic way. Although our analysis has indicated some of the additional information that may be worth tracking, we are not confident that we have identified all of the additional information that might be worth capturing. Our main conclusion on future data tracking is, therefore, that the Department of Health and Wellness and district health authorities sit down and take stock of the information that is currently being tracked and identify the other information that it would be useful and feasible to capture. In addition, we identify a number of the metrics we think should be tracked, including data about the timing of changes in patient status relative to Review Board hearings and other requirements of the Act; potential causal relationships between the 72-hour involuntary psychiatric assessment period and percentage of involuntary admissions; the extent to which the harm criterion and the deterioration criterion are each used; and exercise of police authority under the Act.

Conclusions About the Role of Quantitative Data Tracking in the Functioning of the Act

If quantitative data is to play a role in improving the functioning of *IPTA*, data must not only be tracked but also applied.

For this to happen, the information that is tracked needs to be put into the hands of those who have direct responsibility for implementing the legislation. Our consultations with stakeholders suggests that

the information that the Department has may not be getting into the hands of district health authorities as frequently or in a form that is useful to district health authorities.

Further, our impression is that the Department and the districts are not communicating enough about the data and what it signifies. If this impression is correct, it may be because the information is not being collected or organized in an information system that lends itself to this kind of on-going sharing and dialogue. Whatever the barriers, they should be addressed so that the data which the Department tracks, including the additional data it tracks in the future, can be more seamlessly shared and frequently discussed with the districts so that it can inform decision-making at both the district and system levels. This may require a move towards a provincial mental health information system.

IPTA should make it clear that the Department of Health and Wellness is responsible for both tracking relevant data on the functioning of the Act and also for analysing it on a continuing basis to identify patterns or trends that may warrant inquiry and require deeper analysis. The Act should also give the Department the clear authority to make such inquiries or to make sure that they are made.

Publication of more of the data that is available would enable stakeholders to have more informed discussions about the functioning of the Act, which would in turn improve the functioning of the Act. Unlike data provided to us, the published data (as well as the data shared with districts) should, wherever possible, be in a format that facilitates interpretation, including graphs showing trends over time.

Functioning Relative to Patient Well-Being

The functioning of *IPTA* relative to patient well-being ultimately depends on the contributions that the treatments provided under the Act make to patient well-being. The psychiatric therapy provided under *IPTA* consists largely of the injection of psychotropic medications. There is deep disagreement among experts on mental health legislation about the contribution this kind of treatment makes to the well-being of patients.

We limit ourselves in this Report to evaluating the functioning of *IPTA* relative to patient well-being on the premise that appropriate treatment for certain mental illnesses includes psychotropic medications that must be sometimes taken involuntarily if they are to be taken. The question is whether *IPTA* and the process of implementing *IPTA* are putting this premise into effect to maximize patient well-being and to minimize the harm that coercive treatment with psychotropic medications has the potential to inflict. What we heard leads us to give, with important qualifications, a generally positive answer to this question.

Overall, we came away from our consultations with stakeholders with a positive view of the changes taking place in policing relative to its role in mental health and in the relationship between the mental health system and policing relative to how they serve mental health patients better by working together.

We also heard that positive change has happened and continues with respect to the patient experience in the hospital. Many of the family members of persons treated under the Act who shared negative experiences in getting their loved one admitted were very positive about the care their loved one received once in hospital and about the positive difference it had made. In particular, we were encouraged by the confidence that we heard over and over again about the opportunities that exist for making things better for patients.

Numerous concerns related to patient well-being are discussed in more detail in the full Report. The issue of emergency room waiting times and waiting in emergency rooms under police guard was frequently mentioned. Another concern was the limited extent to which pharmacological therapy was complimented by other kinds of therapy. There were concerns strongly raised by First Voice about the adverse consequences that can flow from a determination that a person with mental illness lacks capacity. A frequently recurring theme was the need to educate providers throughout the health care system about mental health and caring for patients with mental illness. More specifically, it was stressed during our consultations that people who work in mental health are not immune to stigmatizing attitudes and behaviours.

Functioning Relative to Human Rights Principles

The objectives of *IPTA* are to balance protection of human rights, including the right to refuse medical care, with the authority to treat involuntarily. It does so within the framework of the human needs approach to legislation on involuntary psychiatric treatment. It gives wider latitude than legislation on other models does to psychiatrists to determine the patients who require involuntary hospitalization and treatment.

It is important to distinguish between human rights arguments that are about the legality of legislation and human rights arguments that are about whether a legislature has made the right policy choices relative to human rights. Because our human rights are ultimately protected in the *Canadian Charter of Rights and Freedoms*, one can get the impression that what is at stake in the debate over the human needs model is the constitutionality of the model itself. In our view, the courts are unlikely to go so far in prescribing how governments are to legislate in this difficult and complex area. Moreover, in our view, the law of human rights does not suggest that the human needs approach is unconstitutional.

The debate becomes a legal debate where the question becomes the constitutionality of the specific legislative provisions that are used to bring the human needs model or approach into effect in a particular jurisdiction. At that level, we think that *IPTA* is generally compliant with applicable human rights laws.

We also think that the law of human rights raises serious concern about the constitutionality of two of the provisions found in *IPTA.* One of these is section 18, which applies a different test for capacity to *IPTA* patients as compared to patients under the *Hospitals Act*. The other is section 39, which sets out the circumstances in which and the basis upon which substitute decision-makers are required to disregard a patient's prior capable informed expressed wishes. We conclude that both provisions should be reconsidered on human rights policy grounds, because of their potential to stigmatize and reinforce

prejudice against people with mental illness. We also believe that both provisions are vulnerable under section 7 of the *Charter*, which guards against deprivations of liberty and security of the person except in accordance with principles of fundamental justice, and under section 15 of the *Charter*, which guarantees equality on the basis of mental disability. The section 15 concerns are reinforced by the United Nations *Convention on the Rights of Person with Disabilities*.

It is also important to emphasize that the implications of *IPTA* for human rights depends very much on how it is implemented. In that respect, we believe that the various recommendations we make to ensure the Act is more consistently interpreted in accordance with more standardised processes, and better developed understandings of the meaning of key concepts, will help to ensure appropriate concern for human rights is strongly integrated into the functioning of the Act.

The Review Board established under *IPTA* plays an essential role in ensuring that the operation of the Act accords with applicable human rights principles. No aspect of the functioning of the Act caused us greater concern than what we learned about the functioning of the Review Board. We make a number of very specific recommendations on how the problems can be addressed, including through necessary problem-solving dialogue among the key players. But our core recommendation is that the problems identified with the administrative functioning of the Review Board should be addressed as an immediate priority.

Functioning Relative to the Mental Health System

The functioning of *IPTA* is obviously a very important part of Nova Scotia's mental health system. It was also clear to us that the mental health system is not the mental health *care* system. It includes all of the institutions, processes, and systems that either contribute to or detract from the mental health of Nova Scotians. Obvious examples are the economy, families, and local communities, the broader health care system, the education system, the community services system, and the policing and justice systems.

In general terms, the importance of mental health and of the mental health system are relevant to the functioning of *IPTA* in three broad ways:

- They are important variables in determining the number of people with mental illness and the number of those who eventually become patients under *IPTA*;
- They determine the resources that are available to care for those receiving treatment under *IPTA*; and
- They have a great deal to do with the recovery, or lack of recovery, of the same patients after they have been treated under *IPTA*.

We heard about progress being made on each of these fronts during this review process. But the overriding messages were that not enough is being done in a proactive and integrated fashion at the prevention stage, the treatment stage, or the recovery stage to improve the lives of those living with mental illness. In this respect, Nova Scotia is not alone; mental health is comparatively underfunded throughout Canada relative to other kinds of health.

In this context, we conclude that a broader legislative framework for mental health and the broader mental health system could play a role. It may be part of what is needed to help to ensure there is broad, coordinated, and sustained effort to build on the progress being made, including under the mental health and addictions care strategy, "Together We Can."

Specifically, a Mental Health and Addictions Care Planning Act could ensure that Nova Scotia law places equal emphasis on the positive determinants and enablers of mental health as it does on involuntary hospitalization and treatment. Second, it could create a legislative framework for institutionalizing the collaboration that is currently going on between the parts of the mental health system that work under the jurisdiction of different ministers and under legislation that is inhibiting rather than enabling of collaboration and coordinated action. Third, it could help Nova Scotia become one of the provinces that leads the way in redressing the imbalance that has long existed across Canada between the priority attached to mental health compared to physical health.

We also heard enough to conclude that the functioning of *IPTA* is inhibited closer to home by the way in which the acute care portion of mental health is organized and operated. In this review, we heard many positive things about how the districts work together to do what is right for patients and to share resources, experience, and knowledge. But we also heard about the frictions and difficulties they face in collaborating and the burden this can sometimes impose on patients, as well as on families and others. The difference in available resources between large and small districts and between Capital and the rest was often mentioned. More generally, we heard a concern about how the system works in resolving issues that can only be addressed at the system level, such as the transfer of patients between districts and to and from metro when more specialized service is needed.

We do not have the expertise or all the information that would be needed to provide specific advice on how these and similar issues should be addressed. There are some relatively simple things that can be done, however, and some of these are identified in the full Report.

Deeper solutions may require a more basic rethinking of how the acute care part of mental health is configured and governed. This Report contains many recommendations of a directional nature as to how this could be done. Their common theme is that the implementation of the Act should become more of a robustly coordinated provincial effort that is facilitated and led by the Department of Health and Wellness.

Functioning in Relation to Nova Scotia's Mental Health Policy Objectives

We consider the functioning of *IPTA* relative to Nova Scotia's mental health objectives, as articulated in "Together We Can – The plan to improve mental health and addictions care for Nova Scotians," from two perspectives: from the perspective of how the objectives of Nova Scotia's mental health strategy could improve the functioning of *IPTA* and from the perspective of how the better functioning of *IPTA* could contribute to achievement of the objectives of the strategy.

We conclude that many of the priorities laid out in the strategy address improvements in the broader mental health system that will improve the functioning of *IPTA* as they are realized. The strategy

prioritizes early intervention and prevention, reducing waiting times, better planning in acute mental health care, stronger information systems, more collaboration between government departments, and reducing stigma. Progress in the implementation of these priorities could improve the functioning of *IPTA* directly, for example by reducing waiting times, or indirectly, for example by improving access to services and supports that prevent acute mental illness of recovery from it.

We also conclude that improvements in the functioning of *IPTA* could contribute to the achievement of the strategy's policy objectives. For example, we point out that expanding *IPTA*'s guiding principles to include cultural safety and equality will contribute to the strategy's concern for the unique needs, traditions, and ways of First Nations and diverse communities. We point out that elimination from *IPTA* of provisions that may contribute to stigmatization and prejudice against persons with mental illness and that may be vulnerable to challenge under human rights law, will contribute to the reduction of stigma against people with mental illness, as envisaged by the strategy. As another example, we point out that the goal of the strategy to make access more timely and easier regardless of where people live and to make "every door the right door" will benefit from the range of province-wide initiatives we recommend to support the effective implementation of *IPTA* at the local level.

Functioning of Specific Sections of *IPTA*

As part of this review, we looked closely at specific sections of *IPTA* to understand their intent, functioning, and implementation, and the issues that arise from these elements. The sections reviewed are:

- Voluntary Admission
- Medical Examination and Involuntary Psychiatric Assessment
- Judicial Order for Examination
- Powers and Responsibilities of Police
- Substitute Decision-Making
- Certificates of Leave
- Patient Advisor Service and Patient Rights
- Privacy and Confidentiality

The full Report includes an overview of the findings and relevant issues as well as our conclusions. Here we wish to present information on two of these sections: one is voluntary admission and the other is medical examination and involuntary psychiatric assessment.

VOLUNTARY ADMISSION

Under *IPTA*, individuals may be admitted to a psychiatric facility as an involuntary patient. We frequently heard concerns about the category of voluntary patients who lack capacity. Many used the phrase "voluntary but incapable" to describe these patients. We heard that it is therapeutically preferable, and consistent with the guiding principles of the Act, to admit a patient on a voluntary basis

whenever possible. Many respondents felt, however, that incapacity was incongruous with the status of "voluntary patient."

Concern was raised that patients felt, and sometimes were told, that they would maintain their voluntary status until they sought to leave hospital. Also, we often heard concerns that a patient's status was changed from involuntary to voluntary close to the time a Review Board hearing was to take place. Different explanations for the status changes were shared with us.

In the end, however, significant and frequent concerns were raised with us about the lack of oversight for this population of patients. The Review Board does not have authority to review matters related to voluntary patients; such patients must seek redress from the courts. There was strong consensus that there should be a review of "voluntary but incapable" patients and that the Review Board was the appropriate body to conduct the review. Some stakeholders suggested that *IPTA* should make the category of "voluntary but incapable" patient explicit.

The Act should provide for the Review Board to review matters relating to voluntary patients who lack capacity. There are different ways to accomplish the appropriate oversight that the Department of Health and Wellness should actively explore.

Medical Examination and Involuntary Psychiatric Assessment

We feel the legislation is clear as to the purpose of the medical examination: it is an examination by a physician for the purpose of determining if the criteria for conducting an involuntary psychiatric assessment under the Act are present.

The phrase "medical examination" is commonly used by the health care system to describe a variety of physical examinations conducted by physicians. We accept that the commonality of the phrase contributes to the confusion about its role in the legislation, despite the legislation's clarity. One consultation participant suggested that the term "clinical examination" might assist with clarifying existing confusion. We agree that changing the term could be helpful.

With respect to the requirement for two physicians to complete the certificate for involuntary psychiatric assessment, we were asked to consider changing this requirement in light of practical realities that are frequently determined to justify a departure from the requirement. We feel strongly that the requirement for two physicians should remain. Many statutes require two psychiatrists to involuntarily admit a patient. *IPTA* requires a single psychiatrist make this decision. To buttress this requirement, it is all the more important that two physicians examine the patient in the first instance to determine whether detention for involuntary psychiatric assessment is appropriate. We recommend that education efforts be made to reinforce the requirement in section 10 for two certificates for involuntary psychiatric assessment, subject to truly exceptional circumstances.

There is understandable confusion about the relevance of capacity to the medical examination and the application of the *Hospitals Act*. We believe that a common test for capacity would resolve confusion. It would avoid the uncertainty currently caused by a need to apply different tests for capacity, or different

legislation on capacity, to different stages of the clinical process set out in *IPTA*. If a common test is not adopted, then there is a need to clarify the application of the test for capacity to the medical examination.

We do not believe the legislation should authorize involuntary treatment during a medical examination. The Act contains a "trigger" for taking away an individual's autonomy, and it is important that autonomy not be removed prior to that determination.

The impact of *IPTA* on police human resources is significant. The role of the police under the Act is an important one that needs to be balanced with other traditional policing responsibilities in the community. There is disagreement among stakeholders as to whether the reference to an "authorized individual" who can maintain custody of a person brought to the hospital by police can be someone designated by the district health authority. Clarity on this would be helpful.

A comprehensive Memorandum of Understanding should be developed on the implementation of the provisions of the Act relevant to the role of the police in retaining custody of patients during a medical examination. In the alternative, *IPTA* should be amended either to be silent on the nature and extent of the obligation of police or to limit the obligation of police to a defined number of hours.

The time-limit for detaining a person for an involuntary psychiatric assessment is an important protection in *IPTA*. We heard different views about whether 72 hours is the appropriate length of time and that practical difficulties meeting the timeframe cause psychiatrists and the system more generally to err on the side of admission. We conclude that no changes should be made to *IPTA* in this regard, but that data should be tracked and analysis conducted to determine the impact on patients of the shift from the seven-day observation period applicable under the *Hospitals Act* to the three-day assessment period applicable under *IPTA*.

Future Reviews of *IPTA*

IPTA was highly controversial and hotly opposed. Many of the arguments were about how the Act would operate once it was put into effect. The legislature responded to these arguments by making an independent review of the Act in its sixth year of operation part of the Act itself.

Although the opportunity to review quantitative data was limited, and the opportunity to do so with stakeholders was precluded, the review has brought attention to the need for improvement on how the operation of the Act is tracked and analysed through quantitative data. It has identified, through the analysis of data it was able to undertake, a range of questions about the functioning of the Act that call for further inquiry.

The review has also given a diverse range of stakeholders an opportunity to express and exchange their views on the Act and its operations. This qualitative data has brought attention both to concerns about the operation of the Act and opportunities for improvements that are validated – or largely validated – on the basis of qualitative data alone. The review has given those with experience with the Act, as well as experts in mental health legislation, the opportunity to propose many good ideas for improvements

to the Act or its operation. This Report endorses many of these ideas, recommends consideration be given to others and puts others "on the record" so they can be considered and debated in the future as the implementation of the Act continues to evolve.

These benefits warrant an amendment of *IPTA* to the effect that the Act shall be independently reviewed in every sixth year of its operation. However, the independent reviews of the future should be thought of as culminating events in a process of evaluation and improvement that is continuous and on-going.

In addition planning for future reviews should start with a consideration of options for ensuring that the review process is enabling as it can be of participation by people with the lived experience of mental illness, including by proactively addressing the barriers than can discourage or impede this participation.

Review Under Section 59: Community Treatment Orders

Objectives in Authorizing Community Treatment Orders

IPTA authorizes the provision of involuntary psychiatric treatment outside of a psychiatric facility to those who are placed by a psychiatrist on a community treatment order (CTO). When the Act was being debated in the legislature, this was one of its most controversial elements.

In *IPTA*, the prior hospitalization criterion is one of two that must be satisfied, in addition to the criteria for hospitalization, before a community treatment order can be issued. This is intended to ensure that CTOs are only used for patients who would likely be hospitalized if they were not put on an order. More specifically, our understanding is that the prior hospitalization criteria is intended to focus community treatment orders on the so-called "revolving door patients," those who may be in and out of hospital many times if a way is not found to stabilize and maintain their mental health in the community.

We conclude that *IPTA* should clearly state the statutory objective of making CTOs part of the mental health legislation of Nova Scotia. Currently, although there is a general view that the purpose of CTOs is to reduce involuntary hospitalization, this is a rationale that has to be inferred from the provisions and, more specifically, from the presence in the legislation of the prior hospitalization criteria. Our consultations with stakeholders suggested that the effectiveness of CTOs is also being evaluated against other objectives, which can but do not necessarily contribute to avoidance of future hospitalization. Whatever the legislative rationale, it should be stated explicitly to ensure (1) community treatment orders are used when it is consistent with their rationale and not to serve other purposes, and (2) that their effectiveness is evaluated against their intended objective.

Use of CTOs

Data provided by the Department of health and Wellness indicates that 107 CTOs had been issued by the end of 2012. The completeness of this data is, however, under continuing examination. Information available through a study of CTO effectiveness at the capital District Health Authority suggests 122 CTOs had been issued in that district alone.

Although no CTOs were issued in the first year or so after the coming into force of *IPTA*, we heard that the use of CTOs is growing. This is consistent with the experience in Ontario where the law has provided for CTOs since 2002. Growth in the use of CTOs increased in Capital District after the creation of a CTO coordinator in 2010. However, in some districts, the use of CTOs has started very recently and only a few CTOs have been issued.

We heard that the use of CTOs was limited by two factors: the amount and complexity of administrative work associated with putting them in place and overseeing them, and the limited availability of the community services and resources which must be available before a CTO can be issued. It seems clear that these constraints are greater outside of Capital.

Growth in the use of CTOs can probably be expected to continue as practitioners and the system gain experience with them. We heard that psychiatrists and other members of the mental health system find the process involved in creating and administering a CTO less daunting once they have been through it several times and that the need for dedicated human and other resources for the administration of CTOs is being recognized. Growth in the use of CTOs will also be encouraged by the fact that psychiatrists and other providers are generally positive about the patient outcomes being achieved with CTOs.

Effectiveness of CTOs

Those who participated in the consultations on the basis of experience with CTOs in Nova Scotia were generally positive about their effectiveness. Most of what we heard was broadly consistent with what was heard about the effectiveness of CTOs in the review recently completed in Ontario.

We heard from several patients who were grateful for the stability that being on a CTO had brought to their lives. In general what we heard from individuals who had experience on CTOs, or from their advocates, was largely positive or accepting of them.

Most of the family members who spoke to us about CTOs were positive about the difference a CTO had made to their loved one. Other family members were more sceptical of the value of CTOs. For some, the issue appeared to be more a concern that CTOs were not properly organized or monitored or enforced strictly enough.

People in the mental health system were generally positive about the effectiveness of CTOs. We were told that CTOs were preventing recurring hospitalizations of patients. We were provided some empirical support for this generally held view in a presentation on a study completed at the Capital District Health Authority by Dr. Christopher Murphy under the supervision of Dr. Scott Theriault. It found 31 of 44 patients studied had less hospitalization after being placed on a CTO than before. It also found that patients on CTOs had a longer median length of time between hospitalizations than they did before being placed on a CTO.

We were told that CTOs were generally successful in giving patients sufficient incentive to stay on their medications and that this in turn allowed them to live more successfully in the community than would

otherwise be the case. A number of psychiatrists told us that these positive results depend very much on the patients who are placed on a CTO.

We heard CTOs can play a useful role in marshalling community resources that would otherwise be difficult to align to meet the needs of a particular individual. We also heard concerns across the province about the unavailability of shelters and other kinds of residential facilities that are able, or able and willing, to accept residents on a CTO. We heard that a CTO can have a positive impact on the relationship between the person on the CTO and the team which provides them with treatment, support, and services. We also heard a concern from community mental health workers that the coercive dimensions of CTOs can be a barrier to building and maintaining cooperative relationships with their clients.

We heard different views about what the literature on CTOs said about their effectiveness. Much of this literature assesses the effectiveness of CTOs in reducing hospitalizations. A number of "quasi-experimental" studies show that patients on CTOs have a reduction in hospitalizations, usually as compared to their rate of hospitalization before going on a CTO. In addition, a number of studies show a positive impact on quality of life, homelessness, participation in community services, and on risk to self and others. Patients who have positive attitudes to a CTO associate the CTO with access to services, employment, and better relationships. Those who have negative perceptions resent the coerciveness and invasiveness of a CTO and regard it as stigmatizing.

The few randomized controlled trials on CTOs suggest that they do not have a significant effect on hospitalization. They also do not provide evidence that people on CTOs did significantly better than those in control groups on social functioning or quality of life, although they do indicate that people on CTOs were less likely to be victims of crime. A recent randomized controlled trial in England showed that people released from hospital on a CTO did no better in avoiding subsequent hospitalization over a 12 month period than did patients released under a conditional leave that applied a similar level of involuntary treatment as a CTO but for many fewer days (102 days compared to a median of 255 days for those on CTOs).

Methods Used to Evaluate CTOs

CTOs are being evaluated on a patient by patient basis. This is clinically appropriate and required by *IPTA* since *IPTA* says that a CTO shall not be renewed unless it is determined to have been effective. It is not, however, the kind of evaluation that was contemplated by section 59 of *IPTA*. This requires the kind of study completed by Dr. Murphy at Capital District Health Authority, but on a larger scale and as part of a broader evaluative framework established by the mental health system.

IPTA should continue to make express provision for targeted evaluation of CTOs by an independent review. This review should, however, be one that takes place over the next five years, not one that takes place in five years. The review should be conducted as an academically rigorous review by qualified health services researchers with expertise in program evaluation who are tasked to produce a peer-reviewed analysis and report.

Understanding the experience of persons on CTOs and also the system's experience with CTOs requires that a comparable level of data with respect to CTOs and patients on CTOs be tracked and analysed as is tracked and analysed for hospital patients. This is currently not the case.

Other issues relating to CTOs

In stating the criteria for the issuing of a CTO, clause 47(3)(a)(iii) requires a psychiatrist to be of the opinion that, as a result of the mental disorder, the person does not have the full capacity to make treatment decisions. This language is problematic because the difference between capacity and "full capacity" is not clear. It is also problematic because it applies a different standard for capacity to people with mental illness than is applied to people with physical illness. It may, therefore, reinforce stereotyping and prejudice and be subject to challenge under applicable human rights laws, particularly the *Charter of Rights and Freedoms*.

We consistently heard that *IPTA* is complex with respect to CTOs and that the process of designing, issuing and administering a CTO is also complex. We conclude that the Act should be amended to more clearly delineate the responsibilities for management and supervision of the CTO of the issuing psychiatrist and the community psychiatrist who agrees to accept management and supervision responsibilities under the CTO. We also conclude that the Act should be amended to authorize the amendment of a CTO.

We conclude that addressing the difficulty the system faces in accessing and organizing the community services that are required to support a person living in the community on a CTO may require a more systemic effort on the part of the mental health care system as whole, working at a systemic level with partners in other parts of the broader mental health system. Particularly important to this broader collaboration are the community-based organizations that work with people with mental illness and the various kinds of facilities and programs that operate under the mandate of the Department of Community Services. The police may also have a role to play.

This will raise concerns that limited community services will be accessible to people on a CTO on a preferential basis. We take the view that if *IPTA* is to authorize CTOs, policy and administrative steps to ensure the effectiveness of CTOs to the well-being of those placed on CTOs should also be taken. In addition, we are influenced by the discussions we heard in the Cape Breton Health Authority and in the focus groups we held at the end of our process, that people placed on CTOs should have some priority in accessing available resources and services since they are those in the community who have the greatest clinical need for those resources and services.

For this to be true, the criteria for CTOs must continue to limit CTOs to those who are the persons in the community with the greatest clinical need. This is one of the reasons we conclude that the "prior hospitalization criteria" should be retained. The other reason is that the argument that a CTO is always a least restrictive alternative to hospitalization rests on the assumption that CTOs result in less hospitalization than would otherwise occur and we do not think this assumption has been validated. In addition, our understanding of *IPTA* is that it introduced CTOs on the understanding that their

performance *in Nova Scotia* relative to this key assumption would be systematically monitored and evaluated. This monitoring and evaluation has not occurred to date.

We conclude that *IPTA* should be amended to recognize the least restrictive alternative of voluntary care in the community, to make the Act's approach to care in the community symmetrical with its approach to hospital care.

We conclude that the issue of the cost of medications for those placed on a CTO is an issue that should be addressed.

Part 1: Background

1. Introduction

1.1. Background

The *Involuntary Psychiatric Treatment Act* (*IPTA*) is the legislation that governs the provision of psychiatric treatment on an involuntary basis and on a voluntary basis, when in hospital.[1] The legislation has been in force since July 2, 2007. Section 84 of the *Involuntary Psychiatric Treatment Act* requires an independent review of the entire Act during the year commencing July 3, 2012. The Act, pursuant to section 59, also requires that the Minister of Health and Wellness undertake a review of community treatment orders (CTOs) during the year commencing July 3, 2012, and, specifically, whether community treatment orders were or were not used during the review period; the effectiveness of community treatment orders during the review period; and the methods used to evaluate the outcome of any treatment used under community treatment orders.

On October 4, 2012, we were appointed by the Minister of Health and Wellness to conduct both of the reviews required under sections 59 and 84, in accordance with a "Statement of Work" (Appendix A) that guided the review. It sets out the scope of the review, the documents to be submitted, and the process to be followed.

The Statement of Work called for a comprehensive review of the functioning of the Act. We were mandated to consider:

(1) The direct functioning of the legislative provisions;

(2) The contextual factors that may directly or indirectly affect the operation of the Act as it applies to those impacted or potentially impacted by its functioning; and

(3) The effect of significant developments in provincial, national and international law and policy as related to mental health, including the Nova Scotia Mental Health Strategy announced by the Department of Health and Wellness in 2012.

For clarity, the Statement of Work confirms that our review was to explicitly include the matters set in section 59 of the Act, i.e., whether community treatment orders were or were not used during the review period; the effectiveness of community treatment orders during the review period; and the methods used to evaluate the outcome of any treatment used under community treatment orders.

The Statement of Work mandates us to provide advice to the Minister that is reasonable and able to be implemented within the current fiscal reality on the following matters:

(1) Whether the objectives of the Act continue to be the right objectives or whether they should be revised, clarified or strengthened;

[1] SNS 2005, c 42.

(2) Whether the Act is effectively meeting its current objectives and is otherwise functioning effectively and appropriately or whether the functioning of the Act is in need of improvement, in specific areas or more generally;

(3) Whether:

- amendments should be made to the Act or to associated legislation; or

- changes should be made in the administration of the Act or of associated legislation to improve or strengthen the functioning of the Act relative to its proper objectives, patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, including as articulated in Nova Scotia's mental health strategy ("Together We Can: The plan to improve mental health and addictions care for Nova Scotians"); and

  In the event and to the extent amendments to the Act or associated legislation or changes in administration are recommended, the nature and the objective of the legislative amendments or the administrative changes that the review would recommend.

The Statement of Work instructed us to proceed by considering relevant information pertaining to the current functioning of the Act and the literature on mental health and mental health legislation that is relevant to the mandate of the review. It called for focused discussions with stakeholders and experts who are able to provide perspectives, information, and advice that are relevant to the mandate of the review. We were to build upon but avoid duplicating the consultations and other work completed in the development of Nova Scotia's mental health strategy: "Together We Can: The plan to improve mental health and addictions care for Nova Scotians."[2] We were also to consider the advice provided to the Minister of Health and Wellness by Honourable Justice Gérard V La Forest in a report in January 2012 on the conduct of the reviews and the work completed in the preparation of that report, which included discussions with stakeholders and research on mental health legislation.

[2] Nova Scotia, "Together We Can: The plan to improve mental health and addictions care for Nova Scotians" (2012) online: http://www.gov.ns.ca/health/mhs/reports/together_we_can.pdf ["Together We Can"].

1.2. Overview of Report Structure

This Report is in three Parts.

The current Part, entitled Background, describes the process we used to carry out our review under section 84 and 59 of *IPTA*. It explains our approach to gathering and analysing qualitative and quantitative data and to our research in primary and secondary literature on mental health legislation.

Part 2, entitled Issues, Analysis, and Conclusions, presents our principle findings. It begins with a brief Introduction that sets out four key conclusions that apply to the review. The balance of Part 2 deals first with our findings under section 84 and then with our findings under section 59.

The discussion of our findings under section 84 is in turn divided into two sub-parts that correspond to the first two parts of our mandate (i.e. our "Statement of Work") from the Minister. The first of these sub-parts, therefore, deals with our obligation to provide advice to the Minister "that is reasonable and able to be implemented... on whether the objectives of the Act continue to be the right objectives or whether they should be revised, clarified, or strengthened." In doing so, we consider: the overall objectives of the Act as we understand them; address the guiding principles which are stated in the Act to be the purpose of the Act; consider whether the Act should be expanded to become what some call comprehensive mental health legislation; and consider the rationale for broadening the attention the Act gives, as an Act focused on psychiatric treatment, to the measures that can or must be taken on a provincial scale to ensure the Act's effective implementation across and throughout the province. In discussing whether the objectives of the Act should be kept the same or revised, clarified or strengthened, we reach a number of conclusions that become the basis of recommendations set out in Part 3 of the Report.

The discussion of our section 84 findings then turns to the second part of our mandate, which is to provide the Minister with advice "that is reasonable and able to be implemented" on whether the Act is functioning to meet its objectives. This discussion is divided into two sub-sections. First we consider whether the overall functioning of the Act is meeting its objectives. In doing so, we consider the overall functioning of the Act relative to its objectives (i.e., its overall objectives) and the overall functioning of the Act relative to each of the dimensions of the Act's functioning on which we are tasked by the third part of our mandate to make recommendations. Accordingly, we consider the overall functioning of the Act relative to each of the following topics: patient well-being; applicable human rights principles; the importance of mental health and the mental health system; and Nova Scotia's policy objectives as articulated in Nova Scotia's Mental Health and Addictions Care Strategy. In discussing the overall functioning of the Act, we reach a range of conclusions that become the basis for recommendations set out in Part 3 of the Report.

Our discussion of the functioning of the Act under section 84 then addresses the functioning of specific sections or groups of interrelated sections of the Act. For each of the sections or groups of sections discussed, we provide an overview of the section or sections, discuss the issues that were identified through the review process with the section or sections being discussed, and then offer our conclusions

on how to address the issues that we conclude should be addressed. Again, these conclusions become the basis for recommendations found in Part 3 of the Report.

The Report then turns to the second sub-part of Part 2, which contains our findings on CTOs under section 59 of the *IPTA*. After a brief introduction that provides an overview of what the Act says on CTOs, we deal with the first part of our mandate as it relates to section 59. In other words, the Report considers the objectives of CTOs. This leads to conclusions about the objectives of CTOs that become the basis for recommendations found in Part 3 of the Report.

The Report then addresses the second part of our mandate relative to CTOs by considering the functionality of the provisions on CTOs. It does so primarily by addressing the specific questions identified in section 59, which are: the use being made of CTOs; the effectiveness of CTOs; and the methods being used to evaluate the outcome of treatment under CTOs. We also consider a number of other issues that arose in consultations with stakeholders that are relevant to the functionality (effectiveness) of the provisions of *IPTA* on CTOs. The conclusions we reach on each of these aspect of CTOs become the basis for recommendations on CTOs that are set out in Part 3 of the Report.

Part 3 of the Report contains our recommendations. It responds to the third part of our mandate, which requires us to provide advice to the Minister "that is reasonable and able to be implemented" on whether amendments should be made to *IPTA* or associated legislation or changes should be made to the administration of *IPTA* or associated legislation. The individual recommendations appear in Part 3 in the sequence that corresponds to the sequence in which the associated conclusions appear in Part 2 of the Report. They are also listed under headings that correspond to the heading under which the associated conclusions appear in Part 2.

2. Process

The process for our review included:

- Attention to previous work, as mandated in the Statement of Work
- Engagement of the Nova Scotia Health Research Foundation
- Establishment of the Technical Reference Group
- Documentary research
- Input regarding human rights issues
- Public and stakeholder consultation
- Data review

2.1. Attention to previous work

As indicated earlier, the Statement of Work required us to build upon but seek to avoid duplication of the work completed in the development of Nova Scotia's mental health strategy. Towards this end, we reviewed the mental health strategy and progress report issued by the Department of Health and Wellness.[3] We considered the Report and Recommendations of the Mental Health and Addictions Advisory Committee, "Come Together,"[4] the research commissioned by the Advisory Committee and the materials published on its webpage,[5] and the report about the consultations prepared by the Nova Scotia Health Research Foundation which supported the work of the Advisory Committee.[6] We also spoke with members of the Advisory Committee and the project coordinator.

The Statement of Work also required us to consider the report of January 2012 of the Honourable Justice Gérard V La Forest and the associated work, which underpins that report. This work included documentary research, which included a review of academic literature, reports, legislation, case law, and international documents. We also considered the information that was gathered for that earlier report by talking informally with a variety of individuals and organizations. We obtained the permission of the participants in those discussions to use that information as part of the review. As the purpose of the discussion during those informal consultations was for the mandate of planning for the Independent

[3] "Together We Can," *supra* note 2*;* and, Nova Scotia, "Together We Can: The plan to improve mental health and addictions care for Nova Scotians, Our First Year" (2013) Progress Report on the Nova Scotia Mental Health Strategy, online: http://gov.ns.ca/health/mhs/reports/MHS-Together-We-Can-One-Year-Update.pdf ["Together We Can: Progress Report"].

[4] "Come Together: Report and Recommendations of the Mental Health and Addictions Strategy Advisory Committee" (March 2012) online: http://www.gov.ns.ca/health/mhs/reports/MHAS_2012_Full.pdf ["Come Together"].

[5] Nova Scotia Mental Health Strategy Advisory Committee, & Nova Scotia Health Research Foundation, "Mental Health Strategy Background Document: A summary of the current state of mental health and addictions services in Nova Scotia" (24 June 2011) online: http://www.nshrf.ca/sites/default/files/mental_health_and_addictions_summary_document_09.14.11.pdf.

[6] Nova Scotia Health Research Foundation, "Mental Health and Addictions Strategy: Consultation Results and Evidence from Other Sources" (2011) Submitted to the Department of Health and Wellness; and, Nova Scotia Health Research Foundation, "Nova Scotia Mental Health and Addictions Strategy Working Document" (2011).

Review of the *Involuntary Psychiatric Treatment Act*, we held additional consultations with many of the same individuals and organizations in carrying out this review. The report of January 2012 is attached as Appendix B.

2.2. Engagement of the Nova Scotia Health Research Foundation

The Nova Scotia Health Research Foundation (the "Foundation") was established by the *Health Research Foundation Act.*[7] Its objects include assisting and collaborating with individuals and organizations conducting research in the field of health policy.

The review engaged the services of the Foundation to provide technical support and assistance in engaging individuals with appropriate expertise to support the work of the review. The support provided by the Foundation was in the following areas:

- Advice, expertise, and assistance related to the consultation process used for the review;
- Advice, expertise, and assistance in engaging individuals with appropriate expertise to assist the review in qualitative and quantitative data analysis, focus group facilitation, and editing;
- Hosting and administering the review's webpage; and,
- Engaging specialised expertise to assist with focus groups and completion of the final report.

2.3. Establishment of the Technical Reference Group

We asked the Department of Health and Wellness to facilitate the establishment of a Technical Reference Group that would be available to us throughout the review process. The Group was established in December 2012. Its membership is attached as Appendix C.

The role of the Technical Reference Group was to provide suggestions on the factors or considerations we might take into account or the inquiries, consultations, or research we might undertake, and to answer our questions of a factual or technical nature about the Nova Scotia mental health system and the role *IPTA* plays or could play in that system.

We received assistance from members of the Technical Reference Group through: their review of the discussion paper we developed to inform the consultation process; input regarding the collection of relevant data; assistance with the interpretation of quantitative data; input regarding technical interpretation of published research; and reaction to some provisional recommendations with the goal of helping us identify areas where further consideration or information may be needed.

2.4. Documentary Research

In addition to reviewing the information outlined earlier, as required by our mandate, we built upon the documentary research that was completed as part of developing Justice La Forest's of January 2012.

[7] *Health Research Foundation Act,* SNS 1998, c 14.

This included consideration of academic literature, "grey" literature,[8] domestic and international legislation, domestic and international case law, and international documents.

The main areas where we built upon the research completed for Justice La Forest's January 2012 report include, but are not limited to: review of literature and studies related to community treatment orders; Canadian and international review board structures and authorities; Canadian mental health jurisprudence; international mental health legislation and jurisprudence; human rights literature and documents including the evaluative tool for mental health legislation prepared for the Mental Health Commission of Canada[9] and the United Nations *Convention of the Rights of Persons with Disabilities*[10]; literature related to rights to health care and social services; and key Nova Scotia documents related to mental health legislation. We hired a Masters of Law graduate and three law students to assist us with the documentary research, all of which assisted us on a part-time basis. A list of key documents reviewed is included at the end of the Report.

2.5. Input Regarding Human Rights Issues

Our mandate required us to consider "applicable human rights principles." In addition, we took note of the recommendation coming out of the Inquiry into the Death of Howard Hyde that the independent review of the *Involuntary Psychiatric Treatment Act* "should include a thorough legal analysis of the legislation's conformity or lack thereof as the case may be to the Charter and the United Nations *Convention of the Rights of Persons with Disabilities* and recommend amendments as applicable."[11] In the time we were given to conduct the review and the resources available, we were limited as to the options available to address the applicable human rights issues.

In addition to our documentary research and stakeholder consultations on human rights issues as they relate to the Act, we benefited from input provided by a number of experts in mental health law. We received very helpful submissions from Professor Elaine Gibson, Professor Sheila Wildeman, and other members of the Dalhousie Health Law Institute at the Schulich School of Law, Dalhousie University. We are very appreciative of our discussion with and the voluminous materials shared by Professor Archibald Kaiser of the Schulich School of Law, Dalhousie University. Lawyers with Nova Scotia Legal Aid also provided helpful submissions with regard to human rights issues.

To supplement our knowledge and to help us contextualize what we heard with respect to human rights issues, we engaged Professor of Law Emeritus, Hugh Kindred of the Schulich School of Law, Dalhousie

[8] "Documentary material which is not commercially published or publically available, such as technical reports or internal business documents": *The Oxford English Dictionary*, online, *sub verbo* "grey literature".

[9] Christine Ogaranko, Beverly Froese & Nicole Chammartin, "Equality, Dignity and Inclusion: Legislation that Enhances Human Rights for People Living with Mental Illness: Mental Health and Human Rights Evaluation Instrument" (30 November 2011) Report to the Canadian Mental Health Association ["Equality, Dignity and Inclusion"].

[10] *Convention on the Rights of Persons with Disabilities* and *Optional Protocol*, 13 December 2006, 2515 UNTS 3. online: http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf [*CRPD*].

[11] "Report of the Fatality Inquiry into the Death of Howard Hyde" (30 November 2010) (Chair: Anne S Derrick, Provincial Court Judge) online: http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf [Hyde Report].

University and Professor of Law, Peter Carver of the Faculty of Law, University of Alberta. Professor Kindred is a recognized expert in the field of international law. Professor Carver is a recognized expert in the fields of constitutional and mental health law.

We engaged Professor Kindred to help us contextualize what we heard on the United Nations *Convention of the Rights of Persons with Disabilities* (the "Convention") in the broader framework of international law and how it applies in Canada. We discussed with Professor Kindred:

- The objectives of the Convention within international law;
- The nature of the obligations that the Convention imposes on Canada as a ratifying country;
- The applicability of Canada's obligations to the provinces;
- The enforcement of the Convention; and,
- The nature of Nova Scotia's obligations under the Convention relative to the subject matter of the *Involuntary Psychiatric Treatment Act* and other aspects of mental health that might be addressed in mental health legislation.

We engaged Professor Carver to help us contextualize what we heard on human rights issues more generally in the broader fields of constitutional law and disability law, including the Convention. We discussed with Professor Carver issues related to:

- Apprehension for assessment;
- Involuntary committal to psychiatric facilities;
- Consent to treatment;
- Review processes and advocacy;
- Patient rights and protections within psychiatric facilities;
- Community treatment orders; and,
- Positive rights to mental health support and services.

2.6. Public and stakeholder consultation

2.6.1. Webpage Materials

We invited feedback from the public and stakeholders through our webpage, which included a discussion document, an email address, and a toll-free phone number. The webpage address and toll-free telephone number were advertised in newspapers.[12] We also publicized the information through contact with stakeholders and asked them to share the information as widely as they could. A link to the webpage was on the Department of Health and Wellness' main webpage and on the Mental Health Branch's webpage.

[12] These were: *Antigonish Casket*, *Chronicle Herald*, *Metro – Halifax*, *The Coast*, *Amherst Daily News, Cape Breton Post, NG Evening News, Truro Daily News, Citizen Record, Guysborough Journal, Bridgewater Bulletin, Lighthouse Log, Pictou Advocate, Port Hawkesbury Reporter, Digby Courier, Kings County Advertiser, Shelburne Coast Guard, Yarmouth Vanguard,* and *Le courrier.*

We posted the discussion document in two formats: (1) a survey to be completed online; and, (2) a Microsoft Word document that could be completed electronically or printed for handwritten completion. The Microsoft Word version of the document is attached as Appendix D. A total of 7 responses to the discussion document were submitted. The online survey was viewed 126 times.

We received 5 written submissions through our email address.

We received 4 voicemail submissions or submissions resulting from contact made through our toll-free telephone number. The public was invited to leave their submissions anonymously if they wished and 2 individuals did so.

The email address and toll-free telephone number also supported communication with the public and stakeholders with respect to the consultation process.

2.6.2. Meetings

We held over 70 consultations that allowed us to hear the views of over 350 individuals including those representing patients, the health system, law enforcement, Review Board, advocates, peer support, and families. A list of individuals and organisations who participated in our consultations is attached as Appendix E. In this section we identify the number of people who attended each type of meeting. We note that some individuals attended multiple meetings, usually attending in a different role depending on the nature of the meeting. In the list of participants they are identified only once.

2.6.3. Public Meetings

We hosted a public meeting in each district health authority, for a total of 10 public meetings. Some meetings were held in district health authority facilities and some were held in community facilities, such as schools or fire halls. The public meetings were advertised through a general provincial advertisement in the *Chronicle Herald*, followed by targeted advertising in community newspapers. We also asked advocacy organizations, stakeholders, and district health authorities to help publicize the public meetings. Attendance at each meeting ranged from 0-16 people and included individuals with lived experience (First Voice), family members, advocacy organizations, community support organizations, health care professionals, academics, and one member of the judiciary. The small numbers allowed us to conduct the meetings in an interactive and conversational format. A total of 77 attended the public meetings.

Two stakeholders put us in contact with 2 individuals who could not attend the public meetings. These individuals provided input over the phone.

2.6.4. Targeted Stakeholder Meetings

We met with organizations and individuals in small groups or on an individual basis about their perspectives on the legislation. We identified these stakeholders through the previous informal consultations conducted by Justice La Forest, our knowledge of the communities and the issues, by

reviewing the list of participants in other mental health reviews and processes, by asking stakeholders for their input as to who should be consulted, and by responding to individuals who contacted us. Two organizations, Nova Scotia Rainbow Action Project and Immigration Settlement & Integration Services, indicated they did not feel they had a particular perspective about the legislation and supported the review by sharing information about how individuals that they serve could provide input through the avenues described on our webpage.

Participants in the targeted stakeholder meetings included: First Voice; families and substitute decision-makers; provincial advocacy organizations; mental health care advocates; patient support groups; organizations and individuals who advocate on health issues on behalf of African Nova Scotians, First Nation and aboriginal Nova Scotians, and Acadian Nova Scotians; academics; psychiatrists; district health authority staff; policing; Emergency Health Services; the patient advisor service; the Review Board; Legal Aid Commission; community supports; and governmental departments and committees.

As our consultation process progressed, we discussed strategies with some stakeholders for encouraging more First Voice participation, including individuals under the authority of a community treatment order. We are very grateful for all of the support we received in this regard, but would like to particularly acknowledge

- The Canadian Mental Health Association (Halifax-Dartmouth Branch), which organized a meeting for us in Halifax attended by 22 individuals;
- The Canadian Mental Health Association (Nova Scotia Division), which connected us with two individuals that we spoke with privately;
- The Schizophrenia Society of Nova Scotia, which invited us to a peer support and recovery group in Halifax attended by 12 individuals;
- The Crossroads Clubhouse, which organized a meeting for us in Sydney attended by 7 individuals;
- The Compass Program, which facilitated a meeting for us in Truro attended by 2 individuals; and
- The Changing Rhythms for Mental Health association, who facilitated a meeting for us in Bridgewater with 3 individuals.

Before most meetings we distributed a discussion guideline, which re-framed the Review's mandate in the form of questions. The discussion guideline is attached as Appendix F. Each meeting was conducted in an informal manner and we invited participants to share whatever information they felt was relevant for the purposes of the Review. Most participants did not directly respond to the discussion outline in the meetings, but rather provided relevant input through the presentation and conversation that took place. There were some meetings where we did not distribute the discussion outline. This was determined appropriate where the meetings called for additional attention and sensitivity and an informal and non-threatening environment.

We met with 128 individuals as part of our targeted stakeholder meetings.

2.6.5. District Health Authority Meetings

We met with organizations and individuals in small groups when we visited each district health authority. Participants in the meetings included: First Voice; families and substitute decision-makers; provincial advocacy organizations; community supports; psychiatry; district health authority staff; policing; Emergency Health Services; patient advisors; governmental departments; and community health boards.

We followed the same approach for the meetings in the district health authorities as was outlined with respect to the targeted stakeholder meetings.

The Mental Health Directors and their staff were instrumental in organizing the stakeholder meetings in the district health authorities. They helped identify appropriate stakeholders to participate in the meetings. They also took on the administrative responsibility for organizing the stakeholder and public meetings. In addition to the administrative support, the Mental Health Directors and their staffs provided very helpful substantive input regarding the language and operation of the Act, the mental health system, quantitative data, and other issues.

We met with 182 individuals as part of our stakeholder meetings held in the district health authorities.

2.6.6. Focus Groups

After all of the public and targeted stakeholder meetings were completed, we identified and invited individuals representing a variety of roles and perspectives to participate in one of two focus group sessions. A total of 18 individuals representing law enforcement, family, health care providers, psychiatrists, patient advisors, lawyers, and the Review Board participated in this part of the process. Acting upon the strong advice from advocates of persons living with mental illness, we did not specifically seek First Voice representation in the focus groups, although we are aware that such representation was present.

The purpose of the discussion was to validate that what we believe we had heard was comprehensive and representative for selected issues. The discussion was also aimed at exploring some issues for deeper understanding. A professional facilitator was engaged for the focus groups. The participants in each of the focus groups are listed in Appendix G.

2.7. Data Review

2.7.1. Qualitative Data

All of the notes from the public and stakeholder meetings, telephone submissions, discussion document responses and other written submissions we received up to May 15, 2013 were shared with the Nova Scotia Health Research Foundation on a confidential basis for the purposes of assisting with analysis.

The Foundation used a qualitative analysis software program called Atlas.ti to help analyse the notes and submissions. The Foundation's report is attached as Appendix H.

The Foundation's report identifies and summarizes emergent themes. It does not contain every detail or issue that stakeholders shared with us. In addition to the Foundation's report, we relied on our notes, recollections and interpretation of the all of the information we heard or received up to June 21, 2013.

2.7.2. Quantitative Data

In our Statement of Work, the Department included metrics related to the *Involuntary Psychiatric Treatment Act*. As anticipated in Justice La Forest's report of January 2012, we determined that we required additional information to address our mandate. As such, we made efforts to gather information from a variety of sources.

We asked the Department to provide us with information that would help us better understand the patient profile and experience under the Act. This information included information about demographics, involuntary assessments and admission, referral sources, diagnosis and reasons for admission, the duration of admissions, status changes during admission, certificates of leave, community treatment orders, discharges and re-admissions. We benefited from the input of our Technical Reference Group in developing the list of "data questions" submitted to the Department. The Technical Reference Group and the Department assisted us in contextualizing and interpreting the available data. The questions asked and the Department's response in the form of charts and some graphs, as well as identification of where data was not available, are attached as Appendix I.

The Forms prescribed in the *Involuntary Psychiatric Treatment Act Regulations* contain information that is not captured in Departmental databases, including information relevant to the application of assessment and admission criteria, community treatment orders and voluntary admissions. The Department only collects some of the information on the Forms in the course of providing administrative support to the Review Board. In the context of this Review, we were limited in the time and other resources we had to conduct a full review and analysis of the Forms completed since *IPTA* came into effect. In recognition of the time constraints under which our mandate required us to work, and sensitive to the amount of work we would be imposing on the district health authorities to gather the Forms, we decided to ask the districts to provide us with all of the Forms completed for the year 2012. We received responses from seven districts: Annapolis Valley, Cape Breton, Colchester East Hants, Guysborough Antigonish Strait, IWK, Pictou, and South West Nova.

We requested information from the Chiefs of Police and the Commanding Officer RCMP relating to the exercise of police authority under the Act. Four agencies responded to the request. The letter requesting the information, along with the information received is attached as Appendix J.

We requested but did not receive information from the Department of Justice, Court Services with respect to applications made under section 13 of the *Involuntary Psychiatric Treatment Act.*

We requested and received information from the patient advisor service, Empowerment Connection, with respect to their responsibilities under the Act. It is attached as Appendix K.

We reviewed the statistics presented in the annual reports of the Review Board for the years July 3, 2007 – March 31, 2011, these are attached as Appendix L. The annual reports for the years ending March 31, 2012 and March 31, 2013 have not been tabled in the Assembly pursuant to section 80(2) of the Act, and we are told by the Department, are not finalized. We have also reviewed the annual reports of the Psychiatric Facilities Review Board that operated under the mental health provisions of the *Hospitals Act*[13] prior to the proclamation of the *Involuntary Psychiatric Treatment Act.*

[13] *Hospitals Act*, RSNS 1989, c 208 [*Hospitals Act*].

Part 2: Issues, Analysis, Conclusions

1. Introduction

Our mandate is to provide advice to the Minister of Health and Wellness on the objectives of *IPTA*, on whether *IPTA* is meeting its objectives and on whether amendments should be made to *IPTA* or associated legislation or changes made in the administration of *IPTA* or associated legislation. In writing this Report in accordance with this mandate, we have been guided by four considerations of a more general nature that we set out here to frame the more detailed analysis, which follows.

First, by a significant margin, most of those who participated in the review spoke positively about *IPTA* and its general thrust. This view was expressed with particular conviction by the family members of those who have been treated under the Act, many of whom were in a position to compare their experiences under *IPTA* with their experience under the provisions of the *Hospitals Act* that *IPTA* replaced. Most of those who did not explicitly express a positive view of the legislation as whole recommended specific changes to particular provisions or to the administration of the Act rather than wholesale changes to the legislation itself. In consequence, the strong impression we took from what we heard was that the controversy that greeted *IPTA* when it was being debated in the legislature in 2005 has significantly dissipated.[14]

Not everyone agreed on the general merits of *IPTA*. Some First Voice participants raised fundamental objections to involuntary psychiatric treatment and deep concerns about the pervasive vulnerability they feel once they have been diagnosed with a mental illness that can result in involuntary treatment. We also heard from others, including experts in mental health law, who think strongly that the legislation is wrong in principle because of its almost exclusive focus on involuntary psychiatric treatment and because of the breadth of authority it provides for that kind of treatment. In addition, it has always to be kept in mind that *IPTA* deals with the rights of the individual that our society has recognized as our fundamental rights. As our mandate recognizes, such legislation must conform to those rights independently of whether or not the majority of people who choose to participate in a Review process think it is good or bad legislation.

Yet, the general theme of what we heard about *IPTA* was strongly positive. This leads us to conclude that stakeholders want the conversation on mental health legislation to move forward by concentrating on making *IPTA* better, not by revisiting the debates about *IPTA* that took place when it was proposed. This is what we have tried to do in writing this Report.

Second, we learned from our consultations that it takes the health care system time to adjust to new mental health legislation. Indeed, we learned that this process of adjustment continues and that it is at

[14] Nova Scotia, Legislative Assembly, *Hansard*, 59th Ass, Sess 1 (17 May 2005) at 7752 & (20 October 2005) at 8595.

variable stages across the district health authorities. This may reflect the failure of the system to give implementation of *IPTA* sufficient priority: accordingly, we make specific recommendations to address that possibility. But it also reflects the inherent complications of transitioning a complex integrated system of care from one legislative framework to another. We believe this is an additional reason to focus our attention on the things that can be done to improve *IPTA* and its operation, rather than on reconsideration of the debates that took place in the past.

Third, the approach that *IPTA* takes to involuntary psychiatric treatment is very consistent with the approach taken in mental health legislation in most of Canada. This approach is called by some the human needs approach to mental health legislation because of the emphasis it places on the benefits that involuntary psychiatric treatment can provide to those who are determined to need it.[15] It is an approach that is sharply criticized by those who think that the purpose of legislation in this area is to protect people against unwarranted involuntary treatment, the "civil libertarian" model.[16] Nevertheless, it has become the predominant approach in Canada and in many comparable countries.[17] Moreover, for those who favour this approach, one of the strengths of *IPTA* is the level of concern and protection it provides to individual rights.

Fourth, legislation built on a human needs model is necessarily legislation that places greater confidence and trust in physician decision-making. This is because it defines physician authority in broader and more discretionary terms than legislation written on other models. In our view, the protections against abuse and inconsistency that are built into all legislation that authorizes involuntary treatment become all the more important under the human needs model. Indeed, we think such legislation calls for more than protection of individual rights and equal treatment through after-the-fact review of individual decisions. It calls for proactive preventive measures of a systemic nature to ensure that the legislation is interpreted and applied in a consistent fashion within defensible parameters.

[15] John E Gray, Margaret A Shone & Peter F Liddle, *Canadian Mental Health Law and Policy*, Second Edition (Markham: LexisNexis Canada Inc, 2008) at 12.

[16] See, e.g., H Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 2d ed (Markham & Vancouver: Butterworths Canada, 2002) at 251-330.

[17] See, e.g., *Mental Health Act*, RSO 1990, c M.7; *Mental Health Services Act*, SS 1984-85-86, c M-13.1; *Mental Health and Related Services Act 2002* (NT); *Mental Health Act 2007* (UK), c 12.

2. Review Under Section 84

The first part of our mandate requires us to "provide advice to the Minister that is reasonable and able to be implemented... on [w]hether the objectives of the Act continue to be the right objectives or whether they should be revised, clarified, or strengthened." In this section we limit ourselves to the question of whether the objectives of *IPTA* should be revised, clarified, or strengthened. To the extent that we find that revision, clarification, or strengthening is called for we will deal with our recommendations for how this is to be done when we turn to the third part of our mandate. Our mandate requires us to consider whether amendments to legislation or changes in administration should be made (either in reference to *IPTA* or associated legislation) to improve or strengthen the functioning of *IPTA* "relative to its *proper objectives*, patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, as articulated in Nova Scotia's mental health and addictions strategy."

2.1. Objectives of *IPTA*

At a high level, the objectives of *IPTA* are unmistakable: unlike mental health legislation in some other provinces, the Act is exclusively concerned with psychiatric treatment and primarily with involuntary psychiatric treatment. Beyond that, the objectives of *IPTA* as regards psychiatric treatment become debatable. Some would say that the objectives are to enable involuntary psychiatric treatment at the expense of the liberty and autonomy of people with mental illness. They would point to the breadth of the risk criteria for involuntary admission found in *IPTA* compared to the risk criteria of the provisions in the *Hospitals Act*, which *IPTA* replaced.[18] They would point to the addition to the law of "likelihood of serious deterioration" as an alternative criterion to harm for involuntary admission and treatment. They would also point to the introduction of community treatment orders and certificates of leave, under which *IPTA* authorizes involuntary psychiatric treatment outside of hospitals.

Others would say that the objectives of *IPTA* are to combine access to involuntary treatment and the benefits it provides to those who would otherwise be deprived of those benefits with protection of individual rights. They would point to the exclusion from involuntary admission under *IPTA* (but not under the *Hospitals Act*) of those who have capacity and those who would not benefit from psychiatric treatment. They would also point to section 2 of *IPTA*, which says that the purpose of *IPTA* is to ensure that issues dealing with mental health are dealt with in accordance with eight guiding principles, all of which encompass aspects of respect for individual rights. They would probably also point to the patients' rights advisory service *IPTA* authorizes and that has been established. They would also stress

[18] *Hospitals Act*, *supra* note 13: "36 (1) A person may be admitted to a facility by the execution of two medical certificates… (2) A medical certificate shall state that a qualified medical practitioner has reasonable and probable grounds to believe that
(a) the person suffers from a psychiatric disorder; and
(b) the person should be admitted to the facility because
(i) he requires the in-patient services provided by that facility, and
(ii) he requires care that cannot be adequately provided outside the facility because he is a danger to his own safety or the safety of others."

the positive contributions that involuntary psychiatric treatment provided under the Act can make to the lives of those who receive it.

The first interpretation of the objectives of *IPTA* would be consistent with an understanding that the purpose of legislation on psychiatric treatment should be to protect people from being subjected to such treatment to the greatest extent possible. The second interpretation would correspond to the human needs understanding of the purpose of such legislation, which places greater emphasis on the benefits involuntary psychiatric treatment can provide to those who are determined to need it.

In our view, it is the second interpretation of the objectives of *IPTA* that best accords with the provisions of the Act. It also accords with the explanation of the policy objectives of *IPTA* that were given when it was proposed for consideration in the House of Assembly.[19] It accords as well with the understanding of the objectives of the Act articulated in this Review by the majority of those who participated.

It follows that the overall objective of *IPTA* was to institute a version of the human needs approach to the law on involuntary psychiatric treatment in Nova Scotia.

So understood, it was clear to us that the current objectives of *IPTA* were largely supported by those who participated in the Review. In other words, *IPTA*'s objective of making involuntary psychiatric treatment applicable on broader grounds and in the community as well as in hospital subject to the conditions, protections, and safeguards set out in the legislation was widely supported by those who participated in the Review.

It was also clear to us that the major provisions of *IPTA* are closely and directly related to *IPTA*'s objectives. A significant change to the major provisions of *IPTA* would require a complete rethinking of the basic core objectives of *IPTA*. Although our Review has identified a rationale for a number of significant amendments to *IPTA*, it has not revealed a rationale for legislative restructuring on that scale. We would be concerned that the resources that would be required for such an undertaking and the associated adjustments it would necessitate in the mental health system could be better utilized by ensuring that good care is provided and individual rights are protected under the legislative framework provided by *IPTA*.

2.1.1. Guiding Principles

The objectives of *IPTA* are addressed directly in section 2 of the Act. It says that the purpose of *IPTA* is to ensure that issues dealing with mental health are dealt with in accordance to eight guiding principles. In full, section 2 reads as follows:

> The purpose of this Act is to ensure that issues dealing with mental health are dealt with in accordance with the following guiding principles:
>
> (a) persons of all ages with mental disorders are entitled to be treated with dignity and respect;

[19] Nova Scotia, Legislative Assembly, *Hansard*, 59th Ass, Sess 1 (17 May 2005) at 7752 & (20 October 2005) at 8595.

(b) each person has the right to make treatment decisions to the extent of the person's capacity to do so;

(c) treatment and related services are to be offered in the least-restrictive manner and environment with the goal of having the person continue to live in the community or return to the person's home surroundings at the earliest possible time;

(d) the primary mode of admission to a psychiatric facility shall be as a voluntary patient wherever possible;

(e) treatment and related services, where possible, should promote the person's self-determination and self-reliance;

(f) the person has the right to a treatment plan that maximizes the person's potential and is based on the principles of evidence-based best practice;

(g) persons with mental disorders should have access to mental health services as close to the person's home as practicable;

(h) any declaration of involuntary admission or declaration of incapacity is made on the basis of evidence.

One way of understanding the effect of section 2 is to say it lays out the principles that are to guide the interpretation and administration of the rest of the Act, as well as the management of mental health issues more generally. This is the understanding that was most often conveyed to us during the Review. The other way of understanding section 2, which is our understanding, is to say that it makes interpretation and administration of the Act in accordance with the guiding principle the very purpose of Act.

The guiding principles can be summarized as calling for a patient-centred approach that includes a strong emphasis on patient rights. They say "persons of all ages with mental disorders are *entitled* to be treated with dignity and respect," that "each person has the *right* to make treatment decisions to the extent of the person's capacity," and that "the person has the *right* to a treatment plan that maximizes the person's potential and is based on the principles of evidence-based best practice." Evidence-based decision-making is emphasized a second time, in clause (h), which says, "any declaration of involuntary admission or declaration of incapacity is made on the basis of evidence."

Given the rest of the Act, the entitlement to treatment with "dignity and respect" according to evidence must be taken to include involuntary treatment where it is determined to be required. This would be consistent with the design of the Act in accordance with the human needs model of mental health legislation. But overall, the guiding principles emphasize that involuntary treatment is to be the exception. Clause (c) says "treatment and related services are to be offered in the least-restrictive manner with the goal of having the person continue to live in the community or return to be person's home surroundings at the earliest possible time." Clause (d) says "the primary mode of admission to a psychiatric facility shall be as a voluntary patient wherever possible." Clause (e) says "treatment and related services, where possible, should promote the person's self-determination and self-reliance."

The views we heard on the substance of the guiding principles listed in section 2 were very positive. We were encouraged by the frequency with which one or more of the guiding principles were mentioned by psychiatrists, other mental health professionals, and members of the police as they talked to us about other parts of the Act or their roles interpreting and administering the Act. Two that were referenced often were the principle that persons with mental disorders were to be treated with dignity and respect and the principle that treatment and related services are to be offered in the least restrictive manner. The number of times these and other guiding principles were referenced by participants in the Review suggests the presence in *IPTA* of the guiding principles does matter to how *IPTA* is understood, interpreted, and administered.

Conversely, we were also told that the guiding principles are contradicted by the rest of the legislation, and, specifically, by its exclusive concern with psychiatric treatment with an emphasis on involuntary treatment. More frequently, we heard that aspects of the administration of the Act do not live up to the guiding principles. For example, those who raised concerns about the conditions under which some patients are held in seclusion and some of those who expressed concerns about the functioning of the Review Board process invoked the guiding principles to amplify their concerns.

We also heard submissions that the guiding principles are incomplete. Several people said a guiding principle relating to cultural awareness and understanding needs to be added to the Act. While some said the issue was cultural sensitivity in the administration of the Act, others expressed the view that the more encompassing concept was that of cultural safety because it embraces the person's confidence that their culture is being appropriately and sensitively taken into account.[20] The recommendation for a new guiding principle to address these issues was strongly supported by representatives of First Nation and aboriginal communities, the African Nova Scotian community, and the Acadian community.[21]

We were also urged to recommend that equality of treatment between people with mental illness and other kinds of health issues and between people with different kinds of mental illness should be added to the Act's list of guiding principles. The rationale for doing so would not be to make equality applicable to mental health issues: within the limits of their applicability, this is already the case under the *Human Rights Act*[22] and the *Charter of Rights and Freedoms*.[23] Instead, the rationale would be to ensure equality of treatment was brought to the attention of those who deal with mental health issues along with the other norms currently set out in the guiding principles.

---

[20] "Cultural safety" has been defined as "an environment which is safe for people where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, or learning together with dignity and truly listening": A Eckermann et al, *Binang Goonj: Bridging cultures in Aboriginal health* (Armdale, NSW: University of New England, 1994), quoted in Robyn Williams, "Cultural safety- what does it mean for our work practice?" (1999) 23:2 Australian and New Zealand Journal of Public Health 213. The importance of cultural safety in mental health is recognized in Nova Scotia's mental health and addictions strategy, "Together We Can," *supra* note 2 at 23.

[21] "Together We Can," *supra* note 2 at 22.

[22] *Human Rights Act*, RSNS 1989, c 214.

[23] *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

In our view, guiding principles on cultural safety and equality would also be consistent with the mental health and addictions strategy, "Together We Can," which prioritizes the needs of "Aboriginal and Diverse Communities," including by building "cultural aspects into how mental health and addictions services and programs are provided."[24] The strategy expressly endorses the applicability of the concept of "cultural safety" to the provision of mental health services.

It was also proposed to us that the *Convention on the Rights of People with Disabilities*, which came into force in Canada and therefore in Nova Scotia in 2010, should be included in the guiding principles. Specifically, it was proposed that we recommend a guiding principle that would say that issues dealing with mental health are dealt with in accordance with the Convention. It is important to recognize that doing so would not bring the Convention into force in Nova Scotia—the Convention is already in force in Nova Scotia. For example, even without being referenced in *IPTA*, the Convention applies to the interpretation of *IPTA* under the principle that international law is relevant to the interpretation of Canadian statutory law.[25] Including a guiding principle on the Convention would ensure this is understood by all those who make decisions under *IPTA*, but it would not change the law.

Putting a reference to the Convention in the guiding principles may, however, raise broader issues than the proposed guiding principles on equality and cultural safety. The guiding principles set out in the Act do not deal only with the interpretation of *IPTA* but with "issues dealing with mental health." The Convention deals with a broad range of social and economic rights that go well beyond the scope of the matters dealt with in *IPTA*. Like all Canadian governments, the Nova Scotia government is responsible for implementing the Convention within its jurisdictional sphere. This responsibility is enforced through Canada's accountability under the Convention to report to the monitoring process established in the Convention on Canada's implementation of the Convention.[26] Putting a guiding principle on the Convention into *IPTA* in relation to "issues dealing with mental health" may raise the question of whether the principle made the Convention enforceable in the courts relative to the management of those issues. This would be a significant step for the role that the courts and litigation might play in determining mental health policy and policy in a number of other fields. In light of this, although we think there should be a reference to the Convention in *IPTA*, it should be limited to the specific matter of the relevance of the Convention to the interpretation and administration of *IPTA*.

In sum, our view is that the guiding principles should be expanded to include a guiding principle on cultural safety and a guiding principle on equality between people with mental and physical health issues and between people with different mental health issues. We also conclude that the *Convention on the Rights of Persons with Disabilities* should be referenced in the Act, but recommend that this be

[24] "Together We Can," *supra* note 2 at 22-25.

[25] *Canadian Foundation for Children, Youth and the Law v Canada (Attorney General),* [2004] 1 SCR 76 [*Canadian Foundation for Children*]; and *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817 [*Baker*].

[26] *CRPD*, *supra* note 10, art 33.

done in a separate provision confirming that *IPTA* is to be read and applied consistently with Canada's accepted obligations under the Convention.[27]

There are two other changes of a more specific nature that we propose for section 2. The first relates to the opening language of section 2. It says that the purpose of the Act is to ensure "that issues with mental health" are dealt with in accordance with the guiding principles that are specified. It is very positive that the language "issues dealing with mental health" encompasses but is not limited to the interpretation and administration of *IPTA*. There is, however, a risk that this language will be interpreted as referring only to general issues of mental health and not to the interpretation and administration of *IPTA*. What we heard convinces us that the phrase "issues dealing with mental health" is generally understood to include the interpretation and administration of *IPTA*. It would, however, eliminate the risk for misunderstanding on this point and perhaps strengthen the understanding of the relevance of the general principles to the operation of the Act if the language was expanded to make explicit reference to the interpretation and administration of the Act. It would then read to the following effect: "The purpose of the Act is to ensure that issues dealing with mental health, *including the interpretation and administration of this Act*, are dealt with in accordance with the following guiding principles."

The second specific change concerns the final guiding principle, which says "any declaration of involuntary admission or declaration of incapacity is made on the basis of evidence." This language does not encompass certificates for involuntary psychiatric assessments or the issuing of community treatment orders. There is therefore a concern that it could be read as suggesting that decision-making based on evidence is less important in relation to those decisions. To avoid this misreading of the Act's objectives, it would be better if the guiding principle read as follows: "*any certificate for involuntary psychiatric assessment*, declaration of involuntary admission, declaration of incapacity *or community treatment order*, is made on the basis of evidence."

2.1.2. The Protection of the Rights of Patients Under Involuntary Evaluation, Assessment, and Treatment

For understandable reasons, much of the focus in debates on legislation that authorizes involuntary psychiatric treatment is on the criteria and processes that are prescribed for evaluating, assessing, and treating patients involuntarily. In other words, the debate often focuses on how the legislation protects the right of the patient not to be subject to involuntary evaluation, assessment, and treatment.

In *IPTA* as in similar legislation, the protection of this right includes the admission and treatment criteria themselves, the expertise of the doctors who interpret the criteria, peer review of physician determinations, administrative overview of the process inside district health authorities, and review of

[27] Canada's ratification of the *CRPD* is subject to the following reservation: "To the extent that Article 12 may be interpreted as requiring the elimination of all substitute decision-making arrangements, Canada reserves the right to continue their use in appropriate circumstances and subject to appropriate and effective safeguards. With respect to Article 12(4), Canada reserves the right not to subject all such measures to regular review by an independent authority, where such measures are already subject to review or appeal."

involuntary hospitalizations and community treatment orders by the Review Board. The Act also requires a declaration of involuntary admission or a renewal of a declaration to be filed with the chief executive officer of the district health authority, who is then to inform the patient and the patient's substitute decision-maker of the declaration or its renewal and of the patient's right to apply to the Review Board and to retain and instruct counsel. The Act provides patients with a right to be informed of their positive right to speak with a patient advisor once they have been involuntarily admitted into hospital or placed on a community treatment order. The Act also directly provides patients with a right to be represented by counsel before the Review Board.

Legislation such as *IPTA* typically also provides protection to a closely related but distinct set of patient rights: the rights of the patient during the process of involuntary evaluation, assessment, and treatment. In other words, the objective of such legislation is typically not only to protect the rights of patients in relation to the applicability of the legislation (the right not to be involuntarily evaluated, assessed, or treated), but also through the course of the application of the legislation once it has been properly determined to be applicable (broadly, the right to be treated properly in both a clinical and general sense while being involuntarily evaluated, assessed, and treated).

IPTA contains or is subject to provisions that provide this kind of protection to patients. Under the *Hospitals Act*, the patient is assumed to have capacity unless and until a determination is made that they lack capacity. Until then, no treatment other than emergency treatment can be undertaken without the patient's consent. When treatment happens on the basis that the patient lacks capacity it can only happen with the consent of the patient's substitute decision-maker.

It is also noteworthy that *IPTA* provides certain positive rights to patients or recognizes that patients have such rights. A person who is brought to a hospital for evaluation under the Act by police has a right to be returned by the police to the place at which they were taken into custody if the evaluation determines that the person should not be held for the 72-hour psychiatric assessment. The provisions of the Act on CTOs can be interpreted as giving the patient a right to the care and services provided for in the community treatment plan that has to be prepared whenever a CTO is issued. Section 64 also provides protection for patient rights: it says a person detained for a psychiatric assessment, admitted to a psychiatric facility or placed on a CTO "shall not be deprived of any right or privilege enjoyed by others by reason of receiving or having received mental health services." The authority of the Governor in Council under section 83 to make regulations includes the power to make regulations "respecting patient rights."

Most broadly, the guiding principles can be interpreted as recognizing that patients are to be evaluated, assessed, and treated with recognition that they continue to have rights. Specifically, they say: "persons of all ages with mental disorders are entitled to be treated with dignity and respect"; that "each person has the right to make treatment decisions to the extent of the person's capacity to do so"; that "treatment and related services are to be offered in the least-restrictive manner and environment'; that "treatment and related services, where possible, should promote the person's self-determination and

self-reliance; and "the person has the right to a treatment plan that maximizes the person's potential and is based on the principles of evidence-based best practice."

We heard however that *IPTA* was not as strong or as clear in offering protection to the rights of patients being evaluated, assessed, and treated under the authority of the Act as it should be. One example was the request from family members, supported very strongly by the Nova Scotia Schizophrenia Society, for more clarity on the need for consent from substitute decision-makers, on behalf of patients, for treatments beyond psychiatric treatments and more specifically beyond pharmacological treatments. More broadly, the experts in mental health law who spoke with us agreed that the Act should provide more extensive and explicit protection to rights of patients in care under the Act, particularly to those being treated under a declaration of involuntary admission.

Patient rights in the following areas were frequently mentioned: the use of restraint, seclusion, and other "control measures"[28]; general protection against abuse or use of treatments to punish[29]; and protection of and opportunity for private communications.[30] Most jurisdictions also guarantee access to information for patients. A wide range of approaches to protecting patient rights in these and other areas were brought to our attention, including: prescribing in statute or legislation substantive standards, limitations, or processes to be followed on use of certain treatments or medical procedures; general prohibition against abusive or exploitative treatment, including use of treatment to punish; statement of a patient "bill of rights"; mandatory documentation of the use of certain treatments; requiring certain procedures to be approved by a second psychiatrist; and oversight by a designated official.

In our consultations, we did not hear a lot about patient experiences that would infringe the kinds of rights of patients in care that might be explicitly protected in legislation. We are very aware, however, that we have not conducted the kind of review that would bring to light the problems in this area that may exist. And we did hear very strong concerns from legal aid lawyers about conditions at which patients were kept in "quiet rooms" in some facilities. Even if the abuse that would be explicitly prohibited by such provisions is not a broader problem, prevention rather than reaction is the right legislative posture. We are, therefore, in general agreement that the objectives of *IPTA* should be to provide explicit protection to the rights of patients who are being involuntarily treated under the Act.

We are also influenced by several other considerations in concluding that one of the objectives of *IPTA* should be to provide more explicit protection to these kinds of patient rights.

---

[28] H Archibald Kaiser, "Restraint and Seclusion in Canadian Mental Health Facilities: Assessing the Prospects for Improved Access to Justice" (2001) 19 Windsor YB Access Just 391.

[29] This is in keeping with the right under section 12 of the *Charter of Rights and Freedoms, supra* note 23: "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment," and article 15 of the *CRPD*, *supra* note 10.

[30] See, e.g., *Mental Health Act*, RSO 1990, c M.7, s 49 & 53, ensuring documentation of chemical restraints and limiting use of psychosurgery; *Mental Health Act*, RSA 2000, c M-13, ss 14, 15, & 16 guarantee information to patients and private communication; *Mental Health and Related Services Act 2002* (NT), ss 87 – 100 guarantee access to information on treatment, private communication, and a discharge plan, among others; and *Mental Health Act 2007* (UK), c 12, s 122 provides a discretionary right to pocket money, among others.

Most mental health legislation in Canada provides some protections in this area. In addition, there is broad international consensus that one of the functions of mental health legislation is to protect the rights of people with mental illness when they are held in mental health facilities. In the World Health Organizations' *WHO Resource Book on Mental Health, Human Rights and Legislation*, these rights are outlined as including: rights to recognition as a person before the law; privacy; freedom of communication; and an "environment and living conditions… as close as possible to those of the normal life of persons of similar age," including in relation to recreation and leisure activities, education, purchasing or receiving items for daily living, and vocational activities and vocational rehabilitation.[31]

The Resource Book also specifically addresses restraint and seclusion, stating legislation: should only permit their use when they are the only means available to prevent immediate or imminent harm; specify they must be used for only short periods of time; prohibit one period of seclusion and restraint immediately following another; require active and not passive monitoring; prohibit use as punishment or to serve the convenience of staff; promote development of infrastructure or resources to discourage use of seclusion and restraint to compensate for deficiencies in organizational capacity; specify procedures for use of seclusion and restraint; require all seclusion and restraint to be recorded in a manner that makes it reviewable by an external body; and provide for notification of use of restraint or seclusion to family or personal representative (i.e., substitute decision-maker).[32]

Building protection for such rights into *IPTA* (or into regulations under *IPTA*) would not be in tension with the larger objectives of *IPTA*. To the contrary, explicit protection for the rights of patients in care would be consistent with the objective of *IPTA*, through its guiding principles, to ensure that patients are treated in accordance with patient-centred norms. Additionally, greater legislative protection for the rights of patients in care would not be a new thing in Nova Scotia: the provisions of the *Hospitals Act* that *IPTA* replaced protected the rights of patients in relation to correspondence, telephone calls, and mail. It also subjected psychosurgery to special rules.

Finally, building more protection for the rights of patients into *IPTA* would strengthen the protection already provided under the *Protection for Persons in Care Act*[33] and through the jurisdiction of the Ombudsman to investigate complaints from people detained in psychiatric facilities.[34] An explicit statement of patients' rights would make the standard of care and protection required of psychiatric facilities clearer and stronger. It would thereby strengthen the accountability that can be brought to bear under these associated statutes.

Our understanding is that Nova Scotia has policies in place, which address restraint and seclusion. We agree with those who submitted to us that legislated protection is called for. To put it in terms of our mandate, we believe that protecting patients in this way, including but not only relative to restraint and seclusion, should be one of *IPTA*'s objectives.

---

[31] World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation* (2005) at 34 [WHO].
[32] WHO, *supra* note 31 at 65.
[33] *Protection for Persons in Care Act*, SNS 2004, c 33.
[34] *Ombudsman's Act*, RSNS 1989, c 327, ss 11 & 12.

2.1.3. Should the Objectives of *IPTA* be Expanded to Address Mental Health More Generally?

Although it was not a major theme in our consultations with stakeholders, the question of broader mental health legislation was raised. We deal with it here because such legislation, whether in an expanded *IPTA* or in separate legislation, would have different objectives than *IPTA* as currently structured.

Some expressed the view that the narrowness of *IPTA*'s concern with psychiatric treatment was stigmatizing because it strongly associated mental illness with involuntary psychiatric treatment. We heard some of the same people and others express the view that either *IPTA* or another Act should address mental health more generally because of the role legislation could play in improving the mental health system. Typically, the broader legislation envisaged was legislation dealing with the broader framework of mental health policy, particularly as it related to access to the broader spectrum of mental health services. Some went further, urging us to recommend mental health legislation to address the social determinants of mental health, including housing, employment, and social engagement. Members of the Dalhousie Health Law Institute and Professor Archibald Kaiser urged upon us the need for legislation that gave people living with mental illness positive rights to these social determinants of mental health. Others questioned the practicality and workability of such legislation.

Conversely, we were also told that the clarity and honesty of *IPTA* in dealing exclusively with psychiatric treatment and mostly with involuntary psychiatric treatment was one of its strengths. The point made was that the concentration of the Act on psychiatric treatment and more specifically on involuntary treatment communicates the function of the Act clearly and unequivocally. It avoids the problem of having legislation, which is really about involuntary psychiatric treatment, masquerading as legislation that is more generally about mental health.

The additional consideration is that we learned in this Review that even though *IPTA* is a relatively short statute precisely because it is limited in scope, the people who must work with it sometimes struggle with its interpretation and especially with the complex interaction of its various provisions and with the interaction of *IPTA* with other legislation, especially the *Hospitals Act*. This reflects the fact that although the Act governs a clinical process, it is written in the language of legislation as that language is written and interpreted by lawyers. The inaccessibility of the Act to those who must work with it could become a larger problem if its provisions on involuntary treatment were incorporated into a larger statute with more diffuse functions.

In the context of this discussion, it is worth noting again that section 2 of *IPTA* says that its purpose "is to ensure that issues dealing with mental health," are dealt with in accordance with listed guiding principles. In other words, the function of the guiding principles is stated to be broader than guiding the interpretation and administration of *IPTA*. Although most of the guiding principles are closely related to treatment of mental illness and some are specifically concerned with psychiatric treatment, some of the principles are broader. For example, the first guiding principle says that "persons of all ages with mental

disorders are entitled to be treated with dignity and respect" and the seventh says "persons with mental health should have access to mental health services as close to the person's home as practicable."

It may also be relevant to the question of broader mental health legislation that we heard a great deal in the Review about limited and inconsistent availability and lack of access to mental health services other than those governed by *IPTA*. In particular, we often heard that there is inadequate access to preventive and rehabilitative services and to services in the community. Many expressed the view that the limited availability of this broader spectrum of services leads either to reliance on involuntary treatment when it would otherwise be minimized or avoided entirely. We also heard that the limited availability of such services often leads to behaviour that results in criminal charges and ultimately to criminalization. More broadly, we heard many references to the problems of poverty, housing, and social isolation that face those living with mental illness and their families. These are issues, particularly housing and supports in the community, that are targeted in Nova Scotia's mental health strategy.[35] In Bridgewater, we heard about the particular difficulties facing residential care facilities that are struggling without the kind of support they feel they need to properly care for a growing population of people who are ageing with mental illness.[36] This was an example of a broader theme: the difficulties that patients, families, and providers face in navigating the boundaries between different systems, particularly the health system and the community services system.[37]

Accordingly, the issues that might be addressed in broader mental health legislation were of significant concern for many who participated in the Review, even if they did not all connect these issues to broader mental health legislation. Some connected at least some of these issues to Nova Scotia's Mental Health Strategy, "Together We Can," which we are required by our mandate to take into consideration. It recognizes that, "government departments, mental health and addictions care systems, and related programs and services need to work together better than they do now," and that "there are too many uncoordinated services, too many silos facing people who need mental health and addictions care and supports."[38] Most were optimistic about what the strategy might accomplish, particularly in light of the steps that have already been taken under the strategy.[39] There was however, scepticism expressed as to whether the strategy would be fully and effectively implemented in the longer term and some concern about the scope of the strategy.

We have not heard enough in this Review nor had enough opportunity to otherwise research the issue to provide firm advice on the question of whether Nova Scotia should have a broader legislative framework on mental health than is provided by *IPTA*. We have, however, heard enough to conclude that the question should be explored in more depth. We put it this way: the objectives of *IPTA* are suitable for what *IPTA* does, but there is a question as to whether they are sufficient for the broader mental health system within which *IPTA* operates.

---

[35] "Together We Can," *supra* note 2 at 26-27.
[36] "Together We Can," *supra* note 2 at 19-20.
[37] As recognised in "Together We Can," *supra* note 2 at 9 & 27.
[38] "Together We Can," *supra* note 2 at 10
[39] "Together We Can: Progress Report," *supra* note 3.

The same question could be asked of the *Health Authorities Act*, which is one of the statutes that operates in association with *IPTA*.[40] It does deal with the broader aspects of mental health in the context of provincial and district health care services planning, but only in a very general way. And it only deals with the broader aspects of mental health, which come within the jurisdiction of the health care system.

In light of all of the above, our conclusions on the question of whether the broader aspects of mental health should be addressed more extensively in legislation is that this should be put under active consideration. The question to be asked is this: can legislation play a role in helping Nova Scotia to improve access to mental health services beyond those regulated by *IPTA*, to address the social determinants of mental health and to ensure a coordinated and integrated plan of action that cuts across the mandate of all of the relevant government departments? If the answer is positive, the necessary legislation could be enacted either by expanding *IPTA* so that it becomes "comprehensive mental health legislation"[41] or by enacting a distinct statute to work in conjunction with *IPTA* and the *Health Authorities Act*. As stated above, our view is that there are practical reasons for favouring the latter approach.

On the form and content of separate mental health legislation, we have not had the opportunity to give the matter the kind of attention that would be needed to provide detailed guidance. As noted above, it was proposed that we should recommend having positive rights to mental health services and the social determinants of mental health enshrined in legislation. A large body of literature, particularly from international bodies, supports this suggestion.[42] It is also questioned in other literature on grounds such as effectiveness, feasibility, and affordability as well as concern about the institutional competency of courts and other adjudicative bodies.[43] A more fundamental concern is that access to health services and the questions of government's capacity to address social determinants are ultimately questions of policy that must be addressed in legislation accordingly.[44]

We suggest, in accordance with our responsibility "to provide advice that is reasonable and able to be implemented," that a model worth consideration is legislation that provides a statutory framework for mental health planning at the provincial level, building on the release of Nova Scotia's first mental

[40] *Health Authorities Act*, SNS 2000, c 6.

[41] Gray, *supra* note 15 at 397 *et seq*.

[42] Office of the United Nations High Commissioner for Human Rights & World Health Organization, *The Right to Health*, Fact Sheet No 31 (2008); Leslie London, "What is a Human Rights Based Approach to Health and Does it Matter?" (2008) 10:1 Health and Human Rights Journal 65; Siri Gloppen, "Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health" (2008) 10:2 Health and Human Rights Journal 21; Colleen M Flood, Lance Gable & Lawrence O Glostin, "Introduction - Legislating and Litigating Health Care Rights Around the World" (2005) Wayne State University Law School Legal Studies Research Paper Series, No 08-29.

[43] Frank B Cross, "The Error of Positive Rights" (2000-2001) 48 UCLA L Rev 857; Brendan D Kelly, "Mental health legislation and human rights in England, Wales and the Republic of Ireland" (2011) 34 Int'l J L Psych 439; B McSherry & P Weller, eds, *Rethinking rights-based mental health laws* (Oxford: Hart Publishing, 2010).

[44] As discussed in: Brendan D Kelly, "Mental health legislation and human rights in England, Wales and the Republic of Ireland" (2011) 34 Int'l J L Psych 439-454.

health strategy in 2012. In other words, we propose the development and adoption of new legislation that might be called "The Mental Health and Addictions Care Planning Act."

Such legislation could play a positive role in ensuring the broader determinants of mental health are addressed within a statutory framework that assigns responsibility and accountability for progressive improvement in access to mental health services, to the social determinants of mental health and in the mental health status of Nova Scotians. It could in this way help to ensure that Nova Scotia continues to make progress towards its goal of ensuring equity in the allocation of resources between mental and physical health. It could also balance the emphasis that *IPTA* places on psychiatric treatment by focusing greater and more explicit statutory attention on the broader policy aspects of mental health, including the social determinants of mental health and preventive interventions that can reduce reliance on *IPTA*. In addition, legislation that addresses mental health as an area of shared responsibility across government departments and sectors of society could help to ensure the commitment to common effort set out in a multi-year strategy such as "Together We Can" is not frustrated by legislative, jurisdictional, and bureaucratic barriers. At the same time, such a legislative framework would recognize that progress ultimately depends on policy.

We make recommendations in Part 3 of this Report dealing with the possible elements of such a statute.

2.1.4. Should the Objectives of *IPTA* be Expanded to Address Provincial Aspects of *IPTA*'s Implementation?

Like other legislation of its kind, *IPTA* is largely legislation about a process of individualised clinical decision-making. It is legislation that is primarily implemented through decision-making by doctors and in particular by doctors who work in emergency rooms and psychiatrists who work in the mental health units of hospitals. In large measure, the subject matter of the legislation is a field of medical practice. Like other fields of medicine, this one depends on the professional expertise and judgement of each physician, but unlike other fields of medicine, it depends upon the authority of law to hospitalize and treat patients against their will. That is why it is a field of medical practice that requires specific legislative authorization.

We understand that physicians carry out their roles under *IPTA* in a broader institutional context as members of multi-disciplinary mental health care teams. In our consultations with people who work in mental health, we heard many times about the importance of these broader multi-disciplinary teams and their community partners, including from psychiatrists. We also heard about how the work of psychiatrists is subject to a broad range of contextual factors, including the resources made available to mental health within the priorities of the broader health care system and the chosen approach of each district to mental health program design and delivery.

Elements of this broader institutional context are reflected in the provisions of *IPTA*. For example, section 23 requires the chief executive officer of a district health authority, or a person designated by them, to examine each declaration of involuntary admission and each declaration of renewal issued in their district "to ascertain whether or not the declaration has been completed in accordance with this

Act." As another example, under section 26, it is the district chief executive officer or designate who is responsible for ensuring the patient and their substitute decision-maker are informed of the filing of a declaration of involuntary admission or renewal and of the rights of the patient to apply to the Review Board and to retain and instruct counsel.

Yet overall, *IPTA* says very little about the broader system of psychiatric care within which individual physicians carry out the roles that only they can play. In particular, there is very little in the Act about the broader administrative and governance responsibilities of district health authorities relative to the overall functioning of the Act in the district: what is there is more implied than explicit.[45] Likewise, the Act does not explicitly address the broader administrative and governance responsibilities of the Department of Health and Wellness in relation to the overall functioning of the Act across the province. It does not, for example, say that the Minister of Health and Wellness is responsible for the "general supervision and administration of this Act," as many statutes do.

Based on the totality of what we have heard about the functioning of *IPTA*, we think that the silence of the Act in these broader respects is problematic. We can summarize our view, based on all we have heard, as follows: although each district must be responsible for implementing *IPTA*, the implementation of *IPTA* cannot be left to each district. This is, however, what *IPTA*, as currently written, implies.

For example, one of the recurring themes of our consultations has been the widespread concern that there is too much inconsistency in the interpretation and application of the Act, or too much scope for inconsistency. As we will explain later, the empirical data may support this concern. The Act however does not assign any authority or accountability for monitoring the overall implementation of the Act and acting to ensure that apparent inconsistencies are analysed and addressed if validated.

Independently of the question of consistency, the Act does not make any provision for continuous monitoring on a province-wide scale of the cumulative effect of the thousands of decisions that must be made by individual doctors or teams of providers for particular patients relative to the overall objectives of the Act, including the guiding principles. Nor does the Act address authority and responsibility for development and implementation of the common decision support tools, such as common processes for assessing capacity or deterioration that physicians and other clinicians in all districts could use to ensure that the Act is proactively implemented in broadly consistent ways throughout the province.[46] As another example, the Act does not assign responsibility for ensuring that effective education on the Act is provided at the district and provincial levels to all who must work with the Act or who are affected by the Act.[47]

---

[45] For example, although the authority of chief executive officers under section 23 "to ascertain whether or not the declaration has been completed in accordance with this Act" could be interpreted broadly to encompass the substance of the decision that leads to the declaration, our impression is that it is interpreted more narrowly to include only the question of whether the declaration is properly completed and documented.

[46] Auditor General, Nova Scotia, "Health: Mental Health Services" in *Report of the General* (June 2010) 49 at 64-67 [Auditor General Report].

[47] "Together We Can," *supra* note 2 at 31; and "Come Together," *supra* note 4 at 1.2.

More broadly, the Act also does not authorize action on or assign responsibility for issues relevant to the functioning of the Act that go beyond the powers or the capacity of each district health authority. We are sure many of these issues can be addressed by coordination and collaboration between and among district health authorities, working in partnership as necessary with the Department of Health and Wellness. We heard many encouraging things about the coordination and collaboration that currently takes place between districts for the benefit of patients and their families. But we also heard that collaboration and coordination are not as universal or as easy as they need to be if *IPTA* is to be consistently implemented in patient-centred ways. We heard also that the acute care dimension of mental health that is governed by *IPTA* needs a more strategic approach.[48]

Specifically, we heard that the operation of the Act could be improved if certain core issues were addressed at either the regional or provincial level or if a stronger framework for their resolution at the district level was articulated at the provincial level. Some people thought one of these issues was the system's reliance on psychiatric units that may be too small to provide optimal care. Others thought the question of whether the system was too "flat," with most districts responsible for the same range of services, was one that needed to be tackled at the provincial level. Others mentioned that the exploration of more dignified and efficient options for transporting patients than the current reliance on the police was a "system issue" that needed a "provincial solution." The broader question of the role of the police and of the terms and conditions of the evolving partnership between policing and the mental health system was another issue that some said needed to be more clearly worked out at a provincial level, building on the positive work going on in each and every district and the province-wide "Hyde training." Others called for more generally agreed upon interpretations of the Act, particularly on issues on which districts needed to work together.

Throughout this Report we reach a number of conclusions and make associated recommendations about the broad areas of responsibility we think *IPTA* should assign to the Department of Health and Wellness. We do not do so because we have found that there are things that the Department should have been doing under *IPTA* that it has not done. Instead, we do so because we find that *IPTA* does not currently provide a statutory framework for the work that has to be done at the system level if *IPTA* is to be optimally implemented at the district level and for each patient and family. While many of these responsibilities or functions are responsibilities or functions that could be carried out without explicit legislative authority, some are not. Moreover, we have concluded that authority to carry them out should be added to the Act so that everyone, including the Department, has a clear expectation from this point on that the Department has a critical role to play in system leadership.

This may make *IPTA* somewhat distinctive among Canadian mental health legislation. Like *IPTA* as currently written, the legislation of other Canadian jurisdictions is primarily concerned with the clinical aspect of acute mental health care, and more specifically, with the authority of physicians to admit and treat involuntarily. We have noted however, that the legislation of some provinces gives a broader range of specific powers and responsibilities to the Minister of Health than *IPTA* does, including some

[48] As recognised in "Together We Can," *supra* note 2.

that relate to the general system of acute mental health care.[49] Moreover, we have noted that the mental health legislation of a number of countries, including Ireland and Scotland, gives greater attention to the role of central agencies for the overall implementation of legislation that, like *IPTA*, deals primarily with the psychiatric dimensions of mental health care.[50]

In our view, a shift in this direction is particularly appropriate under legislation built, as *IPTA* is, on the human needs approach to legislation on involuntary treatment for mental illness. As mentioned above, the hallmark of such legislation is the greater weight it places on the need of certain patients for treatment and the benefits treatment can provide. The mechanism for doing this are criteria for involuntary admission, which under *IPTA* are also the criteria for involuntary treatment, which give broader clinical discretion to physicians than legislation written on a civil liberties model. In our view, this makes it important that the system accepts responsibility for ensuring this broader authority is consistently used to benefit patients in ways that protects individual rights. To the extent this improves the functioning of the Act, it will also help to ensure that the legislation does indeed respond appropriately to "human need." Accordingly, in this Report we recommend a range of responsibilities be given to the Minister of Health and Wellness by amendments to *IPTA* that will, more than legislation in Canada typically does, ensure that the Minister and Department have broad authority for ensuring the effective implementation of the legislation on a provincial scale on a continuing basis.

Two qualifications are appropriate. First, our recommendations are not that someone other than doctors and their colleagues in other health professions should be making the decisions under *IPTA* that pertain to specific patients. Subject to the oversight over these decisions by the chief executive officer of each district health authority already required by *IPTA*, we think these are decisions that have to be left to clinicians. Instead, our recommendations are about the support that clinicians should be able to count on, the accountability they and their district health authorities should expect, and the system improvements that they and their patients, along with family members, should progressively see as the implementation of *IPTA* evolves.

Second, our recommendations are not that the Minister of Health and Wellness should be given responsibilities or a role under *IPTA* that conflicts with the basic division of responsibilities between the Minister and district health authorities set out in the *Health Authorities Act*.[51] Instead, our recommendations are that the responsibilities given to the Minister under *IPTA* should be consistent with but in some respects more detailed than the responsibilities he or she is given in more general terms by the *Health Authorities Act* for system governance, system planning, standards-setting, and monitoring and evaluation. In our view, this is warranted by the specific nature of treatment given on

[49] See *Mental Health Services Act*, RSNB 2011, c 190, s 3; *Mental Health Act*, RSA, 2000, c M-13, s 49; and *Mental Health Ac*t, CCSM, c M110, s 125.

[50] In some of these countries, a significant part of the responsibility is given to a body that operates at arms-length both from the department or ministry of health and the local health authorities who operate the psychiatric facilities. For example, in Ireland, much of the responsibility for the system is given to a mental health commission. It was suggested to us that Nova Scotia might adopt this model, perhaps by analogy to the role played by Cancer Care Nova Scotia in cancer care. We have not had the opportunity to fully consider this alternative but only mention it here because it was mentioned to us.

[51] *Supra* note 40.

an involuntary basis. It is also warranted by the many benefits that can come to patients, their families and the broader community if "Working Together" by all levels of health system governance is not only a strategic objective but a legislative imperative.

2.2. The Functioning of *IPTA*

2.2.1. Introduction

The second part of our mandate requires us to consider "[w]hether the Act is effectively meeting its current objectives and is otherwise functioning effectively and appropriately or whether the functioning of the Act is in need of improvement, in specific areas or more generally." This part of our mandate necessarily overlaps significantly with the third part of our mandate, which requires us to consider whether amendments to legislation or changes in administration should be made (either in reference to the Act or associated legislation) to improve or strengthen the functioning of the Act, "relative to its proper objectives, patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, as articulated in Nova Scotia's mental health and addictions strategy."

We have addressed this overlap by limiting ourselves in this section to the identification and discussion of the issues that were raised with us regarding the functioning of *IPTA*. In the course of doing so, we indicate the issues that we conclude should be addressed either by amendments to *IPTA* or to other legislation or by changes in administration of *IPTA* or other legislation. The specific amendments or changes in administration we recommend to improve the functioning of the Act will be dealt with in Part 3 of this Report.

We note that the second part of our mandate requires us to ask if *IPTA* is "effectively meeting its current objectives *and is otherwise functioning effectively and appropriately*." The third part of our mandate requires us to consider improvements in the functioning of the Act relative to its "proper objectives" and the broader considerations of "patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, as articulated in Nova Scotia's mental health and addictions strategy." There are two key differences in language: between "current" and "proper" objectives and between "otherwise functioning effectively and appropriately" and functioning relative to "patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, as articulated in Nova Scotia's mental health and addictions strategy." It may be helpful if we explain how we have addressed these differences in wording in the organization of this Report.

On the first difference, we note that we have already concluded that the objectives of *IPTA* are largely the "proper objectives" subject to amendments we have indicated should be made to strengthen the guiding principles and to provide a more detailed framework for addressing issues that need to be addressed at the provincial level. So the objectives against which we assess the functioning of *IPTA* will be the same here as when we turn to the third part of our mandate and the making of recommendations. On the second difference, we have interpreted our responsibility in the second part of our mandate to consider whether *IPTA* "is otherwise functioning effectively and appropriately" to mean the same thing as our responsibility in the third part of our mandate to consider the effectiveness

of the Act relative to "patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, as articulated in Nova Scotia's mental health and addictions strategy."

We have divided this section of our Report between our review under section 84 of the Act as a whole and our review of specific sections or interrelated sections of *IPTA*.

2.2.2. The Overall Functioning of *IPTA*

As laid out in our mandate, we are to consider the general functioning of *IPTA* relative to its current objectives and patient-well-being; applicable human rights principles; the importance of mental health and the mental health system; and Nova Scotia's mental health policy objectives, as articulated in Nova Scotia's mental health and addictions strategy, "Together We Can." In this section we address the overall functions of the Act relative to these matters. In the next section, we deal with the functioning of specific sections or of interrelated sections.

2.2.2.1. The Overall Functioning of the Act Relative to its Objectives

As stated above, *IPTA* is strongly built on the human needs approach to involuntary treatment legislation. The overriding objective of *IPTA* is to establish a framework for involuntary treatment that puts more emphasis on the benefits to patients of such treatment than is typical with legislation built on the civil liberties model. One of the underlying ideas is that, for those who require it, involuntary treatment serves the same values as the protection of the patient's civil liberties, particularly autonomy, in that it enables the exercise of civil liberties. At the same time, legislation framed in terms of human needs includes protection of civil liberties, as indeed it must under constitutional and international law.

2.2.2.1.1. What We Heard From Stakeholders

Most participants in the Review were positive or largely positive about the effectiveness of *IPTA* in meeting its broad objectives. Although there were dissenting views strongly expressed to us, the general view was that the Act enabled psychiatrists and, therefore the health care system, to be responsive to the care needs of persons who were unable, due to their illness, of understanding or appreciating their need for care.

The core message we heard was that *IPTA* allowed the mental health care system to respond more directly to the needs of patients than was the case under the *Hospitals Act.* Our understanding of the difference between the two statutes that accounts for this difference was the change made by *IPTA* in the risk criteria for involuntary admission. Under the *Hospitals Act,* admission beyond a seven-day observation period required a determination that the person was "a danger to his own safety or the safety of others."[52] Under *IPTA*, the risk criterion has been broadened. It is satisfied where there is a risk of "serious harm" to self or others or where the patient "is likely to suffer serious physical

[52] See *supra* note 18.

impairment or serious mental deterioration or both." We heard that this difference has meant that certain patients who would not have been hospitalized previously even though they may have required it can now be hospitalized. We also heard that for patients who might have been hospitalized under either statute, the basis for hospitalization is now more likely to be concern for the patient's well-being. This, rather than the dangerousness of the patient, can now be given as the basis for hospitalization. We heard that this difference can be of therapeutic value to the patient, less traumatic and upsetting for family members and, therefore, less likely to cause harm to familial and other personal relationships.

The concerns about the functioning of *IPTA* relative to its broad objectives came largely from the family members of people with mental illness, and particularly from the parents of adults living with bipolar disorder or schizophrenia. Family members expressed concern to us that the Act was sometimes being applied as if it only applied to persons who were dangerous.[53] In other words, they expressed concern that psychiatrists were not giving effect to the changes that *IPTA* made to the risk criteria. The specific concern frequently mentioned was that the serious deterioration component of the risk criteria for involuntary admission was not being given full effect. Some family members shared very personal experiences with us about the great difficulty they had experienced or continue to face in getting care and treatment for their son, daughter, sister, or brother. Although some of these experiences were shared by family members who also said the system was getting better, others were related to us by family members who spoke of continuing difficulty and frustration. Some police officers shared with us a parallel frustration based on their inability to understand some of the decisions not to admit some of those they took to hospital for medical examination.

Family members also shared concerns that the police were sometimes unduly hesitant to use their authority under section 14 of *IPTA* to take persons into custody for the purpose of transporting them to a hospital for a medical examination under section 8. Again, the specific concern was often the unwillingness of police officers to exercise their authority to take a person into custody on the basis that the person "is likely to suffer serious physical impairment or serious mental deterioration, or both." Some police officers confirmed that this may indeed be the experience of some family members: they said flatly they are not prepared to make what they regard to be a clinical judgment for the purpose of taking a person into custody.

A third and closely related concern frequently voiced by family members was that both doctors and police officers were not consistently giving sufficient weight to the "collateral information" family members were often able to provide about deterioration. Indeed, it was sometimes said that the concern was deeper: that doctors or police officers were sometimes not even prepared to listen to the information family members could provide to assist in the evaluation of deterioration.

Despite such concerns, most family members were positive about *IPTA* and the changes it made to the law. Their concerns went to how the Act was sometimes being administered, not to the Act itself. In

[53] The concern was supported by the number of people who referred to the harm criterion found in *IPTA* as the dangerousness criterion to differentiate it from the deterioration criterion, even though *IPTA*'s harm criterion is not a dangerousness criterion.

our view, without in any way minimizing the frustrations of family members, it is also important to put their concerns into context. One psychiatrist noted that although it was understandable for family members (or police) to regard a decision not to admit a particular patient as a failure of the system, a decision not to admit, if properly made, is equally an example of the Act working as an appropriate decision to admit. We thought this was a very good way of making the point that the objectives of *IPTA* are about protecting the legal right to be autonomous as well as the need of some patients for treatment that can only be provided if provided involuntarily.

Somewhat similarly, a decision by the police not to take someone into custody does not mean that the police are not fulfilling their role. As with all policing, their role under *IPTA* is to use their exceptional authority in careful and measured ways with due regard for the liberty interests of the person in question. A chief of police made the point by explaining the obligation of the police on a mental health call is to make the right decision for the person who is the subject of the call, giving due regard to his or her liberty, not to do what their family member wants the police to do. Moreover, we think the general hesitancy of some police officers, absent appropriate support, to exercise police authority on the basis of physical impairment or mental deterioration is understandable.

In any event, based on what we have heard, we are not in a position to say that the Act is generally being applied too infrequently. Nor are we able to say it is being applied too frequently. The concern that we have is the different one of potential inconsistency in how the Act is interpreted and applied. In other words, we are concerned that differences in how the Act is being interpreted may be causing too much variation in how the Act is being applied to similarly situated persons.

This was a concern that we also heard from family members, as well as from advocacy organizations and those who work in the mental health system. Moreover, we saw the differences in understanding of the Act among stakeholders, including those who work in mental health, being manifested in our consultations. Some of these differences related to the understanding of key substantive concepts, such as deterioration, which are open to different interpretations. But others related to more mechanical issues on which common understanding should be easier to achieve, such as whether an involuntary psychiatric assessment can be performed in a hospital that does not have an in-patient psychiatric unit.

We understand that legislation such as *IPTA* operates largely on the basis of clinical judgment in a field of medicine that may involve more judgment than most. The judgments that police officers must make under the Act are also highly situational. What the legislation means to a particular patient, therefore, unavoidably depends to some extent on who is called on to make these judgments in relation to each patient. We also understand that legislation such as *IPTA* must be written broadly enough to deal with the differences between patients and the differences in the contextual factors within which the Act must operate. As one psychiatrist who practices in rural Nova Scotia stressed, there may be a range of factors that would quite legitimately lead psychiatrists in rural and urban communities to make different choices in treating clinically similar patients. We heard similar perspectives from police who work in small communities and rural areas.

Yet we also think that legislation such as *IPTA* should be guided in its administration by a comprehensive and continuous effort to ensure that it is interpreted and applied within acceptable parameters. Although the Review Board plays a critical role in this regard, other mechanisms of a more proactive and systemic nature are also available. Because the stakes are so high for all concerned in decision-making under *IPTA*, greater use should be made of these additional tools.

A basic mechanism mentioned many times in our consultations was the provision of education about the Act (as well as training where appropriate) for providers, health administrators, police, judges, partners in the community services sector, substitute decision-makers, patients, and the broader public. We heard training on the Act was provided for mental health professionals and police immediately after the Act was adopted. But we also heard that there was a need for continuing education on the Act at all levels. To illustrate the point, one stakeholder brought our attention to erroneous information about the Act posted on the website of the Department of Health and Wellness while the Review was going on.[54]

More consistent interpretation and application could also be assisted by providing a broader range of decision-support tools to those who work with the Act. We saw encouraging evidence of this already going on. Examples include: the crisis response team in metro, where police and clinical professionals work together in responding to mental health calls that police would otherwise be responding to on their own; the mental health liaison officer created by Cape Breton Regional Police, who serves as the interface between police officers and the mental health staff of the Cape Breton Health Authority; the Community Relations Officer appointed by the RCMP, who has a mandate to support RCMP officers across the province as they deal with an increasing volume of mental health calls; the recent decision under the Mental Health and Addictions Care Strategy to make the crisis line available throughout the province, including to police outside of metro who must respond to mental health calls on their own; the establishment of a community treatment order coordinator in Capital Health; and the utilization of community health nurses trained in mental health assessment in emergency rooms in Bridgewater, Truro, and Kentville, and possibly elsewhere, to help with the capacity assessments that Emergency Room doctors must make as part of the medical examination required by *IPTA*.

We believe, however, that more can and should be done, particularly on a province-wide scale. For example, the province-wide and multi-disciplinary training on capacity assessment that goes on in other provinces, such as Alberta, was brought to our attention.[55] Others suggested similar training in Nova Scotia on the process for assessing risk and, more particularly, deterioration. It was also suggested that protocols for assessing capacity and deterioration could be developed using psychosocial decision-making models used in certain institutions or other jurisdictions and clinical fields. In addition to helping the system achieve and maintain a consistently high standard of practice, these approaches might help to address the concerns of family members that collateral information is not sufficiently or consistently taken into account.

[54] See, e.g., online: http://www.novascotia.ca/health/mhs/pubs/ipta/IPTA_Facts_for_Law_Enforcement.pdf.
[55] See the "Regional Capacity Assessment Team – Mental Health" service, online: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1009095.

A more basic example is the flow chart for the operation of the Act which we were shown at the IWK: such documents distil the clinical process that *IPTA* mandates section-by-section into a diagram that is more readily understandable to busy health care providers and clinical administrators. Once developed, they could be distributed as part of a "tool kit" such as the ones that the Department of Health and Wellness has developed for other legislation, including the *Personal Health Information Act*.[56]

Many of these kinds of tools can and are being created at the district level. Our concern would be that if they were only created at that level, unwarranted variations between districts would not be addressed. In fact, such variations might be accentuated. Conversely, a provincial approach would help to level the playing field between districts in terms of the tools they have to provide care and protect rights in accordance with the Act. The bottom line is that patients need individualized care under the Act but the care they get should not depend as much on where they live as it seems to currently. The issue is well put in "Together We Can," which envisages a mental health care system in which "Nova Scotians are able to get the care, treatment, and supports they need more easily and in a timely manner regardless of where in the province they live." [57]

It was suggested to us that the provincial role needs to go beyond education and decision-support tools. At a meeting in one district health authority, we were told there was a "hunger" for a sense of what the standards were on questions such as capacity and deterioration. There was a suggestion that specialized resources, such as coordinators for community treatment orders, should really be instituted at the provincial and not the district level to ensure the resources are available to all. At a number of meetings we were told that instead of leaving questions about the interpretation of *IPTA* to each district authority, the Department of Health and Wellness should be willing to play a stronger role in leading a process that produces common interpretations for the system.[58] If nothing else, this could help to resolve or at least clarify some of the differences in understanding which complicate inter-district collaboration.

At one district health authority we were told that there needed to be a more systematic kind of accountability than that provided by the Review Board. The idea seemed to be a kind of clinical file

[56] *Personal Health Information Act*, SNS 2010, c 41.
[57] "Together We Can," *supra* note 2 at 5.
[58] There was a similarity between some of what we heard about harm phases in *IPTA* that are differently understood and what Judge Derrick heard in her inquiry into the death of Howard Hyde about the different understandings of the Health Information Transfer Form and the role they played in Mr. Hyde's tragic death. For example, we heard of disagreements between ER doctors and psychiatrists, and sometimes between districts about the meaning and, therefore, the scope of a medical examination and a psychiatric assessment. Our impression was that these differences sometimes result in patients being moved back and forth between departments of a hospital or from one hospital to another. Somewhat similarly, we heard about different understandings between different police forces or between police forces and districts about what the meaning and, therefore, the duration of the obligation of the police to stay with a patient being examined in an emergency room under section 14 of *IPTA*.

review process that would help to identify, disseminate, and ensure compliance with best practices.[59] It is relevant to note that *IPTA* contains a provision that gives broad protection against liability to those who carry out their responsibilities under the Act in good faith.[60] It was suggested that we should recommend the removal of this limitation on the rights of mental health patients because of the inequality it creates between mental health patients and patients with physical illness. Although we are sympathetic to this perspective, we do not think the recommendation would do much to improve the functioning of *IPTA*. Consideration should instead be given to creating a process of accountability that is designed to create and sustain systemic improvement.

Some of these suggestions could be implemented without authorizing legislation. Others, such as the accountability process that would consist of a review of files to identify, disseminate, and ensure compliance with best practices, would probably have to be legislatively authorized. Viewed more generally, however, all of these options are examples of programs, processes, and systems that can be implemented at a provincial level to ensure the interpretation and implementation of the Act is appropriately guided and, where necessary, directed. Providing this guidance and direction, or ensuring that they are provided through a delegated responsibility to another organization or the districts working together in a coordinated process, is a role that can only be carried out by the Department of Health and Wellness.[61]

As pointed out in our discussion of the objectives of *IPTA*, we think that the Act should be amended to more explicitly and extensively define the mandate of the Minister of Health and Wellness with respect to the overall functioning of the Act. This provision needs to be written in alignment with the division of functions and responsibilities between the Minister and the district health authorities set out in the *Health Authorities Act.*[62] In other words, the role of the Minister would be to provide strategic direction, monitoring, oversight, and funding, while the responsibility of the district health authorities would continue to be for district-level planning, management and provision of mental health care services in accordance with the budget and health services business plan approved by the Minister. However, within this basic framework, the new provisions of *IPTA* would lay out the responsibilities and powers of the Minister to lead, guide, and oversee the implementation and general administration of the Act.

[59] It is to be noted that there is support in international norms for an automatic review of all involuntary admissions in addition to the availability of review on the basis of the application of the patient: see WHO, *supra* note 31 at 67-69; and Kelly, *supra* note 43 at 442.

[60] See *supra* note 1 at s 81.

[61] As noted earlier, however, the legislation of some other jurisdictions assigns these "system governance" responsibilities to a mental health commission, which operates independently of government.

[62] *Supra* note 40.

2.2.2.1.2. What We Learned From the Quantitative Data

2.2.2.1.2.1. Introduction

As indicated earlier when we described our process, we have based our analysis of IPTA on both qualitative and quantitative data. The discussion in this section relates to the quantitative component of our analysis.

The guiding principles in section 2 of *IPTA* emphasize the importance of evidence-based decision-making and best practices. It follows that the administration of the Act, and certainly the evaluation of the functioning of the Act, must be informed by evidence. As soon as we started talking with individuals who work within the mental health care system or who are familiar with its administration, we were cautioned that the availability of quantitative data that would be useful to our work might be limited. This reflects a general sense that not enough data is systematically collected or analysed about the Act's operation, and that not enough data about the operation of the Act is made available to those in the system or to the public.

We sought data that would help us understand the profile and experience of patients under the legislation. In particular, we were interested in what the data could tell us about how the Act is being interpreted and applied both at the provincial and district levels. At a high level, we wanted to understand the demographic profile of the population being treated under the Act, the trajectory of their experience as patients under the Act, and the relative frequency with which specific provisions of the Act were being utilized. More specifically, we were interested in knowing whether levels of involuntary hospitalization changed when *IPTA* was implemented and whether they have changed since implementation of *IPTA*. We were also interested in what quantitative data could tell us about variation between districts, a leading theme in our discussion with stakeholders.

We asked for data from the Department of Health and Wellness, district health authorities, policing organizations, the Department of Justice, and the patient advisor service. We also reviewed the annual reports of the Review Board. In the next section, we outline the nature of the information collected. After that, we set out the conclusions we are able to reach on the basis of this data. These conclusions are modest owing to three factors: the unavailability of certain categories of data; the limited opportunity we have had to analyse the data; and the limited relevance some of the available data has to the questions we are required by our mandate to answer.

2.2.2.1.2.2. Available Data

Department of Health and Wellness Data

The Department provided certain metrics related to the operation of the Act when it appointed us to carry out the Review. Our Statement of Work contained a table based on the data contained in the annual reports of the Review Board from 2007-08 to 2011-12; see Appendix A. It provided us with the numbers on: community treatment orders, certificates of leave, Review Board hearings on involuntary

admissions, patient-cancelled hearings, changes of patient status to voluntary status before a hearing was held, and requests for hearings. We understand that some of the metrics for 2011-2012, particularly on the number of community treatment orders, are under review.

With input from our Technical Reference Group, in March of 2013 we asked the Department for additional information to give us a broader perspective on the operation of the Act. We asked for information on: patient demographics, the percentage of involuntary assessments which result in involuntary admission, referral sources, diagnosis and criteria applied for admission, the duration of involuntary admissions, status changes during admission, the issuance of certificates of leave and of community treatment orders, discharges, and re-admissions. We indicated that, where applicable, pre- and post-*IPTA* comparisons would be needed. Specifically, we asked for admission information for the five years prior to the coming into force of *IPTA* so we could compare hospitalization levels before and after the implementation of the Act. The information we requested is attached in Appendix I.

The Department responded to our request by providing information collected through the Canadian Institute of Health Information's Discharge Abstract Database (CIHI DAD) and by otherwise indicating that it was not able to provide the requested data. For hospitalized patients, the Department was not able to provide data on the following matters: the actual duration of involuntary assessments; the proportion of patients who are admitted under each of the harm criterion and the deterioration criterion; the number of renewals and the applicable criterion for readmission; and the frequency with which patients are changed from involuntary to voluntary or from voluntary to involuntary status. The Department was also not able to provide information on certificates of leave or on transfers between districts that may happen before admission. This is because the CIHI DAD captures inpatient activity only.

For patients on community treatment orders, the Department was not able to provide information on the number of orders revoked, the criteria applied for being placed on an order, the number of requests to peace officers to take custody of patients on orders, or the average elapsed time between the making of an order and readmission to hospital for those who are readmitted. For both hospitalized patients and patients on community treatment orders, the Department was not able to provide information on race, marital status, or country of origin.

We attach as Appendix I the charts prepared for us by the Department. The appendix also includes the Department's notations about the information that it was not able to provide. In all cases, the reason the Department could not provide a category of requested information was that it was a category of information that was not collected. With respect to our request for information comparing involuntary hospitalization levels under the *Hospitals Act* and *IPTA*, minimal information could be provided because of the way the data is categorized and collected. For example, we understand that gathering data about timeframes and lengths of stay would be a laborious process, where it could be done at all, and may not provide information that results in meaningful comparisons as between the application of the *Hospitals Act* and *IPTA*.

We are very appreciative of the work of the employees of the Business Intelligence, Analytics and Privacy Branch of the Department in responding to our information requests. Notwithstanding their efforts, much of the information we requested only became available to us as we approached the end of our mandate when we were in the process of writing this Report. This has limited the time we have had to work with the information provided in response to our questions. The form in which the information was provided to us, in charts or tables rather than in graphs, was another limiting factor. We understand that the length of time required to respond to our questions reflects the fact that departmental staff had to respond to our questions not with data collected or organized to answer such questions but with data collected and organized for general administrative purposes. In itself, this is a situation that should be addressed and on which we make recommendations.

District Health Authorities Data

A great deal of patient information is recorded on the Forms that doctors are required to complete under *IPTA* to, for example, detain a person for a medical examination or an involuntary psychiatric assessment, admit a person to a psychiatric facility, or renew an involuntary admission. Departmental databases do not capture all of the information from these Forms that might be relevant to understanding the functioning of the Act. For example, these databases do not collect information recorded on Forms on whether the patient is being admitted because they may cause harm to self or others or because they are likely to deteriorate. The Department collects these Forms in the course of providing administrative support to the Review Board. To our knowledge, it does not use the information contained on these Forms for any other purpose.

The only way to get a picture of how admission criteria are being applied in the case of involuntary hospitalization and community treatment orders is, therefore, to review the Forms themselves. In the context of this Review, we were limited in the time and other resources we had to conduct a full review and analysis of the Forms completed since *IPTA* came into effect. In recognition of the time constraints under which our mandate required us to work, and sensitive to the amount of work we would be imposing on the district health authorities to gather the Forms, we decided to ask the districts to provide us with all of the Forms completed for the year 2012. We received responses from seven districts: Annapolis Valley, Cape Breton, Colchester East Hants, Guysborough Antigonish Strait, IWK, Pictou, and South West Nova.

Patient Advisor Service Data

The patient advisor service, Empowerment Connection, provided us with its service statistics for the year April 1, 2012 – March 31, 2013. The information identifies how many times the service delivered rights advice in relation to: involuntary admissions, community treatment orders, certificates of leave, and declarations of renewal. It also identifies how many times the service provided assistance to the Review Board and Legal Aid. Of note, where a Review Board hearing was held, the patient advisor attends about 95% of the time, at the request of the patient.

Review Board Data

We reviewed the statistics provided in the Review Board's Annual Reports for the year 2007-2011. Much of this information was included in the metrics provided to us by the Department, as discussed above. The annual reports for 2011-2012 and 2012-13 have not been finalized and were not made available to us. We understand there are concerns about the accuracy of the statistics that are to be reported for these years and the Department is working to resolve them. The metrics provided in the Independent Review's Statement of Work include some of the information reported to the Department by the Review Board for 2011-2012, although as noted above, the accuracy of that information is under review.

Department of Justice

We requested, but did not receive, information from the Department of Justice regarding the number of applications to court made under section 13.

Policing Data

During our meeting with the Chiefs of Police and the Commanding Officer of the RCMP, or their delegates, the participants invited us to contact them about sharing aggregate data or information that their organizations currently collect on the mental health activity of their forces. Our request for information was broad, but included reference to the specific sections of the legislation where police are authorized to act. Our letter to the Chiefs of Police and Commanding Officer RCMP is attached as Appendix J. In response to our letter, we received statistics from the Halifax Regional Police, the Amherst Police Department, Cape Breton Regional Police Service, and the RCMP. We also received statistics in relation to *IPTA* from the Inverness Detachment of the RCMP as a follow-up from a consultation in Cape Breton. With the exception of the Inverness data, which was excluded due to privacy considerations, these statistics are included with our letter in Appendix J.

2.2.2.1.2.3. Conclusions on the Data

In this section, we will address the conclusions we have reached from the quantitative data that relate primarily to the functioning of the Act in relation to involuntary hospitalization.

Based on the information at our disposal and the time we have had to devote to its analysis, we can offer the following conclusions:

1. In any given year, there are between 2,400 and 2,800 people receiving mental health care on an inpatient basis in Nova Scotia hospitals. This size of the in-patient population has been in this range for more than 10 years.[63]

[63] See Appendix I, chart "Total Separations, Unique Patients and Involuntary Admissions from 2007-2011".

2. The number of involuntary admissions, including admissions for the purpose of involuntary assessment, is between 1,000 and 1,300 in any given year.[64] For clarity, the category of involuntary admissions in the Departmental data includes both individuals who are admitted for the purpose of involuntary assessment only and individuals who are admitted following that assessment.[65]

3. The data suggests the number of involuntary admissions has increased significantly under *IPTA*, while the number of in-patients has remained relatively stable. In 2006, the last full year of the operation of the *Hospitals Act* provisions on mental health, there were 885 certifications, meaning there were 885 occasions on which a patient was held for observation.[66] Of these, there were 373 admissions for up to one month or longer. In other words, in the nomenclature of the *Hospitals Act*, there were 373 occasions on which a patient became what that Act called a formal patient.[67] In comparison, in 2008, the first full year of *IPTA*'s operation, there were 1,076 involuntary psychiatric assessments. These resulted in 800 involuntary admissions for up to one month or longer.[68] The numbers for 2006 are similar to those between 2001 and 2005. The numbers for 2008 are similar to those for 2009, 2010, and 2011. One possible interpretation of the data from before and after *IPTA* came into effect is that the increased rate of hospitalization with a roughly stable patient population may mean that the frequency of hospitalization for some patients has increased under *IPTA*. Further analysis would be required either to confirm or invalidate this interpretation.

4. Under the *Hospitals Act*, the equivalent of the 72-hour psychiatric assessment provided for in *IPTA* was an observation period that lasted up to 7 days. Therefore, the 512 certifications that did not result in admission as a formal patient in 2006 resulted in a patient spending up to 7 days under involuntary observation. In 2008, the 276 patients that were involuntarily assessed but not admitted under *IPTA* were released in 3 days or less.[69]

5. It is possible that data of an increasing percentage of evaluated patients being admitted may provide support for the concern raised by several psychiatrists that the result of a three-day assessment period instead of a seven day observation period has resulted in more patients being admitted for longer-term admission. The concern is that without adequate time to make a thorough assessment, psychiatrists will err on the side of caution by admitting the patient under a form of involuntary admission that can result in longer hospitalization simply because the system may manage it as an admission for up to one month. In this way, a change that was

[64] One patient may have more than one admission in any given year. Therefore, 1,300 admissions does not mean 1,300 patients.
[65] See Appendix I, chart "Total Separations, Unique Patients and Involuntary Admissions from 2007-2011".
[66] See Appendix I, chart "Total Separations, Unique Patients and Involuntary Admissions from 2007-2011".
[67] See Appendix I, chart "Total Separations and Length of Stay for Mental Health Patients and Mental Health Patients with Project 304 or Formal Status".
[68] To arrive at the 800 number, we subtracted the number of individuals admitted for less than 72 hours from the total number of individuals involuntarily admitted.
[69] See Appendix I, chart "Total Stay less <= 72 Hrs for Involuntary Admissions by DHA from 2007-2011".

intended to reduce the duration of one form of involuntary hospitalization may have resulted in an increase in another form of involuntary hospitalization that can be of longer duration. Further data and analysis would be needed, however, to determine if this has indeed been the result of the shift from a seven day observation period to a three day assessment period.

6. The data available to us indicates that in 2008 under *IPTA*, the median length of stay for a patient whose entire admission was as an involuntary patient was 3 days. The median length of involuntary stay for a patient whose admission included both voluntary and involuntary status was 5 days.[70] We were not able to get comparable figures for the *Hospitals Act*. This means we cannot say whether the median duration of involuntary admissions is higher or lower than it was under the *Hospitals Act*. The relevance of this is that it would indicate whether the length of involuntary hospitalizations under *IPTA* is longer, shorter or comparable to what it was under the *Hospitals Act*. We therefore cannot say what the increase in the number of involuntary hospitalizations means in terms of number of days spent by patients as involuntary patients.[71]

7. With reference to the operation of *IPTA* since 2007, the data suggests that the operation of *IPTA* has been fairly stable and consistent year to year during the first five years of its operation. In other words, for the province as a whole and for each district, the data is fairly consistent on all available metrics from 2008 through to and including 2011.

8. In particular, year over year involuntary admission levels have remained fairly steady since the adoption of *IPTA*, both for the province and for specific districts. There is a small upward trend, but no significant marked increase. On the other hand, the upward trend is generally observable in every year covered by the data. For Nova Scotia as a whole, there were 1.6% more involuntary admissions in 2011 than there were in 2008, the first full year of the Act's operation.[72]

9. Otherwise, the data provides some support for the questions about consistency of interpretation and administration raised in our discussions with stakeholders. For example, there is variation in the level of involuntary admission between districts as measured by the percentage of admitted patients who become involuntary patients and by the median length of involuntary admissions. For example, whereas the percentage of patients admitted involuntarily in district 2, South West Nova, averaged 20.7%, the percentage of patients admitted on an involuntary basis averaged 46.9% in district 9, Capital. [73] Similarly, for patients

[70] See Appendix I, chart "Median Voluntary and Involuntary Days from 2007-2011".

[71] It has been suggested to us that comparable data might show the number of involuntary days spent in hospital under provisions of the *Hospitals Act* and *IPTA* was similar. Under the *Hospitals Act*, an admission for observation could last up to seven days. Under *IPTA*, an admission for psychiatric assessment is limited to three days. In addition, we were told many patients stabilize within roughly seven days. This could mean that a significant percentage of those who are admitted under *IPTA* after assessment are released prior or close to the point at which they would have been released after observation under the *Hospitals Act*. However, further data and analysis is necessary to know if this is happening.

[72] See Appendix I, chart "Total Separations, Unique Patients and Percentage Involuntary Admissions 2007-2011".

[73] See Appendix I, chart "Total Separations, Unique Patients and Percentage Involuntary Admissions 2007-2011".

with involuntary status only during an admission: the median involuntary stay in district 9 was 3 days in 2011, but it was 10 days in district 2.[74]

10. Some of these differences exist between what would appear to be comparable districts. In other words, the differences are not only between Capital District Health Authority and one of the smaller districts, but between smaller districts. For example, the percentage of patients involuntarily admitted in district 4, Colchester East Hants, averages around 40%, whereas in district 7, Guysborough Antigonish Strait, it averages around 20%.[75] Whereas the median length of stay in district 4 is generally 4 days, the median stay in district 7 varied between 3-11 days.[76]

11. The differences that exist between districts in the percentage of patients who are involuntarily admitted and in the median duration of involuntary admission have remained fairly constant over the five years of *IPTA*'s operation. This suggests that they reflect factors, such as differences between the patient populations, the circumstances of the districts (including, for example, bed pressures) or the approaches to providing mental health care, that are fairly stable and constant over time.

12. There is also some variation among the districts on referral sources for involuntary admissions. For example, in 2011, the main referral source for involuntary admission for district 3, Annapolis Valley, was medical therapist, while the main referral source for district 6, Pictou, was "self, family, friends, colleagues." Overall, however, the data confirms that most involuntary admissions are through the emergency department.[77]

13. Data for 2011, the first year in which the percentage of patients involuntarily admitted after a psychiatric assessment has been tracked as a distinct metric, shows that the involuntary admission rate is generally between 67 and 87 %. It also shows that the lowest admission rate was in district 2, South West Nova, at 21.3% and that the highest rate was in District 8, Cape Breton, at 98%.[78] Assuming this difference in admission rates between districts 2 and 8 is representative of a general difference and not just a difference for 2011, it could reflect a range of variables. For example, it could show a significant difference in the approach to or effectiveness of the medical examinations being conducted in the two districts in screening out patients for whom involuntary admission is not appropriate. It might also reflect significant differences in referral patterns. But it also might show differences in practice patterns that are resulting in similarly situated patients and families being treated differently based on the district in which they live.

14. The number (percentage) of patients admitted as readmissions has stayed relatively steady year-to-year since the adoption of *IPTA* within each district health authority. There is neither a

[74] See Appendix I, chart "Median Voluntary and Involuntary Days from 2007-2011".
[75] See Appendix I, chart "Total Separations, Unique Patients and Percentage Involuntary Admissions 2007-2011".
[76] See Appendix I, chart "Median Voluntary and Involuntary Days from 2007-2011".
[77] See Appendix I, chart "Total Involuntary Admissions for Referral Sources (Percentage) for 2011".
[78] See Appendix I, chart "Involuntary Assessment for Involuntary Admissions for 2011".

significant pattern of decrease or increase in the number of readmissions. There is variation between districts on the percentage of admissions that are readmissions. For example, in district 2, South West Nova, the average percentage of readmissions between 2007-2011 was 11.8%; in district 3, Annapolis Valley, it was 4.7%.[79]

15. For patients who held the status of both voluntary and involuntary patient during the same admission, no discernible trend emerged with respect to the median number of days spent in hospital. In Capital District Health Authority, there appeared to be an increase over time in the median number of days these patients were involuntary. Other district health authorities appeared to be relatively stable in that respect. As a percentage, most patients who held both voluntary and involuntary status during the same admission spent around 65% - 75% of their admission as an involuntary patient.[80]

16. The identified variations between districts may be consistent with what we heard from some stakeholders about unwarranted differences in practice patterns. We are not able to reach that conclusion given the number of variables that may be at play in determining decision-making patterns from district to district. We are able to conclude, however, that the variation among districts warrants inquiry to determine what the causes are and specifically to determine if they reflect differences in practice that should be addressed. The variations, therefore, illustrate the role that continuous monitoring of data on the operation of the Act could play in ensuring that the Act is being interpreted and applied within acceptable parameters.

17. The data that is available does not shed light on how the specific provisions of *IPTA* are being applied in psychiatric decision-making. They do not, for example, tell us whether patients are being admitted more on the basis of harm or deterioration. They do not tell us whether there are differences among districts in the extent to which or the way in which these two components of the risk criteria for admission are applied. They do not tell us whether there are generally consistent differences between the patients admitted under each criterion. The available data also cannot be analysed to see if patients admitted under one criterion do better than patients admitted under the other criterion.

18. The Forms we reviewed from seven districts suggest that the deterioration criterion is being invoked more frequently than the harm criterion, often by a large margin, on Form 2 (Medical Certificate for Involuntary Psychiatric Assessment), Form 4 (Declaration of Involuntary Assessment), Form 5 (Declaration of Renewal of Involuntary Admission), and Form 9 (Community Treatment Order). The exception to this observation was in the IWK where the harm to self or others criterion was more frequently "ticked" on the Forms than was the deterioration criterion.

[79] See Appendix I, chart "Re-Admissions and Rate for Involuntary Admissions by Age Groups for 2007-2011".
[80] See Appendix I, chart "Total and Average Stay with Average Involuntary Stay Ratio from 2007-2011".

19. In 2011, a total of 55 involuntary patients (4.5%) were recorded as being absent without leave from psychiatric facilities.[81] We were told this occurs when patients do not return after being granted a pass to be absent from a facility. The number of involuntary patients who were discharged because they did not return from a pass is small. In many years, there are no patients discharged for this reason in many of the district health authorities. We are told this would mean that all or almost all absences without leave were of short duration that ended with the return of the patient to the facility. In those years when there were patients who were discharged because they did not return from a pass, the percentages by district ranged from 1.3%-4.2% of involuntary admissions.[82]

20. The data reflects the high correlation between mental illness and poverty.[83] For 2011, most people involuntarily admitted were unemployed or their employment status was unknown.[84] Many received financial support from disability pensions or welfare, but for most involuntary patients, the source of their financial support was unknown.

21. The data shows that the patient population treated under *IPTA* is fairly evenly divided between males and females, except at the IWK, where there are a significantly higher proportion of females treated.[85] The large majority of people treated under *IPTA* are young to middle-aged adults.[86] As noted earlier, the data available through the Department of Health and Wellness does not tell us about the marital status, race, or national origin of the patients treated. However, we are told this information would be noted on the hospital records of individual patients. It is, therefore, information that could be tracked on a system basis if the system thought it was potentially of value. We think it may be valuable to improve understanding of the patient population profile and of the operation of the Act in relation to members of communities that are protected by human rights legislation.

22. The data also shows that the majority of people treated under *IPTA* are treated for schizophrenia or bipolar disorder. The most common pre-admission co-morbidity or co-diagnosis has consistently been accentuation of personality traits, followed by mental and behavioural disorders due to use of alcohol or cannabinoids.[87]

23. The information we received from the police forces supports what we were told by representatives of every police force we spoke with: mental health calls to police are increasing

[81] See Appendix I, chart "AWOL for Involuntary Admissions for 2011".
[82] See Appendix I, chart "Discharge Disposition and Rate for Involuntary Admissions from 2007-2011".
[83] See Appendix I, chart "Employment Status by Unique Cases and Involuntary Admissions for 2011".
[84] See Appendix I, chart "Financial Support by Unique Cases and Involuntary Admissions for 2011".
[85] See Appendix I, chart "Unique Cases, Involuntary Admissions and Separations by Gender (Percentages) from 2007-2011".
[86] See Appendix I, chart "Age Levels (Percentages) by Unique Cases and Involuntary Admissions from 2007-2011".
[87] See Appendix I, charts "Average, Median and Total Stay for Top 10 Diagnosis for Involuntary Admissions from 2007-2011" and "Average, Median and Total Stay for Top 10 Pre-Admit Comorbidity for Involuntary Admissions from 2007-2011".

significantly.[88] We should note that, given what we were told by police, the changes taking place in policing about how calls are coded by officers when they are called to deal with situations that have a criminal and a mental health component, it is likely that the information provided to us understates the volume of work being done in policing to address mental health issues under *IPTA*.

24. The data we received from the Patient Advisory Service, although limited to one year, supports what we heard in our consultations with stakeholders: patient advisors are providing an important and appreciated service to *IPTA* patients, indicating that this feature of the Act has worked very well.[89]

25. The data available from the reports of the Review Board for the first three and a half years of the Act's operation (i.e., July 2007-March 2011) indicate a trend towards an increase in the use of community treatment orders, from 10 orders in 2007 to 36 orders in 2011.[90] We will discuss this trend later in this report. The information from the same reports confirmed what we heard in our consultations: that little use is being made of certificates of leave. The use of certificates of leave for this period remained fairly consistent at between two and five per year.

26. Data from the Review Board annual reports and the CIHI DAD show that a large proportion of patients admitted involuntarily do not proceed to a hearing.[91] For example, in 2010-2011, there were 1224 involuntary admissions in the province and 53 Review Board hearings.[92] This may suggest what we were told in our consultations that many patients do not apply for a review because they expect to be out of the hospital before the hearing would happen. This interpretation is reinforced by data showing median lengths of admission in the 3 to 5 day range.

27. Data from the Review Board reports for these years indicate that about 60% of patients are represented by legal counsel at hearings, i.e., 40% of patients are unrepresented.[93] Given that the Act guarantees a right to counsel, this warrants inquiry. It could mean that a high proportion of patients are going forward without counsel because counsel is not available to them, at least not within a time-frame the patient is prepared to accept. This would make the data consistent with what we heard from the Nova Scotia Legal Aid Commission (that it does not have the resources to provide counsel as quickly as needed in all cases, especially outside of metro) and with what we heard from the Review Board (that hearings get adjourned so patients can have the benefit of counsel from the Commission). The information could also mean that many patients are choosing to forego counsel, possibly because of the support they are receiving from the Patient Advisory Service.

[88] See Appendix J, "Policing Data".
[89] See Appendix K, "Empowerment Connection Data".
[90] See Appendix L, "Review Board Annual Reports".
[91] See Appendices L and I.
[92] See Appendix I, chart "Total Separations, Unique Patients and Involuntary Admissions from 2007-2011"1
[93] See Appendix L.

28. Data from the Review Board annual reports show that a large proportion of patients who are scheduled for a hearing have their status changed to voluntary before the hearing. This is consistent with what we heard during our consultations. We understand that as of April 1, 2012, the Department is collecting information about whether patients have more than one involuntary stay during the same admission. It does not collect information about the timing of the status change.

2.2.2.1.2.4. Conclusions About the Data That Should be Tracked in the Future

Our analysis suggests that there is information relevant to understanding the functioning of the Act not currently being tracked in a systematic way that should be tracked systematically in the future. Although our analysis has indicated some of the additional information that may be worth tracking, we are not confident that we have identified all of the additional information that might be worth capturing. Our main conclusion on future data tracking is, therefore, that the Department of Health and Wellness and district health authorities should take stock of the information that is currently being tracked and identify the other information that it would also be useful and feasible to track.

For our part, we think the system should be tracking at least the following additional information:

1. The timing of changes in status of patients relative to the timing for Review Board hearings, or, to the extent applicable, other requirements of the Act.

2. Information that is useful to understanding the relationship between the requirement that involuntary psychiatric assessments must be completed within 72 hours and the percentage of assessed patients who are involuntarily admitted.[94]

3. The median duration of involuntary psychiatric assessments for patients who are not involuntarily admitted.

4. The median duration of involuntary admission for patients admitted following the involuntary psychiatric assessment.

5. The percentage of patients being admitted under the harm criterion and under the deterioration criterion or under both criteria. It seems reasonably clear to us that this information should be tracked at the psychiatric assessment stage because of the differences in opinion that exist in relation to the deterioration criteria and how it is and should be applied. There may also be a rationale for tracking the application of the criteria at the medical examination stage. We observed in our review of the Forms provided to us by district health

[94] The issue here is the question noted above as to whether a 72-hour assessment period, as opposed to the seven-day observation period set out in the *Hospitals Act,* may result in more patients being involuntarily admitted under *IPTA* than would be the case if the assessment period was longer or could be extended in particular circumstances. For example, some suggested the tendency for a shorter assessment period to increase the rate of admissions was higher when the 72 hours expires on weekends.

authorities that more patients were identified during the examination phase as meeting the harm to self or others criteria than when they were admitted (i.e., there could be a difference in how the criteria are evaluated and applied during the examination and admission determinations).

6. The number of voluntary patients who are incapable, the duration of their hospitalization, and changes in their patient status.

7. The percentage of section 8 medical examinations that result in a psychiatric assessment, including:

    - The percentage of people brought to emergency rooms for a medical examination at the direction of a court order issued pursuant to section 13 of *IPTA* who are detained for an involuntary psychiatric assessment;

    - The percentage of people brought to emergency rooms for a medical examination by police who are detained for an involuntary psychiatric assessment.

8. The volume of "mental health calls" being fielded by police and the percentage of these that result in exercise of the authority of the police under *IPTA*. In this regard, we note that several police officers told us that under the *Hospitals Act*, there was a form that police filed with the Department of Justice when they exercised their authority to address mental health calls. Several members of the RCMP told us this was required of them in other provinces.

9. Other information as agreed by the Departments of Health and Justice, the district health authorities, and the policing services to be important to understand the evolving role of the police under *IPTA*.

2.2.2.1.2.5. Conclusions About the Role of Quantitative Data Tracking in the Functioning of the Act

The tracking of quantitative data is important to understanding how *IPTA* is functioning. If quantitative data is to play a role in improving the functioning of *IPTA* it must not only be tracked but also applied.

For this to happen, the information tracked needs to be put into the hands of those who have direct responsibility for implementing the legislation. We are aware that the Department of Health and Wellness already shares mental health data with the district health authorities. However, our consultations with stakeholders suggests that the information that the Department has may not be getting into the hands of district health authorities as frequently or in a form that is useful to them. Our impression is the Department and the districts are not communicating enough about the data and what it signifies. If this impression is correct, it may be because the information is not being collected or organized in an information system that lends itself to this kind of continuing sharing and dialogue. Whatever the barriers, they should be addressed so that the data the Department tracks, including the

additional data we recommend or it otherwise decides to track in the future, can be more seamlessly shared and frequently discussed with the districts so that it can inform decision-making at both the district and system levels. This may require a move towards a provincial mental health information system, as already envisaged in "Together We Can," which recognizes "[a] comprehensive information system is vital to improving mental health and addictions care and treatment for Nova Scotians."[95]

Our analysis of the data now available shows that if data that is tracked is used in this way, it will raise questions about variation in how the Act is being interpreted and administered in different districts. It may also raise questions about how the Act is generally functioning relative to its objectives, including the objectives stated in the guiding principles. For example, our analysis of available data raises questions that should be asked about variation across districts in the percentage of patients who are involuntarily assessed who are involuntarily admitted. It may also raise questions about whether a shorter assessment period than the one provided for under the *Hospitals Act* is causing people to be involuntarily admitted under *IPTA* who would not have been admitted under the *Hospitals Act*.

When data raises questions of this nature, it should prompt inquiry and analysis to determine if there are problems in the operation of the Act that can be fixed either by legislative amendments or by changes in clinical or administrative practices. To ensure that such inquiry and analysis occurs, *IPTA* should make it clear that the Department of Health and Wellness is responsible for both tracking relevant data on the functioning of the Act and also for analysing it on a continuing basis to identify patterns or trends that may warrant inquiry and require deeper analysis. The Act should also give the Department the clear authority to make such inquiries or to make sure that they are made.

Such a legislative mandate can give the Department the authority and responsibility to track and to analyse data and to make inquiries where analysis suggests it is called for. But the quality of the analysis will depend on the tools the Department has to carry out the task. Particularly, it will depend on the strength and interoperability of the information systems used to gather and track the data.

Our impression is that the capacity of the Department to do the analytical work we think *IPTA* should mandate is currently limited by the fact that the data that is available is kept in separate databases and information systems, some of which clearly appear to be very basic. This may be one of the reasons there are currently questions about the accuracy of some of the data, such as the uncertainty that exists about the data the Department currently has from the Review Board on "IPTA metrics" for 2012. It probably also limits the extent to which data from multiple sources can be integrated for analytical purposes to obtain a complete understanding of the dynamics that underlay trends and patterns apparent in one set of data taken in isolation. For example, understanding of differences in the percentage of patients admitted after an involuntary psychiatric assessment might require knowing the number and condition of persons brought to relevant emergency rooms by police. Our impression is that this kind of analysis would currently be very laborious if it could be done at all. Again, this may indicate the need for a mental health information system if the mental health system is to truly have the analytical capacity to use evidence to progressively improve the functioning of the Act.

[95] "Together We Can," supra note 2 at 21.

Finally, based on the volume of data that the Department was able to make available to us for this Review, we think there may be more data on the functioning of the Act being tracked, albeit in indirect ways, than many stakeholders assume to be the case. A good deal of this data is relevant to questions that stakeholders have about how the Act is being implemented and about how it is being implemented in different districts or circumstances. Publication of more of the data that is available would enable stakeholders to have more informed discussions about the functioning of the Act, which would in turn improve the functioning of the Act. Unlike the data provided to us, the published data (as well as the data shared with districts) should, wherever possible, be in a format that facilitates interpretation, including graphs showing trends over time. Publication, of course, would have to be subject to limitations required by applicable privacy laws. Expectations in this regard should, however, be limited by relevant considerations about costs, feasibility, and value, although some of these considerations would presumably be addressed by the implementation of a more seamless information system for the mental health system.

2.2.2.2. The Overall Functioning of the Act Relative to Patient Well-Being

The functioning of *IPTA* relative to patient well-being ultimately depends primarily on the efficacy of the treatments provided under the Act. The psychiatric therapy provided under *IPTA* consists largely of the injection of psychotropic medications. There is deep disagreement among experts on mental health legislation about the contribution this kind of treatment makes to the well-being of patients. The practice of psychiatry is based on the demonstrated effect that such medications can have on mental processes that can result in harm to self or to others or to serious adverse health consequences. But some say we rely on medications to treat mental illness only because our society does not respond to mental disability in more positive ways that recognize that mental disability is socially constructed. On this view, it is the design of society that imposes the limits we associate with the disability of mental illness, not the mental attributes of the person who is said to have the mental illness.

Others assert that what is viewed as mental illness is actually a core part of the identity of the people who are described as being mentally ill. On this view, psychotropic medication is an effacing of equal personhood. From a First Voice perspective, this view was articulated with great clarity and conviction by a young woman who attended both our public meeting in Halifax and a meeting that was organized for our benefit by the Halifax-Dartmouth Branch of the Canadian Mental Health Association.

Apart from acknowledging our awareness of these deep and fundamental debates, we limit ourselves in this Report to evaluating the functioning of *IPTA* relative to patient well-being on the premise that appropriate treatment for certain mental illnesses includes psychotropic medications that must sometimes be taken involuntarily if they are to be taken. This was the perspective of virtually everyone who participated in our process, including most of those who spoke to us as First Voice or as advocates for First Voice. The question is whether *IPTA* and the process of implementing *IPTA* are putting this premise into effect to maximize patient well-being and to minimize the harm that coercive treatment with psychotropic medications has the potential to inflict.

What we heard leads us to give, with important qualifications, a generally positive answer to this question. For many patients, their experience under the Act starts with an interaction with the police. We heard about some very troubling experiences that some patients have had with the police. We are also, of course, very aware of the Howard Hyde tragedy. But we also heard many positive things, especially from mental health professionals and family members, about the positive contributions being made by police forces and individual officers in carrying out their role under the Act. We heard from policing leaders about the growth within policing of an understanding that mental health issues are not just one more thing that the police have been asked to deal with, but rather a core part of the mandate of the police in serving the community in the twenty-first century. We heard also about the growing understanding in policing and among police officers that people with mental illness require a response from police that prioritizes the well-being of the person. We heard about the organized dialogue and collaboration that is taking place between the mental health system and policing in every district in the province and about the positive improvements it is producing in how the Act is applied by police in the field.

Overall, we came away from our consultations with stakeholders with the view that two positive transformations are taking place: one within policing relative to its role in mental health and the second in the relationship between the mental health system and policing relative to how they serve mental health patients better by working together. There can be no doubt that part of the reason is the emphasis on the role of policing in mental health in the wake of Judge Derrick's report on her inquiry into the death of Howard Hyde.[96] Therefore, provincial leadership must continue. But it seems to us that the change happening is also happening because of the positive relationships that have formed between policing and the mental health system precisely because of the critical role given to policing under *IPTA*.

We also heard that positive change has happened and continues with respect to the patient experience in the hospital. One man told us about his own negative experiences in a particular psychiatric unit when he was much younger and compared them favourably to the experiences of a family member who had been recently treated in the same unit. Many of the family members of persons treated under the Act who shared negative experiences in getting their loved one admitted, were very positive about the care their loved one received once in hospital and about the positive difference it had made. Just as we were impressed with the commitment to serving the well-being of patients we heard from police, we were very impressed with the dedication to patient well-being that we heard from mental health administrators and providers. In particular, we were encouraged by the confidence that we heard over and over again about the opportunities that exist for making things better for patients.

The qualifications to this positive overall view of the functioning of the Act relative to patient well-being are important. For example, we heard concerns in several district health authorities about the extent of the health system's reliance on the police to make decisions in the field on behalf of the mental health system. We were told for example, about the much greater role that mental health professionals working in the community, in conjunction with the police, play in other countries, particularly the United

[96] Hyde Report*, supra* note 11.

Kingdom.[97] We were also told that the system can do better than relying on the police to the extent that it currently does in transporting patients to hospitals and between hospitals. Dedicated work on identifying alternatives was called for. One concern was the stigmatization that is unavoidably associated with use of police cruisers as a kind of default mode of transportation, sometimes because of unwarranted concerns about the potential for violence. Another concern was the diversion of limited police resources from other important work, including being available to respond to mental health calls in the community.

The issue of waiting in emergency rooms was mentioned frequently. Tackling waiting times in mental health care is one of the priorities for "Together We Can."[98] One aspect of what we heard about waiting times is the length of time that mental health patients often have to wait in the public waiting area in emergency rooms, both in absolute terms and relative to those with other kinds of illness. It was stressed by numerous people that waiting in a public area is likely to be invasive of privacy and stigmatizing for a patient with mental health in ways it is not for people who are at emergency for other reasons. The stigma is greatly exacerbated when the mental health patient, as is frequently the case, is being "watched" by a police officer until the medical examination called for by *IPTA* has been completed. The issue was both the priority given to mental health patients relative to others and the tendency (according to some) of emergency rooms to want the police to stay with every patient they bring to the hospital, including patients with low or no risk of violence. This might relate to another concern we heard about emergency rooms: that nurses and others who work in them are uncomfortable or uncertain about their interaction with mental health patients. Our sense is that this relates to a larger issue: the support that is or is not given to ER staff and to others in health care to equip them to care appropriately for patients with mental illness.

The need to educate providers throughout the health care system about mental health and care for patients with mental illness was stressed with us many times. More specifically, it was stressed that it cannot be assumed that people who work in mental health are immune to stigmatizing attitudes and behaviours. Education and other efforts to prevent stigmatization need to include those who work in mental health. "Together We Can" promises "public education" to "reduce stigma and address stigma,"[99] but the need for provider education should not be overlooked. The importance of this is underlined by the statements made to us by family members and patients that they regard the people they deal with in the system to be the most important determinant of whether care under *IPTA* contributes to patient well-being. At a recovery and support group organized by the Nova Scotia Schizophrenia Society to which we were invited, one man made the point in a very vivid fashion. He said that if he were given unlimited funds to improve the system he would spend it all on education and training about mental health for those who work in mental health. Everyone at the session agreed with him.

[97] "Together We Can," *supra* note 2 at 14.
[98] "Together We Can," *supra* note 2 at 15.
[99] "Together We Can," *supra* note 2 at 29.

Another issue raised a number of times, particularly by family members of people treated under the Act, was that those treated under the Act get too little of other kinds of treatment. In other words, the concern was that there was too much and even exclusive reliance on pharmaceutical therapy. "Talk therapy," cognitive, and rehabilitative therapy were three of the therapies that people wanted to see used in conjunction with pharmaceutical therapy more frequently. Their view was that these therapies not only can accentuate the benefits of medications but strengthen the patient's capacity to function independently outside the hospital.[100]

One particular aspect of the concern about the narrowness of the therapeutic process under *IPTA* was the inadequate and uneven state of discharge planning. There was an acknowledgement from those in the system that the system generally must do better in this respect.[101] For patients and family members alike, poor discharge planning limits continuity in care and support in ways that are likely to make further readmission under difficult and even traumatic circumstances more likely.[102] It limits the benefit the patient is able to derive from their loss of liberty and their care while hospitalized. Our research on mental health legislation in other jurisdictions revealed that some build the framework for discharge planning into their legislation.[103] This may help to ensure that discharge planning is viewed not only as a good thing but a mandatory thing.

An overlapping but distinct issue was the difficulty some said the system has in treating the whole person, as opposed to the person's mental illness. At one of our public meetings, a father of a young man who had recently been hospitalized under *IPTA* made the point by explaining that, although his son had received excellent clinical care, he was unable while in hospital to in any way express or indulge his love of music. In the father's view, this had made the experience less therapeutic for his son than it would otherwise have been.

There were a number of issues raised about the consequences that can flow from a determination that someone lacks capacity, one of the pre-conditions for invocation of the Act. From First Voice, we heard a concern that they can be treated as lacking credibility on virtually everything once they are determined to lack capacity relative to admission and treatment. Conversely, to the extent they are believed, their personal beliefs can be treated as axiomatically reaffirming their lack of capacity. One participant in a recovery and support group to which we were invited illustrated this by telling us about how his spiritual beliefs, ones he shared with others, were treated as being part of a delusional state. Others objected to being entirely removed from the decision-making process relative to their illness once it was decided they could not make final or ultimate decisions. From an experienced mental health nurse we heard a corroborating concern: that one of the unintended consequences of *IPTA*'s concept that only those lacking capacity can be involuntarily hospitalized may be reduced effort to include

[100] "Come Together," *supra* note 4 at 2.1-8.
[101] This is pointedly outlined in the shortfall in notification to community supports found by the Auditor General in their report*, supra* note 46 at 61.
[102] "Come Together," *supra* note 4 at 2.7-1.
[103] See, *Mental Health and Related Services Act 2002* (NT), section 89, of the Northern Territory, Australia.

patients in their care as much as possible, even though they would ultimately not have a final decision-making role.

We heard concern about the rights of patients on inpatient units, particularly with respect to control and restraint measures. For example, we were told about the lack of bathroom facilities in some of the quiet rooms and its dehumanizing effect.

We heard that the Review Board process too often has adverse therapeutic consequences for patients. In the next section, dealing with the functionality of the Act in relation to applicable human rights principles, we discuss the problems brought to our attention on the functioning of the Board. Here, the point is that these problems have resulted in patients missing the reviews they are entitled to under the Act, in some cases because the position of Board Chair had been allowed to become temporarily vacant. They have resulted in patients and substitute decision-makers not receiving adequate notice of hearings. They have resulted in hearings being adjourned because the attending psychiatrist or a member of the Board has not received notice. This has resulted in the adjourning of hearings because the process has come off the rails in other ways. They have also resulted in patients being discharged on "technicalities," only to be readmitted almost immediately. One psychiatrist who works at the Capital District Health Authority summarized these outcomes as "deeply non-therapeutic." Although we might reserve judgment on what some would characterize as a "technicality," we would otherwise agree with him.

2.2.2.3. The Overall Functioning of the Act Relative to Applicable Human Rights Principles

2.2.2.3.1. Introduction

The objectives of *IPTA* are to balance protection of civil liberties, including the right to refuse medical care, with the authority to treat involuntarily in a legislative framework that gives considerable weight to the benefits patients receive from involuntary treatment when it is needed. In *IPTA* and in other statutes built on this "human needs" model, the core of the legislation is the wider latitude that is given to psychiatrists to determine that a patient is at risk of harm to self or others, or otherwise in need of treatment. Legislation on the civil liberties model would typically limit involuntary hospitalization to situations where the patient is a serious risk of physical danger to self or others. In contrast, under *IPTA*, the risk criteria for involuntary admission are satisfied in either of two scenarios: the psychiatrist determines the person has recently caused or is threatening or attempting "serious harm" to self or others; or that the person is "likely to suffer serious physical impairment or serious mental deterioration, or both."

This "human needs" approach is hotly debated from a human rights perspective. Those opposed say that the right of the person with mental illness to be free from coercive treatment under the authority of the state warrants stronger, more precise, and more objective legislative protection.[104] Those who advocate for the model suggest that it is more protective of human rights than what they might call the

[104] K Brown & E Murphy, "Falling Through the Cracks: The Quebec Mental Health System" (2000) 45 McGill LJ 1037.

traditional model because it takes account of how involuntary treatment serves the values, especially of autonomy, underlying human rights.[105] At a minimum, they would argue that the human needs model provides strong protection to human rights while enabling the provision of necessary care to the patients who need it.

It is important to distinguish between human rights arguments that are about the legality of legislation and human rights arguments that are about whether a legislature has made the right policy choices relative to human rights. Because our human rights are ultimately protected in the *Charter of Rights and Freedoms*, one can get the impression that what is at stake in the human rights debate over the human needs model is the constitutionality of the model itself. In our view, the courts are unlikely to go so far in prescribing how legislatures are to legislate in this difficult and complex area of legislative policy.[106] Moreover, in our view, the law of human rights does not suggest that the human needs approach is an unconstitutional approach. Debates about human rights and the human needs model of legislation on psychiatric treatment are to that extent debates, important ones, about the policy of such legislation.

The debate becomes a legal debate where the question raises the constitutionality of the specific legislative provisions that are used to bring the human needs model or approach into effect in a particular jurisdiction. At that level, we think that *IPTA* is generally compliant with applicable human rights laws. We also think that the law of human rights does raise serious concern about the constitutionality of two of the provisions found in *IPTA*. We discuss these below.

It is also important to emphasize that the implications of *IPTA* for human rights depends very much on how it is implemented. In that respect, we believe it is essential that problems in the functioning of the Review Board be addressed. We also think it important that serious consideration be given to changes to the Act that can help to ensure it is implemented in accordance with robust and general regard for human rights. One example is the recommendations we have made for changes to the guiding principles found in section 2. Another example is our recommendation to add more explicit protections to the Act on the rights of patients in care. A third is our recommendations on measures that could be taken to better ensure that the Act is being consistently interpreted and applied within better-articulated parameters that preserve necessary flexibility. All of these recommendations can play a role, operating together, to ensure *IPTA* not only complies with an arrangement-focused view of justice, which focuses on what legislation says, but achieves a realization-focused view of justice, which focuses on what legislation does.[107]

2.2.2.3.2. The *Charter of Rights and Freedoms*

In the discussion that follows, we reach the conclusion that the constitutionality of two provisions of *IPTA* under the *Charter of Rights and Freedoms* is doubtful. One of these is section 18, which applies a different test for capacity to *IPTA* patients as compared to patients under the *Hospitals Ac*t. The other

[105] Gray, *supra* note 15 at 7.
[106] *Alberta v Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at paras 35-38.
[107] A Sen, *The Idea of Justice* (London: Allen Lane, 2009) cited in Kelly, *supra* note 43.

is section 39 which sets out the circumstances in which and the basis upon which substitute decision-makers are required to disregard a patient's prior capable informed expressed wishes. Before beginning the discussion of the constitutionality of these provisions we need to acknowledge that legal opinions may differ on the constitutional questions at stake, which are not straight-forward. Further, we recognize that the constitutionality of legislative provisions cannot be fully evaluated in the abstract but only in the context of a specific case argued on the basis of particular facts. Despite these qualifications, we think the constitutionality of these two provisions, unlike the general framework of *IPTA*, is highly problematic.

Moreover, we believe that alternatives to sections 18 and 39 of *IPTA* should be considered on the policy basis that these provisions may have a stereotyping effect and may encourage stereotyping towards patients with mental illness even if they do not violate the *Charter*. In our view, they go beyond what is required for the overall functionality of *IPTA* and may actually be counter-productive to those objectives, especially to the objective of ensuring that mental health issues are addressed in accordance with the guiding principles.[108]

2.2.2.3.2.1. Section 7 of the *Charter of Rights and Freedoms*

There is limited case law on the constitutionality under the *Charter* of mental health legislation on involuntary admission and treatment. It is clear however that such legislation deals with the rights to liberty and security of the person, which are protected by section 7 of the *Charter*.[109] This is because such legislation deprives people of these rights.[110] These deprivations are permitted only if they are in accordance with the "principles of fundamental justice." The principles of fundamental justice encompass substantive and procedural justice.[111] Case law makes it clear that courts regard involuntary medication as a very serious encroachment on bodily integrity, which is at the core of the right to security of the person.[112] This would inform the definition and application of the principles of fundamental justice in a case on the constitutionality of legislative provisions, which authorizes involuntary admission and treatment.[113]

It is also clear that the principles of fundamental justice require decisions on involuntary admission and treatment to be procedurally fair. Under *IPTA* and similar legislation in most of Canada, the obligation to be procedurally fair is left in the first instance to the doctors who make the decision on admission and treatment. The Review Board established by *IPTA*, and similar boards in other provinces, are critical to the procedural fairness required by the *Charter*. If patients did not have the right to have decisions on

[108] "Together We Can," *supra* note 2 at 29.

[109] Section 7 reads: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

[110] On liberty see: *McCorkell v Director of Riverview Hospital* (1993), 104 DLR (4ht) 391; and on security of the person: *Fleming v Reid* (1991), 4 OR (3d) 74.

[111] *Re BC Motor Vehicle Act*, [1985] 2 SCR 486.

[112] See *Fleming*, *supra* note 110.

[113] We acknowledge that the rights engaged under section 7 are also covered under sections 9 and 10 of the *Charter*, but feel that this would not substantively alter the legal analysis as discussed below.

their involuntary admission independently reviewed, the authorizing legislation would be very vulnerable to constitutional challenge.[114]

The substantive component of the principles of fundamental justice asks whether the criterion for involuntary admission and treatment set a defensible standard for the deprivation of a person's liberty and security of the person, assuming they are applied in a procedurally fair manner. Limiting provisions that are irrational, arbitrary, disproportionate, or too vague breach substantive justice. The objectives and the effects of *IPTA's* admission criteria would be taken into account in determining whether they established a defensible standard.[115]

Legislation that authorizes involuntary admission or involuntary treatment of capable patients raises serious constitutionality questions. Relative to admission, this was the situation in Nova Scotia when the *Hospitals Act* governed involuntary admission to psychiatric facilities. It is the case today in Ontario.[116]

IPTA addresses this problem by making lack of capacity one of the criteria for involuntary admission. It does this through section 18 in a way that may raise a separate issue under section 7 of the *Charter*. It applies a test for capacity in relation to admissibility and treatment that demands a higher level of capacity from people with mental illness than is required by the test of capacity for people with physical illness under the *Hospitals Act*.[117] Patients under the *Hospitals Act* have capacity if they understand and appreciate their condition, the nature and purpose of the proposed treatment, and the risks and benefits in undergoing or in not undergoing the treatment. In contrast, patients under *IPTA* only have capacity if they "fully" understand and appreciate these matters.[118]

Depending on how it is applied, the more demanding test could be equivalent to authorizing the involuntary admission of people who have capacity. There would then still be a question about whether *IPTA* really does bypass the very real section 7 question of whether involuntary hospitalization of capable people is constitutional. In addition, the application of a different test for capacity to people with mental illness is arguably discriminatory under section 15 of the *Charter*, which guarantees the right to equality. We discuss this distinct human rights concern below.

Another part of the admission criteria under *IPTA* that could raise questions under section 7 of the *Charter* is the risk criteria. More specifically, it is the component of the risk criteria that authorizes admission and treatment when a psychiatrist determines that a person, as a result of that "mental disorder," is "likely to suffer serious physical impairment or serious mental deterioration."[119] The

[114] The right to review of administrative decisions and procedurally fair review has been exemplified in *Baker, supra* note 25; and, *Charkaoui v Canada (Citizenship and Immigration*), [2007] 1 SCR 350.
[115] *United States v Burns,* [2001] 1 SCR 283.
[116] *Mental Health Act*, RSO 1990, c M.7.
[117] See *supra* note 18.
[118] See *supra* note 1 at s 18.
[119] The other "arm" of the risk criterion authorizes admission and therefore treatment where, as a result of a mental disorder, a person is or has recently, threatened or attempted or caused serious harm to self, or where the person is or has recently seriously harmed or threatened serious harm to another person. Although harm is a broad concept, both it and the qualifier "serious" would be interpreted for section 7 purposes as requiring a

questions would be whether this is too low or too uncertain a standard for depriving a person of section 7 rights. The question is a real one even though we acknowledge, as was emphasized to us in consultations, that the deterioration (or physical impairment) needed to satisfy the criterion must be serious deterioration.

In analysing the deterioration arm of *IPTA*'s risk criteria, a court would define "serious" as requiring a severity of deterioration that was proportionate to the deprivation of security of the person at issue in the determination that the criterion was met. It is also important to put the question in context. The majority of provinces have risk criteria similar to that in *IPTA*, though we think that it may establish one of the lower thresholds. In addition, it seems a risk criteria similar to the one found in *IPTA* are found in the mental health legislation of many other countries.[120] These facts would not be determinative in a constitutional analysis, but they would certainly be relevant to such analysis. They show that Nova Scotia's approach is part of a wider national pattern and part of an approach to mental health legislation that Canada shares with countries that, broadly speaking, share our understanding of and commitment to human rights, including that laid out in international human rights treaties and conventions.

In addition, under *IPTA*, the risk criterion is not determinative of admissibility. It is one of five criteria that must all be satisfied before a patient can be involuntarily admitted. The patient must also have a mental illness that falls within the definition of mental disorder found in the Act. This definition is a narrower definition than the one that applied under the *Hospitals Act*. It requires the mental illness to be a "substantial disorder" that "severely impairs" and "in respect of which psychiatric treatment is advisable." The patient must also be determined to be in need of psychiatric treatment in a psychiatric facility. This was not a requirement under the *Hospitals Act*. It must also be determined that the patient would be unsuitable for admission as a voluntary patient. Given the preference for voluntary treatment expressed in the guiding principles, this would suggest that involuntary admission is only permitted where necessary. Finally, as already mentioned, involuntary admission under *IPTA*, unlike involuntary admission under the *Hospitals Act*, requires a determination that the patient lacks capacity.

According to Professor Carver, some of these criteria for involuntary admission are found in all Canadian provinces and all are found in one or more provinces. Nova Scotia makes involuntary admission subject to them all. This simply reinforces the view that involuntary admission does not follow directly from a determination that there is serious deterioration. At least it is not supposed to.

It seems to us, therefore, that *IPTA* provides a framework within which decision-making that complies with section 7 can take place. This very much depends, however, on how this framework is applied.

---

kind of harm capable of justifying admission and treatment in accordance with the objectives of the Act. The other limiting feature of *IPTA*'s harm criteria is that it requires more than a serious likelihood of serious harm but an actual behaviour that could result in serious harm.

[120] See, e.g., *Mental Health Act*, RSO, s 15(1)(f); *Mental Health Act*, RSA 2000, c M-13, s 2(b); *Mental Health Act*, RSBC 1996, c 288, s 22(3)(c)(ii). A flavor for the similarity between the risk criteria in *IPTA* and the risk criteria used in mental health legislation of other States can be taken from EC Fistein et al, "A Comparison of mental health legislation from diverse Commonwealth jurisdictions" (2009) 32 Int'l J L Psych 147-155. Also see, *Mental Health and Related Services Act* 2002 (NT), Northern Territory Australia; *Mental Health Act 2007* (UK), c 12; *Mental Health Care Act*, No 17 of 2002 [South Africa].

From our consultations, we would be concerned that the framework is vulnerable to being watered down in application in ways that reduce its compatibility with section 7 in the following respects:

- We noted a tendency to speak about the criteria for admission as if they consisted entirely of the risk criteria and, more specifically, of the deterioration component of the risk criteria. One aspect of this tendency was the frequency with which we heard the changes from the *Hospitals Act* and *IPTA* "boiled down" to the change made in the risk criterion, with little reference to the other changes made in *IPTA* that are more restrictive of involuntary admission than was the *Hospitals Act*.

- There may be less clarity than there should be about what serious deterioration means and about how it is recognized when it exists. We heard it stressed that the word "serious" was important as meaning that not just some deterioration meets the standard. However, we also heard different views about whether the concept could be further defined. Some said its very purpose was to allow decisions to be made in response to the specific conditions of individual patients and that many factors could be involved in determining the line between deterioration and serious deterioration. Others seem to suggest that the concept could be more clearly defined at a general level. There seemed to be more general consensus that the process for assessing deterioration could be more clearly delineated.

- We heard many times that the patients who are involuntarily admitted lack insight into their illness. We heard that this lack of insight is common with specific disorders, particularly schizophrenia and bipolar disorder. We sometimes heard language that suggested or implied that the disease and the symptom were synonymous. This way of speaking and thinking must be carefully watched as it is ripe with potential for stereotyping people based on their illness. It is contrary to the presumption of capacity laid out in the *Hospitals Act* and emphasized and applied by the Supreme Court of Canada in *Starson v Swayze*, as well as to the Court's firm statement in that case that disagreement with health professionals on diagnosis or treatment, including denial of illness, should not in itself lead to a finding of lack of capacity.[121] In terms of decision-making, thinking and speaking that equate a mental illness and lack of capacity can subsume the determination of lack of capacity, one of the separate criteria to be met for involuntary hospitalization, into the determination that there is a mental disorder. Difficult as it may be clinically or conceptually, *IPTA* is written on the assumption that these are distinct and independent determinations. Moreover, *IPTA* could be said to require that they be separate and independent determinations.

We think measures should be taken to bring greater clarity to what serious deterioration means and to how it should be evaluated. We also think measures should be taken to counteract ways of thinking and talking about *IPTA* and the patients who might be treated under *IPTA* that can corrode the compatibility of *IPTA* with constitutional protections. We think such measures should include those we have proposed for widespread education about the Act, for development and implementation of decision-making

[121] *Starson v Swayze*, 2003 SCC 23.

support tools, and for a more systematic process of accountability to ensure that best practices are developed, identified, shared, and consistently used.

In addition, as was suggested to us, we think the deterioration component of the risk criteria as set out in clauses 8(a), 13(c), 14(d), 17(c), and 47(3)(a)(ii) should be amended to apply where it is determined that the person being assessed is "*reasonably* likely to suffer serious physical impairment or serious mental deterioration, or both," instead of "likely to suffer serious physical impairment or serious mental deterioration, or both." While this will not fully address the concern with the potential subjectivity of the criterion, it will help to emphasize that the standard must ultimately be one that has to be objectively defensible.

It has been argued that section 39 of *IPTA* is questionable under section 7 of the *Charter*.[122] It sets out the basis upon which a substitute decision-maker is to make decisions on behalf of a patient. It provides that such decisions are to be made "in accordance with the patient's prior capable informed expressed wishes" unless those wishes "would endanger the physical or mental health or safety of the patient or another person." In that case, the substitute decision-maker is to make decisions "in accordance with what the substitute decision-maker believes to be the in the patient's best interests."

Case law indicates that the courts are likely to regard legislation overriding previously expressed informed capable wishes as a very serious matter when the consequence is the involuntary injection of mind-altering drugs.[123] There is an argument that the standard set for this in section 39, which is any danger to mental health or safety of the patient or another person, gives too little protection to the capable informed wishes of the patient. It may, however, be "read down" by a court as requiring a threat to physical safety.[124] It may also be problematic from a section 7 perspective that section 39 substitutes a very open-ended "best interests of the patient" basis for decision-making in place of the patient's prior capable informed wishes, instead of requiring the substitute decision-maker to be guided by values and beliefs of the patient, if known. This might be addressed by making the decisions on the basis of the patient's best interests subject to prior approval or review by the Review Board, but preferably the Act should give substitute decision-makers the responsibility of taking known values and beliefs into account.

2.2.2.3.2.2. Section 15 of the *Charter of Rights and Freedoms*

Section 18 and section 39 of *IPTA* also require comment on their compatibility with section 15 of the *Charter*, which guarantees the right to equality.[125]

---

[122] On this issue please also see Jacquelyn Shaw, "One Step Forward, Two Steps Back: A Charter Analysis of s.39 of Nova Scotia's Involuntary Psychiatric Treatment Act" (2009) 4:2 JEMH 1.

[123] See *Starson v Swayze*, 2003 SCC 23.

[124] On "reading down" see *Suresh v Canada (Minister of Citizenship and Immigration*, 2002 SCC 1 at paras 80-99.

[125] Section 15 reads: "Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

As reviewed above, section 18 establishes the test for determining a patient's capacity for the purpose of applying the criteria for admissibility as an involuntary patient. It applies a test for capacity that demands a higher level of capacity from people with mental illness than is required by the test of capacity under the *Hospitals Act* that applies to people with physical illness. A patient under the *Hospitals Act* has capacity if they understand and appreciate their condition, the nature and purpose of the proposed treatment, and the risks and benefits in undergoing or in not undergoing the treatment. In contrast, patients under *IPTA* only have capacity if they "fully" understand and appreciate these matters.

This is a clear difference of legal treatment based on one of the personal characteristics, mental disability, covered by section 15. It is not only a difference on paper: case law from Saskatchewan, which makes the same distinction in its legislation, shows that courts may give effect to the difference in wording by accepting psychiatric conclusions that a patient who would pass the general test does not pass the test for people being psychiatrically evaluated.[126]

The difference appears to be discriminatory using the criteria that the courts use under section 15 to distinguish differences in treatment from *discriminatory* differences in treatment. Specifically, the difference may reinforce and perpetuate stereotypes and prejudices.[127] The stereotype it may reinforce and perpetuate is that lack of capacity and mental health are synonymous. The prejudice it may reinforce and perpetuate is the prejudice that people with mental illness cannot be trusted and respected to make decisions about their own health and medical treatment even when they have the level of capacity that would allow others to make those decisions.

This does not mean that the constitution requires one test or the other. Section 15 does not specify a test for capacity, but rather requires a consistent test unless the reason for having a different test for those with mental illness either makes the difference non-discriminatory or, failing that, one that can be justified under section 1 of the *Charter*.[128]

The ancillary advantage of a common test is that it would no longer be necessary to differentiate between capacity determinations made in relation to patients with mental illness that are made under *IPTA* and those that continue to be made under the *Hospitals Act*. As discussed below, we heard that there is uncertainty and confusion in the system about which test applies to which decisions in the interface between *IPTA* and the *Hospitals Act*. Confusion on such a critical matter should be addressed. One of the advantages of a generally applicable test for capacity is that it would eliminate the source of this confusion, which is the existence of two very similar but different tests in two different statutes that interact in complex and subtle ways.[129]

---

[126] *Saskatoon Regional Health Authority v AB*, 2005 SKQB 153.

[127] See *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143; and *R v Kapp*, 2008 SCC 41.

[128] Such a justification will be discussed in the next section.

[129] Submissions from the Dalhousie Health Law Institute proposed a more fundamental change: the abandonment of stand-alone mental health legislation in favour of comprehensive consent and capacity legislation setting out

The section 15 concern with section 39 also relates to how it differs from the parallel provision found in the *Hospitals Act*. As explained earlier, section 39 sets out the basis on which a substitute decision-maker is to make decisions on behalf of a patient. It provides that such decisions are to be made "in accordance with the patient's prior capable informed expressed wishes" unless those wishes "would endanger the physical or mental health or safety of the patient or another person." In that case, the substitute decision-maker is to make decisions "in accordance with what the substitute decision-maker believes to be in the patient's best interests."

Decision-making by substitute decision-makers for hospital patients not under *IPTA* is dealt with in section 54A of the *Hospitals Act*. It also requires substitute decision-makers to conform to prior capable informed wishes. Like *IPTA*, it provides for exceptions different than those set out in *IPTA*. It says that the substitute decisions-maker shall not follow prior capable informed wishes in two circumstances: if technological change or medical advances makes following the prior wishes inappropriate or if circumstances exist that would have caused the patient to set out different instructions based on what the substitute decision-maker knows of the patient's values and beliefs.

Again, because the difference is on grounds of mental disability, section 15 applies. Again, the difference could be discriminatory and, therefore, contrary to section 15 because it may reinforce and perpetuate stereotypes about and prejudices towards persons with mental illness, specifically that they are self-harming or violent. Again, this does not mean that the duties of all substitute decision-makers must be those currently laid out in the *Hospitals Act*. Instead, under section 15 at least, the issue is the difference in a substitute decision-maker's duties depending on whether the patient has a mental, rather than a physical illness. It is not necessary that the consistent test should be the one currently in place for the substitute decision-makers of patients with physical illness.

A common approach to the responsibilities of substitute decision-makers would seem feasible and desirable. For example, the concern of section 39 of *IPTA* for the safety of others would seem relevant to the responsibilities of all substitute decision-makers, not only those of patients with mental illness. Similarly, the responsibility of substitute decision-makers under the *Hospitals Act* to take account of technological change, medical advances, and circumstances that were unknown to the patient may also be relevant to substitute decision-makers for people with mental illness.

2.2.2.3.2.3. Section 1 of the *Charter of Rights and Freedoms*

If our concerns about sections 18 or 39 under section 7 or 15 of the *Charter* are valid, their ultimate legality would depend on whether the violations could be justified under section 1 of the *Charter*.[130] Section 1 saves laws that infringe *Charter* rights where they are shown to be "demonstrably justified in a free and democratic society." The objectives of sections 18 and 39 would be considered to determine if

---

a universal test for capacity without distinguishing psychiatric treatment from other treatments, combined with a supported decision-making model instead of a substituted decision-making model.

[130] Section 1 reads as follows: "The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

they are "pressing and substantial." The means chosen to advance those objectives would then be considered in determining if they were proportionate to those objectives. [131]

For section 18, we assume that the objective is to minimize the risk to public safety that might arise under legislation that does not provide for involuntary admission of capable persons who could harm others. In other words, the objective seems to be to minimize the possibility of a person meeting the harm criteria but not the capacity criteria. We understand the objective and its importance. It may be the basis of a good argument under section 1 of the *Charter*. But it may also be questionable as to whether it is proportionate to the objectives given the implications for people with mental illness and the broad authority otherwise created by the Act for involuntary admission.

As noted above, section 18 also raises a question about whether *IPTA* can truly be said to have avoided the question that arises under section 7 of the *Charter* when legislation authorizes the involuntary admission of capable people. In fact, because *IPTA* combines decision-making on admission and treatment, too demanding an approach on capacity may result in capable people being involuntarily treated under *IPTA*. In Ontario, where legislation explicitly authorizes involuntary admission of capable people, there is no provision for their involuntary treatment. This could make section 18 more challenging to justify under section 1.

For section 39, we assume the objective is to minimize the number of persons who meet the admission criteria but for whom a choice has to be made between not admitting them at all and admitting them in the knowledge that the options to treat will be limited by prior informed wishes. We are aware and understanding of the conviction with which health care providers say they are not and have no desire to be jailers. We assume the safety of hospital staff or others may be at issue if a patient cannot be treated because of prior informed express wishes.

We understand these objectives and their importance. However, we question whether they justify discrimination against people with mental illness, given the availability of non-discriminatory alternatives and the seriousness of the interest (an informed exercise of capacity relating to bodily integrity) that is impacted by the discrimination.[132]

2.2.2.3.3. The *Convention on the Rights of Persons with Disabilities*

As mentioned earlier, the Convention came into force in Canada in 2010. It imposes obligations on "State Parties," which must account to the international community on their discharge of these obligations through a reporting process laid out in the Convention.[133] In Canada, the obligations of State Parties fall on the provinces to the extent that the Convention (or other international law) deals with matters that are within the jurisdiction of the provinces under the Canadian constitution.[134] The

[131] See *R v Oakes*, [1986] 1 SCR 103.
[132] This issue may fall below the "minimal impairment" requirement included in a section 1 justification; see, *Ford v Quebec*, [2002] 2 SCR 712.
[133] *CRPD*, *supra* note 10, art 33.
[134] GV La Forest, "May the Provinces Legislate in Violation of International Law?" (1961) 39:1 Can Bar Rev 78.

Convention deals extensively with matters within provincial jurisdiction. The obligations it creates are, therefore, binding on each of the provinces (and the territories) as well as the federal government.

The Convention imposes a general obligation on State Parties "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities" and to work towards the full realization of economic, social, and cultural rights laid out in other international laws to the "maximum of [the State Party's] available resources."[135] It also imposes a range of more specific obligations, for example, to take measures: to eliminate discrimination against people with disabilities; to promote awareness with respect to people with disabilities and to combat stereotypes and prejudice; to enable independent living and promote access to facilities and services by people with disabilities; to facilitate the mobility of people with disabilities; and to ensure equal or appropriate access by people with disabilities to education, health and health services, habilitation and rehabilitation services, work and employment, adequate living standards, and opportunities for participation in political and public life and in cultural life, recreation, leisure, and sport.

The underlying philosophy is that of disability as an "evolving concept" under which "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others."[136] In other words, the underlying idea is that the limitations experienced by people with disabilities are caused by society, not by the physical or mental impairment that constitutes the disability. For this reason, the Convention is said to call for a paradigm shift in mental health policy and law: a shift away from a focus on disability as a disease to be treated with coercive measures towards an approach that emphasizes inclusion, social accommodation, and access to support and opportunities.[137]

The Convention article most relevant to legislation dealing with involuntary hospitalization and treatment is Article 12. It calls for "appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity." Safeguards are required to ensure these measures "respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportionate and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review." The Article has been interpreted as precluding substitute decision-making regimes, such as the ones relied on in *IPTA*, the *Hospitals Act,* and in legislation across Canada. It can be interpreted as instead calling for a system of supported decision-making that responds to diminished capacity with assistance with decision-making instead of with removal of decision-making authority.

This interpretation was sufficiently persuasive to prompt Canada to file a reservation to Article 12, to the effect that it ratified the treaty on the basis that substituted decision-making was consistent with the Convention. This means that, as applied to Canada, the Convention is not contravened by legislation that gives decision-making authority for incapable patients to substitute decision-makers. Despite this,

[135] *CRPD*, *supra* note 10*,* art 4(2).
[136] *CRPD*, *supra* note 10 at Preamble, (e).
[137] "Equality, Dignity and Inclusion," *supra* note 9 at 19.

it was suggested by the Dalhousie Health Law Institute that Nova Scotia should explore supported or assisted decision-making approaches as an emerging best practice that might be incorporated into legislation at a later date. A similar suggestion was raised for consideration by a participant at a meeting organized for our benefit by the Canadian Mental Health Association in Nova Scotia. Such an exploration would be consistent with one of the guiding principles found in *IPTA*, which provides that: "each person has the right to make treatment decisions *to the extent of the person's capacity to do so*." It may also be consistent with the general approach taken in Canadian law, that capacity is situational and not global. We therefore think there is merit in this suggestion.

It has also been argued that Article 12 is contravened by involuntary hospitalization and treatment. Canada's reservation to Article 12 did not address this interpretation of Article 12, suggesting that Canada did not accept that Article 12 was capable of bearing this interpretation. Our reading of the Article is that it protects capacity where it exists but does not require State Parties to treat people who do not have capacity as if they do.

On this interpretation, the Convention still has relevance for the constitutionality of sections 18 and 39 of *IPTA* under section 15 of the *Charter*, as discussed above. The Convention requires equality of treatment relative to the issue of capacity. This would be relevant to how section 15 of the *Charter* was interpreted and applied in a case concerning legislation that treated the capacity of people with disabilities differently than the capacity of others. This is what section 18 does by requiring patients with mental health problems to show "full" understanding and awareness and what section 39 does so by putting substitute decision-makers under a different duty to disregard prior capable informed wishes than applies to substitute decision-makers of other patients under the *Hospitals Act*.

Two other articles of the Convention should be noted in connection with *IPTA*. Article 15 requires State Parties to take all effective legislative, administrative, judicial, or other measures to prevent people with disabilities from being subjected to cruel, inhuman, or degrading treatment. Article 16 imposes a parallel obligation to protect people with disabilities from exploitation, violence, and abuse. More specifically, Article 16 specifies that: "State Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities." Our recommendation that *IPTA* be amended to more fully and explicitly deal with the rights of persons in care would help to ensure that Nova Scotia is in compliance with these obligations on a continuing basis.

At its broadest, however, the Convention is not about the subject-matter of *IPTA* but about some or much of the subject-matter that is covered in Nova Scotia's mental health strategy and that we have suggested might be covered in a Mental Health and Addictions Care Planning Act. Professor Kaiser argues that the Convention requires legislation on access to mental health services and the social determinants of mental health and, moreover, that it requires legislation that creates positive rights to the broad range of goods, services, and opportunities that the Convention says State Parties have an obligation to ensure are made equally available to people with disabilities as to others. We do not read the Convention as being that prescriptive as to the measures that State Parties must take to achieve the outcomes contemplated by the Convention. In addition, as discussed earlier there is room for

scepticism as to whether the enumeration of statutory rights to what are largely social and economic rights is the best way to meet the obligations set out in the Convention. There are also questions about whether this would be a feasible approach for Nova Scotia.

On the other hand, if legislation dealing with the broader aspects of mental health policy can over time improve access by those with mental disability to the services, supports, and resources that improve and maintain mental health, such legislation would help to ensure that Nova Scotia meets its obligations under the Convention, as well as its own policy objectives in mental health as articulated in the mental health strategy. Here, it is noteworthy that international guidelines and instruments for evaluating mental health legislation based on international guidance suggest that access to services and to broader determinants of mental health should be addressed in legislation, whether or not it is legislation which creates positive enforceable rights.[138]

2.2.2.3.4. The Functioning of the Review Board

The Review Board established under *IPTA* is made up of lawyers, psychiatrists, and members of the public who have an interest in mental health issues. The main purpose of the Review Board is to review the status of patients admitted as involuntary patients into a psychiatric facility and of patients living in the community on a community treatment order. The Review Board has no authority with respect to voluntary patients. The Board is required to review an involuntary patient's status in the following circumstances:

- when a patient is admitted as an involuntary patient or the patient's involuntary admission is extended and the patient or the substitute decision-maker applies for the review;
- 60 days after the patient is involuntarily admitted;
- every 6 months after the patient is involuntarily admitted for the first 2 years of involuntary admission;
- every year after a patient has been involuntarily admitted for more than 2 years;
- when a community treatment order is made, renewed and on every 2nd renewal;
- when an application[139] is made to review an involuntary admission or its renewal;
- when an application[140] is made to review a community treatment order or renewal of a community treatment order; and
- when an application[141] is made to review a certificate of leave or its cancellation.

Where the Board is requested by a patient to review the status of a patient, the Board must hold a hearing within 21 days after it receives an application. The patient, the substitute decision-maker, and

[138] "Equality, Dignity and Integrity," *supra* note 9; *CRPD*, *supra* note 10; WHO, *supra* note 31 at 81-82

[139] An application for review can be made by the following persons: the patient; a substitute decision-maker; a guardian appointed by law; a person who has been authorized to give consent under the Medical Consent Act' a person authorized by the patient to act on the patient's behalf; the chief executive officer; the Minister; or the Review Board where it believes it is in the patient's interest to have a review.

[140] An application for review can be made by the individuals listed in footnote 139 above.

[141] An application for review can be made by the individuals listed in footnote 139 above.

the patient's psychiatrists are all entitled to participate at the hearing. Other people may be allowed to participate where the Review Board thinks it is appropriate. Within 10 days of the hearing, the Board must provide a written decision.

2.2.2.3.4.1. Administrative Functioning

Under Canadian and international law, legislation that provides for involuntary psychiatric hospitalization must provide for independent review of admission decisions.[142] Such legislation would be simply unacceptable without such review. It follows that the functioning of the *IPTA* Review Board is a significant dimension of *IPTA*'s overall functioning relative to applicable human rights principles.

It was, therefore, disturbing to hear about the many problems that the Review Board has encountered in discharging its mandate since *IPTA* came into effect. There is nothing that gives us more concern about the functioning of the Act relative to its current objectives than the current functioning of the Review Board.

We heard for example, that there was a period of roughly two months in which the Review Board could hold no hearings because appointment of the Chair had lapsed and it took a month to get her reappointment through the government's appointment process for adjudicative bodies. This meant that patients who were entitled to have their admissions reviewed during those two months did not receive the hearings to which they were legally entitled. We heard about a more general difficulty in the scheduling of hearings within the 21-day time frame and about scheduling of hearings or the provision of notice of hearings at the last minute to meet the 21-day time frame.

We also heard about hearings being adjourned because Board members who were expected to participate in the hearing do not appear because they have not been told about the hearing. We have learned that adjournments, sometimes of long duration, have to be given to ensure that patients have counsel, which they are entitled to under the Act. The difficulty here is the capacity of the Nova Scotia Legal Aid Commission, which makes counsel available to all *IPTA* patients regardless of their income status. We heard about the difficulty the Review Board has had in finding appropriate space, especially in some districts, for the conduct of hearings. This has caused another layer of confusion and frustration to the process of scheduling.

There are problems with the flow of the information that is essential to the functioning or accountability of the Board. The Board told us it does not always get information on admissions or community treatment orders or on renewals in a timely fashion from the districts. This problem seems to be worse in relation to community treatment orders, but also present in respect of involuntary hospitalizations. We do not know if it is a problem in the Department or at the district level, but it seems clear there is a problem. Meanwhile, the districts are unhappy with the flow of information from or on behalf of the

[142] *Fleming, supra* note 110; *Universal Declaration of Human Rights,* GA Res 217 (111), UNGAOR, 3d Sess, Supp No 13, UN Doc A/810, (1948) 71; *International Covenant on Civil and Political Rights*, GA Res 2200A (21), UNGAOR Supp No 16 (1966) 52; and *CRPD*, *supra* note 10.

Board, particularly in relation to scheduling and notice of hearings. Substitute decision-makers also told us about last-minute, late, or non-existent notification of hearings.

At a broader level, the Board is required to provide an annual report to the Minister of Health and Wellness that the Minister is required to table in the House of Assembly. The purpose of this report, presumably, is to ensure the accountability of the Review Board for its overall functioning and to allow Nova Scotians to be informed about the functioning of the Review Board and aspects of the Act more broadly. Some annual reports have not been tabled in accordance with this requirement.

There are many factors contributing to the unacceptable administrative functioning of the review board process. For example, on appointments, we heard from the Review Board that the government's appointment process failed to respond to the impending expiry of the Chair's appointment in time to have her reappointed without any gap. From the Department of Health and Wellness, we heard that those who manage the appointment process did not learn of the impending expiry of the term in time to complete the mandatory steps of the government's process for appointing the members of adjudicative tribunals. We were told that this process typically takes 60 days when it operates smoothly. Those who manage it for the Department of Health and Wellness are concerned that they do not always hear about impending vacancies on the Review Board in time to anticipate these vacancies. For example, we heard that there have been a number of unexpected vacancies, such as where a psychiatrist appointed to the Board turns out to be generally unavailable or unwilling to participate.

The deeper challenge relative to appointments is the limited pool of applicants the government has to choose from for appointment to the Board, especially when it comes to psychiatrists. Remuneration levels may be an issue, but another issue is the limited number of psychiatrists who have the expertise, interest, and availability. Essentially, the pool comes down to retired psychiatrists since practising psychiatrists are fully engaged in their practices and would in any event face too many conflicts of interest when cases from their districts require adjudication. We learned that the options of sharing psychiatric resources for review board purposes with New Brunswick and Prince Edward Island has been explored but that the results have not been encouraging.

Meanwhile, the Act does not provide for continuation in office of those who have expired terms until they are either reappointed or replaced. It does not provide for a Vice-Chair to act in the place of the Chair when the Chair is not available or when the office of Chair is vacant. We heard this may cause other administrative problems when the Chair is simply not available to do things that the Act requires the Chair to do. Further, apart from the role of the Chair in appointing members of the Review Board to panels, the Act does not assign administrative responsibility or authority on the Chair. This may contribute to the challenges facing the Review Board in a number of areas, including the contribution the Review Board might make to the efficient operation of the appointments process through succession planning and recruitment.

Another area where the lack of assigned responsibility or authority for the Chair can cause confusion is in relation to the Board's discretion to refuse to review a patient's file where it was reviewed during the previous three months. We were told that the Act, specifically subsection 68(3), is unclear as to whether

the Chair can make the decision to refuse to review the file or whether a panel of the Board must make the decision. We think there is an appropriate role for the Chair in this respect.

On scheduling and the provision of notice of hearings, the level of administrative support being provided to the Review Board, which has no staff or resources of its own, seems to be an important part of the problem. We heard that where a particular employee of the Department was on extended leave, the administrative functioning of the Board suffered significantly. Obviously, if this is true, it cannot be allowed to happen. The functioning of the Board cannot be in such a vulnerable position. From a Review Board perspective, there is a concern that there is a lack of understanding in the Department of the nature of the Board's work as a quasi-judicial entity, given that most of the many agencies, boards, and commissions within the mandate of the Department have a policy or governance mandate. We are not able to say whether this is or is not the case, but given everything we have heard about the functioning of the Review Board, we are concerned that it may be.

The larger problem facing the scheduling process is the fact that the Review Board is effectively limited to holding hearings on Thursdays. This is the day on which both psychiatrists and legal aid lawyers are generally both available, given the practice schedule of psychiatrists and the fact that legal aid lawyers are generally in court or before the Criminal Code Review Board on other days of the week. We have no solution to offer to this, except to say that a general problem-solving discussion between the Department, the Review Board, the district health authorities, and the Legal Aid Commission seems to be called for.[143] In that discussion, everyone needs to focus on making the better operation of the system for patients and family members the top priority, remembering that the proper functioning of the Review Board is integral to the legislative framework for providing care and protecting patient rights created by *IPTA*.

The other contributing factor to the scheduling and notification difficulties being experienced is the reliance of the Board on a system that seems very reactive. Scheduling becomes an issue as the legislatively prescribed date for the hearing approaches. One option or variation we were asked to consider would be to institute a system of scheduling built around pre-determined and fixed "Review Board hearing days" (for example, every Thursday or every second Thursday). All cases approaching 21 days from the date at which a review was requested would be heard on these days. Everyone would know this in advance and therefore be able to prepare accordingly, including by putting the "hearing days," as applicable, in their personal calendars. Hearings on different days would be scheduled for the cases that could not be accommodated on these regularly scheduled days. This would keep case-specific scheduling to a minimum. Alternatively, and no doubt more controversially, everyone who wanted a review would be accommodated within these regularly scheduled review days if it was accepted that

[143] For example, we considered that, as the Act anticipates a hearing in every case, the scheduling of the hearing could be an automatic activity that happens immediately after or indeed as part of the admission process. To make it happen, one option may be to integrate the scheduling of hearings into the admission process. The Review Board would have the authority to intervene and make changes, but otherwise its job would be to show up for the hearing as scheduled by the district health authority. The data showing how few hearings actually occur did not support this as a viable alternative, however, as it might produce more scheduling than is required, thus exacerbating the problem. Other "out of the box" options may be required, however.

some would receive a hearing a few days earlier than 21 days while some would receive it a few days after 21 days. This would be better than the current system under which patients are randomly vulnerable to longer delays and to a lot of uncertainty about when their hearings will happen. But if this variation was thought to be problematic, consideration could be given to accommodating the cases in which the variation from the norm would be greatest on special hearing days scheduled on an "as needed" basis. This would reduce the amount of case-specific scheduling currently needed.

The capacity of the Legal Aid Commission to provide counsel to *IPTA* patients is another issue that needs to be addressed. We were very impressed by the representations we received from the Legal Aid Commission. In particular, we were impressed by the organizational commitment we heard to making sure *IPTA* patients across the province have representation. As indicated earlier, however, we heard that the timely availability of the service varies across the province and has contributed to hearing delays. The Commission provides a vital service not only to these patients, but also to the mental health system. In its absence, the credibility of *IPTA* from a human rights perspective would be significantly reduced.

There is much that needs to be done in improving the administrative functioning of the Review Board. There is a range of options available for getting it done. It is work that must be led by the Department of Health and Wellness, but which requires contributions from the Review Board, the district health authorities, and the Legal Aid Commission. It must be given the highest priority.

2.2.2.3.4.2. The Board's Adjudicative Process

The Board's adjudicative process also attracted comment from stakeholders. Some psychiatrists and substitute decision-makers questioned the adversarial tone and nature of the hearings. One psychiatrist asked if it was not ironic to have an administrative review process continuing to conduct itself like a traditional trial when we now have criminal courts designed to take a therapeutic approach to adjudication in criminal cases. We understand that one person's adversarial process is another person's search for the truth. Yet we believe there may be room for fruitful discussion between the Review Board and its constituencies to explore alternative adjudicative models. There is nothing in the Act that would prevent this or the implementation of different models. The Act gives the Board control over its own procedure. To the extent that new law is required, the broad authority given to the Governor in Council to make regulations on "governing procedures for the Review Board" could be utilized.

We were told that there are times when a patient does not attend a hearing and does not appoint a representative. In those circumstances, although IPTA allows for the Review Board to appoint a representative to attend the hearing and act on behalf of the patient, we were told that it would be beneficial to allow the hearing to proceed in the patient's absence where appointment of a representative was not possible. We see merit to this suggestion as it is consistent with the Board's oversight responsibilities and the importance of a timely hearing.

We were told that patients do not always want a hearing. We were encouraged to consider a recommendation to allow for a patient to waive a hearing, so long as procedural protections were in place to ensure the waiver was a true expression of the patient's wishes. We have some sympathy for

this position, especially in light of what we were told about the anxiety that an approaching hearing can cause in some cases for a patient and their family members. But we are concerned about and sensitive to the power imbalances that could be at play. We believe allowing the Board hearing to proceed in the absence of the patient, as described above, may be a more appropriate way to address this concern.

The Board's limited remedial discretion was brought to our attention by those who were concerned that where the Board finds that a technical error has occurred, such as in the filling out of a Form, it has ruled it has no option but to order the discharge of the patient even where the error does not relate to the question of whether the patient met the admission criteria at the relevant times. We were told this has resulted in patients being readmitted and that this is not helpful to the treatment of the patient. It also causes much unnecessary anxiety for family members. Although we were also told that the Review Board has taken a different approach in some cases, we were asked to recommend legislative amendments that would give the Board remedial discretion where non-compliance with the Act does not go to the question of admissibility at the relevant time. Our view is that if such a change was made, it should give the Review Board the authority to make such orders as it thinks necessary to ensure the non-compliance with the Act is remedied not just for the patient before the Board but for other patients. It should have authority to require the district health authority or psychiatrist in question to report back on the remedial actions that have been taken.

The legal aid lawyers who represent *IPTA* patients told us it was unfair that proceedings were not recorded, since this essentially eliminated any prospect of challenging decisions in the courts on the basis of factual error. Such recordings would be a source of accountability for the Review Board and also for those who participate in reviews. They could be helpful to Review Board members' seeking to refresh their memories or to validate their notes on what was said at a hearing. We think hearings should be recorded.

There is a concern that Review Board decisions are not entered into a filing system or database that is accessible to all board members and to the counsel appearing before the Board. This raises questions about whether the Review Board is developing the institutional expertise that is generally a core rationale for establishing any administrative agency and is certainly warranted for an administrative agency deciding cases addressing fundamental rights. It raises questions about the quality of the representation counsel are able to provide to their clients and about the quality of assistance that counsel are able to provide to different panels of the Review Board. It could raise questions about the consistency of the adjudication being provided by the Review Board. It may, therefore, constrain the contribution the Review Board can make to the need for common understanding of key legislative phrases throughout the clinical community that makes decisions under *IPTA*.

One solution would be to make decisions public, with all identifying information removed. This would ensure they were available to all members of the Board, all counsel, all rights advisors, all advocacy organizations, all family members, and to all those working in mental health. It would contribute to the accountability of the system and to public understanding of the system. Concerns, however, were expressed that this would unavoidably violate the privacy of mental health patients and their families, especially those from small rural communities. In this respect, Nova Scotia was said to be different from

Ontario, where review board decisions are now public documents. But not everyone in Ontario lives in Toronto—Ontario has small communities too. Moreover, our assumption would be that once it became expected that written decisions will be public, they would be written in ways that minimize or exclude the kind of personal detail that is likely to expose identities. We are confident that the Review Board could learn this approach to decision writing from the example of other administrative agencies that walk the line between transparent adjudication and protecting sensitive personal information.

Our conclusion is that the feasibility of moving to publicly available decisions should be actively considered. It would address the concerns we have about the specialized expertise of the Board and the ability of counsel to play their proper roles without creating the complex questions that may arise if these problems are addressed in more targeted ways. For example, it would avoid the question of which counsel is entitled to access and the question of what counsel can and cannot share with clients. Public decisions would also contribute to more clarity and understanding across the health care system and in the public on how key legislative phrases, like "serious deterioration," are to be interpreted.

In the event, however, it is determined that public reasons for decisions should not or cannot be done, we strongly believe a process needs to be put in place to ensure access to all decisions of the Review Board by all Review Board members and all counsel appearing before the Review Board.

2.2.2.3.5. Other Legislation Affecting Persons with Mental Illness

Our mandate asks us to consider not only *IPTA,* but also associated legislation. Throughout this Report, we refer to a number of associated statutes, including the *Personal Directives Act*, the *Health Authorities Act*, and the *Hospitals Act*, each of which directly interact with the operation of *IPTA*. In our consultations, several other statutes were raised because they may also apply to or have broader implications for the persons subject to *IPTA* by virtue of their applicability or potential applicability to persons with mental illness.

The other statute of this nature mentioned most often was the *Adult Protection Act*.[144] The others are the *Incompetent Persons Act*, the *Inebriates' Guardianship Act,* and the *Narcotic Drug Addicts Act*.[145] As different as each of these statutes is to the others, they all authorize intervention into the lives of people who are determined to lack capacity relative to their ability to manage their affairs. They therefore all have implications for the interests, needs and rights of people with mental disabilities. This includes or could include the people who might be subject to *IPTA*.

It was submitted to us that all of these statutes should be reviewed to ensure that Nova Scotia's laws, not just *IPTA*, are consistent with the rights and best interests of people with mental disabilities, including under applicable human rights laws. The concern expressed was that these laws use outdated language and concepts to address the needs, interests and rights of people with mental disabilities. They are therefore stigmatizing and, in various respects, discriminatory in their actual or potential

[144] RSNS 1989, c 2.
[145] RSNS 1989, c 218; RSNS 1989, c 277; and RSNS 1989, c 307.

application to people with mental disability. They give broad and highly discretionary authority to intervene in coercive ways into the lives of people with mental disabilities.

On the *Adult Protection Act*, we also heard a different perspective. This Act was typically mentioned by those who were not concerned that it was applied too broadly, but rather too narrowly. The concern was that the Act is generally not interpreted to be applicable to those who are "*IPTA* patients," even though by its broad terms, it seems that it could be interpreted to be applicable to people with a "mental disorder" as defined in *IPTA,* should they become an "adult in need of protection." The context for these references to the Act was the difficulty that families, police, the health system, and the community services network often face in getting support and assistance in addressing the vulnerability of persons with mental illness when they are not in hospital.

We have not had the time to consider these issues in any depth. We are sympathetic to the view that *IPTA* is one of a number of provincial laws that address mental disability and should, therefore, be viewed in that context. For those with mental illness, it is important that Nova Scotia legislation, not *IPTA* only, be consistent with applicable human rights principles and laws. In the case of the *Adult Protection Act*, there is the distinct question raised by some stakeholders of the role it does or could play in the functioning of the broader mental health system, which shapes the functioning of *IPTA*.

Our final point on this topic is to simply observe that our understanding is that the *Inebriates' Guardianship Act* and the *Narcotic Drug Addictions Act* are no longer in use, although they are still in force. They seem to clearly reflect the ideas and values of a different time. There would, therefore, seem to be a strong rationale for their repeal.

2.2.2.4. The Overall Functioning of the Act Relative to the Importance of Mental Health and the Mental Health System

The functioning of *IPTA* is obviously a very important part of Nova Scotia's mental health system. As we travelled through the district health authorities it was clear, however, that there is universal agreement that the functioning of the Act depends on the importance attached to mental health more broadly and on the strength of the broader mental health system. It was also clear to us that the mental health system is not the mental health *care* system. It includes all of the institutions, processes, and systems that either contribute to or detract from the mental health of Nova Scotians. Obvious examples are the economy, families and local communities, the broader health care system, the education system, the community services system, and the policing and justice systems.

In general terms, the importance of mental health and of the mental health system are relevant to the functioning of *IPTA* in three broad ways: they are important in determining the number of people with mental illness and the number of those who eventually become patients under *IPTA*; they determine the resources that are available to care for those under treatment under *IPTA*; and they have a great deal to do with the recovery, or lack of recovery, of these patients after they have been treated under *IPTA*. We heard about and saw progress being made on each of these fronts during this review process. But the overriding message was that not enough is being done in a proactive and integrated fashion at the

prevention stage, the treatment stage, or the recovery stage to improve the lives of those living with mental illness.[146] In this respect, Nova Scotia is not alone, as many have reached the conclusion that mental health is comparatively underfunded throughout Canada relative to other kinds of health.[147]

We heard nothing to lead us to conclude that more legislation is the ultimate solution. We are not naïve as to the role that more legislation can play in accelerating or expanding the progress that is being made. We do, however, believe that a broader legislative framework for mental health and the mental health system generally could play a role. Indeed, it may be part of what is needed to help ensure there is a broad, coordinated, and sustained effort to build on the progress being made, including under the mental health strategy, "Together We Can."

Specifically, mental health planning legislation could ensure that Nova Scotia law places equal emphasis on the positive determinants and enablers of mental health as it does on involuntary hospitalization and treatment. Second, it could create a legislative framework for institutionalizing the collaboration that is currently going on between the parts of the mental health system that work under the jurisdiction of different ministers and under legislation that is inhibiting rather than enabling of collaboration and coordinated action. Third, it could help Nova Scotia become one of the provinces that leads the way in redressing the imbalance that has long existed across Canada between the priority attached to mental health compared to physical health.

We also heard enough to conclude that the functioning of *IPTA* is inhibited closer to home, by the way in which the acute care portion of mental health is organized and operated. In this review we heard many positive things about how the districts work together to do what is right for patients and to share resources, experience, and knowledge. But we also heard about the frictions and difficulties they face in collaborating and the burden this can sometimes impose on patients, as well as on families and others. The difference in available resources between large and small districts and between Capital and the other districts were often mentioned. In Cumberland District Health Authority and in Pictou District Health Authority, two districts without involuntary in-patient psychiatric units, we heard a great deal about the challenges they and their patients face in getting timely access to coordinated care under the Act. In Colchester District Health Authority and in Guysborough Antigonish Strait Health Authority we heard about the challenges they face in being primarily responsible for responding to the needs of the two other districts, while discharging their responsibility to serve their own patients. More generally, we heard a concern about how the system struggles to address issues that can only be addressed at the system level, such as the transfer of patients between districts and to and from metro when more specialized service is needed.

We do not have the expertise or all the information that would be needed to provide specific advice on how these and similar issues should be addressed. There are some relatively simple things that can be

[146] Nova Scotia Health Research Foundation, "Mental Health and Addictions Strategy: Consultation Results and Evidence from Other Sources" (2011) [Submitted to the Department of Health and Wellness].

[147] G Roberts & K Grimes, "Return on Investment: Mental Health Promotion and Mental Illness Prevention" (Canadian Policy Network at the University of Western Ontario, 2011).

done, however. For example, if Pictou District Health Authority is not to have an involuntary in-patient unit, the Aberdeen Hospital should not be designated as a psychiatric facility, as it currently is. As another example, there should be no district health authority that is not served by a designated facility (or facilities) which is designated as the facility for that district, whether the facility is in the district or in another district. And of course, the resources provided to the districts that have the facilities to serve multiple districts would have to be adjusted accordingly. We were told that the role and responsibility of the chief executive officer in Cumberland County needed to be clarified. The definition of chief executive officer under *IPTA* is linked to the district having a designated psychiatric facility, which Cumberland County does not. Districts play a role in the operation of *IPTA* and the role of any chief executive officer of any district that does not have a designated facility should be clarified. To put it another way, when a patient from a district health authority that does not have a designated facility is treated under *IPTA* in another district, which chief executive officer is the chief executive officer for purposes of *IPTA*?

More substantial solutions may require basic rethinking of how the acute care system in mental health should be configured. For example, the view was expressed in two districts that most psychiatric units are too small to provide optimal care and that it would not be feasible to fix this by increasing the size of all units. Instead, it was suggested that a tiered system should be created with greater and sharper differentiation between the services available in all districts, the services available in the districts mandated and resourced to provide more specialized services for larger regions, and the services to be delivered at a provincial level. Several people suggested that acute mental health care, and perhaps mental health more generally, needed more of a province-wide programme management approach. This aligns with directions on "quality of care" laid out in "Together We Can," which calls for "more efficient care by acting on studies on the placement and locations of beds" and for specialty networks to address the impracticality of having all specialty services in all districts.[148] The role Cancer Care Nova Scotia has played in making this happen in treatment for cancer was mentioned several times as a possible model.

2.2.2.5. The Overall Functioning of the Act Relative to Nova Scotia's Mental Health Policy Objectives, as Articulated in Nova Scotia's Mental Health and Addictions Strategy

We have considered this aspect of our review of the functioning of *IPTA* from two perspectives: from the perspective of how the objectives of Nova Scotia's mental health strategy could improve the functioning of *IPTA* and from the perspective of how the functioning of *IPTA* could address the mental health policy objectives.

Throughout our consideration of the overall functioning of *IPTA*, we have identified multiple alignments between what stakeholders told us about the functioning of *IPTA* and Nova Scotia's mental health policy objectives, as articulated in the mental health strategy, "Together We Can." Further points of overlap

[148] "Together We Can," *supra* note 2 at 19-20.

can be identified in our consideration later in this Report of the functioning of the specific sections of *IPTA*, as well as in our review of the functioning of community treatment orders.

This shows congruence between what stakeholders said is needed to improve the functioning of *IPTA* and what the strategy, reflecting stakeholder input, aims to improve in the mental health system more generally. Specifically, what we have heard on the functioning of *IPTA* validates the importance the strategy places on priorities such as: early intervention aimed at mental health promotion and illness prevention; shorter waits and better care through peer and other community supports; improved planning and delivery of acute care services; stronger information systems; addressing the needs of aboriginal and diverse communities; improved collaboration between government departments, including on housing and supports in the community; and reducing stigma, including through public education. Progress in these areas under the framework of the strategy could improve the functioning of *IPTA* either directly, for example by reducing waiting, or indirectly, for example by improving access to services and supports that prevent acute mental illness or assist in recovery from it.

As we have noted already, stakeholders were generally positive about the strategy and hopeful about what it might accomplish. There was, however, a "wait and see" perspective, grounded in uncertainty about whether the strategy would be fully implemented, especially in the longer term. There was also some disappointment that the strategy was limited in the range of actions it called for to address the broader objectives. We interpret this to mean there was support for the objectives, but concern that the associated actions were not sufficiently ambitious, comprehensive, or specific.

Ultimately, these reservations about a particular strategy can only be addressed by its effective implementation and by evaluation that shows it has significantly advanced the objectives. The credibility and the effectiveness of the governance choice of using a province-wide long-term strategic planning process to comprehensively improve the mental health system is a larger question. Without repeating what we have said above about broader mental health legislation, framed as mental health planning legislation, we reiterate the role it could play in giving the process a statutory framework. This framework could define the objectives to be advanced, the policy fields to be addressed and the accountability of the players for development, implementation, and evaluation of the strategy. In short, it could help to ensure the process stays on track and continues to make progress towards the objective in both the short and longer terms.

On the contributions that *IPTA* could make to the mental health policy objectives, we begin with an observation: even though section 2 of *IPTA* says the purpose of *IPTA* is to ensure that "issues dealing with mental health" are dealt with in accordance with the guiding principles, neither *IPTA* nor the guiding principles are referenced in "Together We Can." The functioning of *IPTA* was, however, mentioned in "Come Together," the report of the Mental Health and Addictions Strategy Advisory Committee upon which the strategy is based.[149] It is important that effective implementation of *IPTA* in accordance with its dual objective of making necessary treatment available and protecting human rights is understood to be a necessary part of improving mental health and health care in Nova Scotia.

[149] "Come Together," *supra* note 4.

The recommendations we propose elsewhere in this Report based on our analysis of the appropriate objectives of *IPTA* and the functioning of *IPTA* relative to those objectives have the potential to ensure *IPTA* contributes to the policy objectives set out in "Together We Can." Here we give just a few examples.

The addition to section 2 of *IPTA* of guiding principles on cultural safety and equality will help to ensure, as envisaged in "Together We Can," that:

> The unique needs, traditions, and ways of First Nations citizens, diverse communities, and specific groups within our province will be respected and met to ensure that there is dignity and respect for all, and barriers to care are removed.[150]

It will help to ensure there is health equity, defined in "Together We Can" as the "opportunity for health for all, regardless of age, gender, ethnicity, religion, sexual orientation, or socioeconomic status."[151]

A number of our recommendations will advance the goal of "Together We Can" to ensure "Nova Scotians are able to get the care, treatment, and supports they need more easily and in a timely manner, regardless of where in the province they live."[152] They will help to ensure "responsiveness to the needs of Nova Scotians experiencing mental health… problems."[153] Some of these are: the recommendations we make for concerted effort on decision-support tools relative to application of key concepts such as deterioration and capacity, more and continuous education on the Act, and continuing monitoring and evaluation on a provincial basis through improved information tracking and analysis to guide the implementation of the Act.

The recommendations we make to address the differences in legal treatment imposed on people with mental illness by sections 18 and 39 of *IPTA,* and those we make calling for more education on stigma in the mental health system, will help the strategy to ensure that "[t]he stigma and discrimination faced by Nova Scotians living with these illnesses will be reduced, and there will be greater respect, compassion, and understanding of these issues throughout our province."[154] They can also be part of the response to the strategy's recognition that "[s]tigma is a real and significant barrier to people seeking care, treatment, and support."[155]

The recommendations we make for a more cohesive and coordinated implementation of *IPTA* on a provincial scale will help to achieve the strategy's principle that "every door is the right door" in acute mental health care.[156] They will help to address the concerns of families who, as recognised by the strategy, now "often find it difficult to navigate the maze of trying to get assessment, treatment, and

[150] "Together We Can," *supra* note 2 at 5.
[151] "Together We Can," *supra* note 2 at 6.
[152] "Together We Can," *supra* note 2 at 5.
[153] "Together We Can," *supra* note 2 at 6.
[154] "Together We Can," *supra* note 2 at 6.
[155] "Together We Can," *supra* note 2 at 10.
[156] "Together We Can," *supra* note 2 at 10.

care" and who "are sometimes not sure where to turn on weekends or nights."[157] They can also help to address the current reality that "[s]ervices are not always easily obtainable or equally available in all areas of the province," especially in rural areas. These recommendations will help the strategy to "close the gaps to ease the transition from one program or service to another for individuals and families."[158]

Our recommendation on data tracking and evaluation and on application of the conclusions to guide continuing improvement in the implementation of *IPTA* will reinforce the emphasis that "Together We Can" places on evidence-based policy, evaluation, and accountability.

Our recommendations to improve the functioning of the Review Board are critical to three of the guiding principles of "Together We Can": accessibility, respecting individuals, and ensuring dignity. They also have an important contribution to make in ensuring the overall system functions less like a maze to be navigated and more like a health system "centred on [patient] needs and those of their families, though greater collaboration."[159]

In sum, like the many stakeholders we learned from in this process, we understand that a mental health strategy needs to deal with many things beyond psychiatric treatment. But given the importance of psychiatric treatment to the broader picture and what we have heard from stakeholders about the need for improvements in *IPTA* and in its implementation, it is clear that comprehensive improvement to mental health care must encompass a range of improvements to *IPTA* and its implementation.

2.2.3. The Functioning of Specific Sections and Related Sections

2.2.3.1. Introduction

Having discussed the overall functioning of *IPTA*, we now turn to the aspects of the legislation when issues relevant to the functioning of specific parts of the Act were brought to our attention. We do not discuss all of the provisions of the Act but confine ourselves to those on which we heard issues that in our opinion warrant consideration in light of our responsibility to propose legislative or administrative changes relative to *IPTA* or to associated legislation.

2.2.3.2. The Title of the Act

The sense that people have of the objectives of any statute is initially conveyed by the statute's name. It is obvious that in the case of *IPTA*, the name of the Act sends a clear message that the Act deals with involuntary psychiatric treatment and that its objectives lie exclusively in that direction.

As stated above, we heard that some regard the focus of the legislation on involuntary psychiatric treatment to be stigmatizing. Others thought the same focus was one of the Act's strengths, primarily on the basis that the serious nature of involuntary psychiatric treatment is at risk of being glossed over or obscured when provisions dealing with such treatment are included within a broader mental health

[157] "Together We Can," *supra* note 2 at 9.
[158] "Together We Can," *supra* note 2 at 5.
[159] "Together We Can," *supra* note 2 at 5.

statute. As explained above, we favour the latter view. One of our reasons is the possibility that a more focused statute may be more accessible and understandable to mental health providers.

Even so, we acknowledge that the name of the Act may be stigmatizing. We also find the current name may be problematic because it does not accurately convey the Act's current scope. Although the Act does deal primarily with involuntary treatment, it also provides for voluntary treatment. Moreover, its guiding principles make it clear that voluntary treatment is to be "the primary mode of admission to a psychiatric facility… wherever possible." So it is clear that the Act does not deal only with involuntary psychiatric treatment but with psychiatric treatment more generally. Like the Truro police officer who stressed this point to us, our concern is that the title of the Act may be unnecessarily stigmatizing and misleading. Moreover, we are concerned that its current title may be sending a message to health care providers that the intention of the Act is at odds with its guiding principles.

We expect the Act's title may have been chosen to avoid the impression that the legislation applied to all psychiatric treatment or to the practice of psychiatry. This impression would, however, be quickly dispelled by the provisions of the Act itself, which are incapable of being interpreted and applied in these broad ways. Given the possibility that the current title has adverse consequences for a very vulnerable population, we conclude that it would be better to have legislation with a title that was somewhat broader than the scope of the Act than to continue with a title that is potentially stigmatizing and is narrower than its scope.

We conclude, therefore, that the title of the Act should be changed to the "Psychiatric Treatment Act" or to some other title that better reflects the scope of the Act and, in particular, the emphasis it places on voluntary treatment.

2.2.3.3. Section 3: Interpretation

2.2.3.3.1. Overview

Like most legislation, the *Involuntary Psychiatric Treatment Act* defines terms that are used throughout the statute. We did not hear much about the interpretation section of the Act during our consultations. When people did raise concerns about definitions, they often did so by highlighting the relationship between the particular definition and other sections of the Act and the effect of this relationship on the interpretation or functioning of the Act. This is not surprising since the definitions, of course, only function in relation to specific sections of the legislation. We will reserve our discussion of most of the concerns raised about defined terms for later so that they can be situated and understood in the context of their function within the Act.

In the discussion document posted on the *IPTA* Review's webpage, we sought input on the definition of "mental disorder." We stated *IPTA* provides for involuntary assessment of those who are suspected of having a mental disorder and for involuntary treatment of those who are determined to have a mental disorder. For this reason, the definition of "mental disorder" in the Act is very important. We also highlighted this definition in some of our discussions with stakeholders.

2.2.3.3.2. Issues

While we discuss most of the definitional issues later in this section, it is appropriate to address the input we received regarding the defined term "attending psychiatrist" and "mental disorder" at this point.

Section 3(a) reads: "'attending psychiatrist' means the physician who is responsible for the examination, care and treatment of a patient in a psychiatric facility." Some psychiatrists and mental health professionals indicated that this definition can contribute to confusion about the role of different medical specialties under the Act. It is not clear from the definition whether it refers only to psychiatrists who are responsible for the care of a particular patient or whether it makes any physician who is responsible for care of a patient under the Act the "attending psychiatrist" for the purpose of the Act, whether or not they are a psychiatrist. We heard that in some districts it is often the family physician who admits and cares for the patient while in a psychiatric facility, this may at times be done under the direction of a psychiatrist. Several psychiatrists and mental health professionals indicated that this was both an appropriate and necessary practice, particularly outside of Halifax. One psychiatrist suggested that the term should be changed to "attending physician" to reflect both the operational reality and the language of the definition.

Section 3(q) reads: "'mental disorder' means a substantial disorder of behaviour, thought, mood, perception, orientation or memory that severely impairs judgement, behaviour, capacity to recognize reality or the ability to meet the ordinary demands of life, in respect of which psychiatric treatment is advisable." We did not receive much input regarding this definition, but what we did receive was generally positive. One person suggested broadening the types of treatments referenced to include those beyond psychiatric treatments.

2.2.3.3.3. Conclusions

The term "attending psychiatrist" is used in sections 21, 23, 24, 25, 42, 69, and 76. All of these provisions are linked to the declaration of involuntary admission under section 17 which must be completed by a psychiatrist, either by renewing or changing the patient's status or addressing issues of review by the Review Board. These functions seem consistent with what one would expect of the treating psychiatrist. However, it seems to us appropriate that discussion take place about the role that other physicians and mental health professionals may play in these regards.

Based on what we heard, we do not feel that we are in a position to recommend a change to the definition of "mental disorder." We note that broadening the definition to other kinds of treatment would have the effect of broadening the kinds of mental health issues that could lead to involuntary admission and treatment.

2.2.3.4. Sections 4-7: Voluntary Admission

2.2.3.4.1. Overview

Under the *Involuntary Psychiatric Treatment Act*, individuals may be admitted to a psychiatric facility as:

- a voluntary patient who is capable of making treatment decisions;
- a voluntary patient who is incapable of making treatment decisions; or
- an involuntary patient.

A person may be admitted to a psychiatric facility as a voluntary patient if a psychiatrist believes the person would benefit from being admitted. A person meets the criteria to be admitted as a voluntary patient under the Act if the person:

- either is capable of consenting to treatment or has a substitute decision-maker who can consent to treatment on his or her behalf; and
- does not meet the criteria for being admitted as an involuntary patient.

If a voluntary patient requests to be discharged from the psychiatric facility, section 7 allows the patient to be detained and kept in the facility for up to three hours for the purpose of a medical examination that is to be conducted within three hours.

2.2.3.4.2. Issues

We frequently heard concerns about the category of voluntary patients who lack capacity. Many used the phrase "voluntary but incapable" to describe this category of patient. We heard that it is therapeutically preferable, and consistent with the guiding principles of the Act, to admit a patient on a voluntary basis whenever possible. Many respondents felt, however, that incapacity was incongruous with the status of "voluntary patient." Concern was raised that patients felt, and sometimes were told, that they would maintain their voluntary status until they seek to leave hospital. One mental health professional described this as: "you're voluntary until you decide to leave."

We heard frequent concerns that a patient's status may be changed from involuntary to voluntary close to the time a Review Board hearing was to take place. Different explanations for the status changes were shared with us. Some worried that the change was sometimes prompted by a desire to avoid a hearing. Others said patients were often better after being treated in hospital for several weeks and no longer met the involuntary criteria by the time the hearing date arrived. For some, this meant the Act should require an earlier review of admissions by the Review Board, either on application by the patient or automatically. Some speculated that the scheduling of a hearing prompted psychiatric review and the patient may have been well enough to be made voluntary before that time. Some stakeholders

suggested the Review Board should have the authority to review a change in patient status where an involuntary patient's status is changed to voluntary shortly before a scheduled Review Board hearing.

Significant and frequent concerns were raised about the lack of oversight for this group of voluntary patients; for this, voluntary patients must seek redress from the courts by applying under the *Hospitals Act* for a review of a declaration of capacity.[160] There was considerable agreement that there should be a review of "voluntary but incapable" patients and that the Review Board was the appropriate body to conduct the review. Some stakeholders suggested that *IPTA* should make the category of "voluntary but incapable" explicit.

In relation to section 7, which allows for the detention of a voluntary patient for a physician examination, psychiatrists and mental health professionals felt this was an important authority under the Act. Without this provision, we heard worries that nurses on the night shift would be without legal authority to detain a patient who, for example, may be suicidal and trying to leave the facility. Some participants in our consultations suggested that the authority under section 7 of the Act should be expanded to include individuals who may be waiting for examination in the emergency department or other locations in the hospital (i.e. where they are not yet a patient, voluntary or involuntary).

2.2.3.4.3. Conclusions

There is serious cause for concern about the lack of oversight for voluntary patients who lack capacity. The Act should provide for the Review Board to review matters relating to these patients. There are different ways to accomplish the appropriate oversight that the Department of Health and Wellness should actively explore.

One option is where decisions on admission are made for a voluntary patient under section 6 by substitute decision-makers, the admission should be subject to review by the Review Board. At least two questions would need to be considered: the basis on which the decision can be reviewed by the Review Board, since the patient is not being involuntarily admitted against the criteria in section 17; and whether the triggering event for the review should be admission, admission and a prescribed length of stay or an application by the patient.

An alternative and more elaborate approach would be to make the category of "voluntary incapable" explicit in the legislation. Other jurisdictions have taken this approach, including South Africa.[161] This approach raises some challenging issues including how such a category should be defined and whether its explicit mention might lead to circumvention of the more rigorous process for involuntary admission. While further discussion and careful crafting are required, we encourage the Department to actively investigate the merits of this approach.

We also believe the Review Board should have jurisdiction to review the admission of a patient whose status as an involuntary patient is changed to that of a voluntary patient prior to the patient's scheduled

[160] *Hospitals Act*, *supra* note 13, s 58(2).
[161] *Mental Health Care Act 17 of 2002*, (South Africa) at ss 27-30.

hearing at the Review Board. We make a recommendation to that effect. This will add to the protection provided to patients by our earlier conclusion.[162] Care should be taken to avoid creating barriers or disincentives to making patients voluntary where that is the right thing for the patient. We also think it should be observed that if the status of patients is being changed to avoid Review Board hearings, this in an issue that should be addressed within the internal processes of district health authorities or their medical staffs. In addition, it is our view that the monitoring of patients should be such that a medical determination that a patient has improved to an extent to warrant a change in status should rarely be prompted by preparation for an impending hearing.

With respect to the suggestion that the Act include authorization to detain individuals who are waiting for examination in the emergency department or other locations in the hospital, we are concerned that this may act as a deterrent for individuals who want to seek help but are worried about being involuntarily detained. We encourage the system to continue working on other kinds of options, including reducing wait times in emergency departments.

2.2.3.5. Sections 8-16: Medical Examination and Involuntary Psychiatric Assessment

2.2.3.5.1. Overview

IPTA allows for a physician to examine a person and determine whether the person should have an involuntary psychiatric assessment done. This examination is referred to as a "medical examination" under the Act.

The police are often the first contact a person may have with *IPTA*. They are authorized to take a person for a medical examination where they believe:

- the person apparently has a mental disorder;
- the person will not consent to go for a medical examination;
- it is not feasible to ask a judge to order the medical examination; and
- the person:
    - as a result of the mental disorder, is threatening or attempting to cause serious harm to himself or herself or has recently done so, has recently caused serious harm to himself or herself, is seriously harming or is threatening serious harm towards another person or has recently done so;
    - as a result of the mental disorder, is likely to suffer serious physical impairment or serious mental deterioration, or both; or
    - is committing or about to commit a criminal offence.

[162] Data on changes of status, including in relation to scheduled hearings, should be tracked and monitored by the Department of Health and Wellness.

The police are also authorized to take a person for a medical examination where a judge orders under section 13 that the person be taken for a medical examination.

The police must stay with the person while the medical examination is completed. If the person is not recommended for an involuntary psychiatric assessment, the police must take the person back to where the person was taken into custody or some other appropriate place.

After examining the person, the physician will complete a certificate for involuntary psychiatric assessment where:

- the physician believes the person appears to have a mental disorder;
- as a result of the mental disorder, the person is
    - threatening or attempting to cause serious harm to himself or herself or has recently done so, or has recently caused serious harm to himself or herself, or is seriously harming or is threatening serious harm towards another person or has recently done so; or
    - is likely to suffer serious physical impairment or serious mental deterioration, or both; and
- the person would benefit from psychiatric inpatient treatment and is not suitable to be admitted as a voluntary patient.

The Act requires two physicians to complete a certificate for involuntary psychiatric assessment for the person unless "compelling circumstances exist and where a second physician is not readily available to examine the person…" If such circumstances exist, one physician's certificate is sufficient.

The purpose of the involuntary psychiatric assessment is to determine whether the person should be admitted to a psychiatric facility as an involuntary patient. The person may be held for the assessment for a maximum of 72 hours. If after that time the person has not been admitted, he or she must be released.

After an involuntary psychiatric assessment is completed, the person will be admitted as an involuntary patient if a psychiatrist determines:

- the person has a mental disorder;
- the person needs psychiatric treatment in a psychiatric facility;
- as a result of the mental disorder, the person is
    - threatening or attempting to cause serious harm to himself or herself or has recently done so, or has recently caused serious harm to himself or herself, or is seriously harming or is threatening serious harm towards another person or has recently done so, or
    - is likely to suffer serious physical impairment or serious mental deterioration, or both;
- the person is not suitable to be admitted as a voluntary patient; and

- as a result of the mental disorder, the person does not have the capacity to make admission and treatment decisions

The Act requires the attending psychiatrist to examine and assess the patient's mental condition at set intervals to determine if the patient's status as an involuntary patient should be renewed. The length of time between renewals of the patient's status varies between one and three months depending upon how long the patient has been admitted as an involuntary patient.

2.2.3.5.2. Issues

Scope of medical examination

We heard different views from psychiatrists and general practitioners about the purpose of, and therefore the scope of, the medical examination under the Act. We heard different views about whether the medical examination was aimed at ruling out organic explanations for the patient's behaviour before a psychiatrist reviewed the patient under the Act. There was sometimes an equating of "medical clearance" with the medical examination under the Act. In a practical sense, the question is what is the scope of the diagnostic work that is supposed to happen in the emergency department, as opposed to in the inpatient unit? Some emergency room physicians were not clear about their responsibility or ability to complete Form 2, the form that triggers the involuntary psychiatric assessment by a psychiatrist. The concerns about the scope of the medical examination appeared to play out in the dynamics between district health authorities, particularly between those that do and those that do not have involuntary inpatient units. In that scenario, it seemed to us the medical examination happens in one district and the psychiatric assessment in another. Differences in understanding about the scope of the clinical evaluation to happen at the medical examination can become differences in understanding between the districts about what aspects of the evaluation happens in each district.

Certificate for involuntary psychiatric assessment

Psychiatrists and emergency room physicians questioned the requirement for two physicians to complete a certificate for involuntary psychiatric assessment. The Act allows for one physician to complete the certificate under compelling circumstances and where a second physician is not readily available. We were told that, from a practical perspective, in a busy emergency department these circumstances were frequently met or interpreted as being met. We were also told that where a second physician was available, that physician was unlikely to disagree with or question the first physician's determination of the need for an involuntary psychiatric assessment.

Wait times and police concerns regarding the medical examination

As we have already noted, there was a fair bit of discussion about the issue of waiting for a medical examination in the emergency department. We heard a lot of concern that the wait for the medical examination to be completed in the emergency department can be extensive. Patients, families, and

police felt the wait itself was non-therapeutic and dissuaded individuals from going on their own initiative or willingly. Also, waiting sometimes meant the individual left before being seen.

The requirement that police who take a person into custody stay with the person until the medical examination has been completed is found in section 16. It is reasonably clear that the medical examination referenced is the one to be carried out under section 8 for the purpose of deciding if there should be an involuntary psychiatric assessment. There seems, however, to be different understandings between some police forces and some hospitals as to what is required, and what should be required, of police under the Act. Some police have said they interpret or will interpret section 16 to mean "seen by a health care provider." Health care providers have expressed the view that the police are, and should be required, to stay as long as completion of the section 8 examination takes.

We heard that police forces and district health authorities have been working, and continue to work, to address concerns about lengthy waits, as well as the location where the wait takes place We were told in various districts that average waiting times have been reduced significantly with positive effects for patients and police. Some district health authorities have a room separate from the main emergency department waiting area for patients with mental illness. Many stakeholders, including patients, families, and police, indicated that the separate waiting area was positive from a therapeutic perspective. It was also thought to reduce the stigma patients may feel by having to sit with a police officer in the public waiting area. On the other hand, a concern was also raised that a separation of patients with mental illness from others was also stigmatizing and some worried it would take the pressure off efforts to reduce unacceptable waiting, the real problem.

Police felt their presence in the emergency department often was not necessary, as in their assessment the individual posed no risk of violence. As indicated above, they also feel their presence could be stigmatizing and non-therapeutic. The requirement for a police officer that takes custody of a person under the Act to retain custody of that person until the medical examination is completed is set out in subsection 16(2). It reads:

> 16(2) The peace officer or other authorized individual shall remain at the place of the medical examination and shall retain custody of the person until the medical examination is completed.

There is disagreement about whether "other authorized individual" could include hospital staff. In our view subsection 16(2) contemplates someone other than a police officer remaining with the person undergoing the medical examination, but it appears that no district health authority has attempted to authorize an individual under this provision. Some policing representatives expressed the view that the requirement for a police officer to remain with the detained person until the completion of the medical examination was inconsistent with the direction in section 16(1) which requires the officer to "convey the person by the least intrusive means possible without compromising the safety of the person." Reference was also made to the guiding principles in the Act, which requires "treatment and related services… to be offered in the least-restrictive manner and environment…"

We were told there are protocols in place in other jurisdictions that provide for priority to be given to patients brought to hospital by police and that give police the option to transfer custody of non-violent patients to hospital staff. We heard that in some district health authorities, individuals brought in by the police were given a priority when triaging took place. In addition to the protocols referenced, our attention was drawn to section 10.3 of New Brunswick's *Mental Health Act*,[163] which limits the time a police officer is required to remain with a person in a medical facility to three hours. The section reads:

> Notwithstanding section 10.2, a peace officer or other person may release a person detained in the peace officer's or other person's custody under section 9 or 10 on the expiration of three hours after the person has been taken to a medical facility, physician's office or psychiatric facility.

Under *IPTA*, where an individual is taken into custody but not recommended for involuntary psychiatric assessment, section 16(3) requires the police or other authorized individual to arrange and pay for the return of the individual to the place where they were taken into custody. We heard concern that this requirement can be onerous for police, particularly in rural communities and where the individual may have been transported outside of the district for the examination. A few police officers made the argument that this role was inappropriate and treated persons experiencing a mental health crisis differently from those experiencing a physical health crisis. They gave the example of when a person calls an ambulance because they are experiencing a heart attack, the ambulance does not return the person home after the physician has assessed the person.

As a general statement, we heard from a number of people that staff in the emergency department are not always as comfortable with mental health patients as they would be if there was better support and education provided to them relative to mental health issues and their roles in providing service to people with mental illness.

Assessment period

The Act allows 72 hours for the completion of the involuntary psychiatric assessment. We heard different views as to the appropriateness of this length of time. Some doctors told us 72 hours is the right amount of time to carry out the assessment, while some said it was not long enough, especially when the 72 hours corresponds with a weekend. As a result, some psychiatrists will err on the side of caution and admit the individual as an involuntary patient. On the other hand, we heard that the 72 hours is sometimes longer than is needed and is sometimes used as a tool to manage workload by detaining the patient for the full 3 days when it may not be necessary.

As discussed earlier in this Report, the data suggests that the 72-hour period may be contributing to involuntary admissions. In this respect, we concluded that the Department of Health and Wellness should track data regarding the potential causal relationship between the requirement that involuntary psychiatric assessments must be completed within 72 hours and the percentage of assessed patients who are involuntarily admitted.

[163] *Mental Health Act*, SNB 1973, c M-10.

A number of psychiatrists and mental health care professionals told us that it is unclear as to when the 72-hour involuntary assessment period starts.

Assessment criteria

Most of the issues raised with us about the criteria for the medical examination, the involuntary psychiatric assessment, and involuntary admission centred on the criteria of capacity (or its absence), and on the deterioration "branch" of the risk criteria.

We heard a variety of perspectives and concerns about the issue of capacity. We were told that the wording in *IPTA* may lead to the view that the assessment of capacity is only relevant to the psychiatric assessment and not to the medical examination. Unlike the criteria for involuntary admission under section 17, the criteria under section 8 for the certificate for involuntary assessment that flows from the medical examination does not explicitly refer to capacity. This raised questions for some physicians as to whether they needed to assess the person's capacity as part of the medical examination. In addition, physicians expressed confusion about whether the assessment of capacity during the medical examination is to be conducted pursuant to the *Hospitals Act* or *IPTA*.

As discussed earlier in this Report, concerns about the variation in the interpretation and application of the capacity criteria under section 18 and the deterioration branch of the risk criteria were raised by stakeholders. As discussed above in section 2.2.2.1 (The Overall Functioning of the Act Relative to its Current Objectives), the use of province-wide, multi-disciplinary training programs and protocols could be helpful towards achieving and maintaining a consistently high standard of practice in applying these criteria.

Some psychiatrists and mental health professionals raised concern and uncertainty about the scope of treatment that can be provided involuntarily while a patient is undergoing a medical examination under section 8 or involuntary psychiatric assessment under sections 8 and 10.

Some clinicians suggested that a psychiatric resident should be authorized to conduct an involuntary psychiatric assessment. Currently a psychiatrist is required. This issue was raised in the context of some district health authorities that have higher year psychiatric residents working in their facilities, as well as in the context of residents filling locum[164] positions in the province.

2.2.3.5.3. Conclusions

We conclude the legislation is reasonably clear as to the purpose of the medical examination: it is an examination by a physician for the purpose of determining if the criteria for conducting an involuntary psychiatric assessment under the Act are present. However, the phrase "medical examination" is commonly used by the health care system to describe a variety of examinations conducted by physicians. We accept that the commonality of the phrase contributes to the confusion about its role in

[164] *Black's Medical Dictionary*, 42d ed, *sub verbo* "Locum Tenens: Usually shortened to 'locum', this means a doctor who stands in for another, for example during absence due to holidays or sickness."

the legislation, despite the legislation's clarity. A psychiatrist suggested that the term "clinical examination" may assist in clarifying existing confusion. We agree that changing the term to something less generic could be helpful. The applicable concept is evaluation for the purpose of determining whether the criteria for an involuntary psychiatric assessment are present.

With respect to the requirement for two physicians to complete the certificate for involuntary psychiatric assessment, we are of the view that the requirement for two physicians should remain. Some statutes require two psychiatrists to involuntarily admit a patient. *IPTA* allows a single psychiatrist to make this decision under broad admission criteria. It is therefore all the more important that two physicians examine the patient in the first instance to determine whether detention for involuntary psychiatric assessment is appropriate. We recommend that the operation of this requirement be examined with a view to making sure it operates as an effective safeguard for patients, as contemplated by *IPTA*.

The impact of *IPTA* on police human resources is significant. The role of the police under the Act is an important one that needs to be balanced with other traditional policing responsibilities in the community. When an individual detained by the police under the authority of *IPTA* is potentially violent or disruptive, there was consensus amongst the stakeholders we spoke with, including the police, that the police should retain custody of the individual until the completion of the medical examination. When, however, an individual awaiting the medical examination is not at risk of becoming violent or disruptive, we feel it is appropriate and preferable from a therapeutic and stigma-avoidance perspective, as well as a human resource perspective, that alternative security approaches be considered. We feel this is already contemplated in section 16, but that section 16 could be clearer in this respect.

Similarly, we support the suggestion that alternative transportation options should be explored in relation to the requirement under subsection 16(3) to return an individual who is not recommended for involuntary psychiatric assessment to the place he or she was taken into custody. This is an appropriate requirement because the individual's liberty rights were affected to conduct the medical examination and often the person will be a considerable distance from the place at which they were taken into custody; we acknowledge, however, that the police may not be the most appropriate mode of transportation.

It would be helpful to provide guidance on how section 16 of the Act should be generally implemented. There are different options for providing this guidance, including the creation of a regulation under the Act or other mechanism, such as a Memorandum of Understanding between the health and policing systems. We favour the development of a Memorandum of Understanding that would address issues around the well-being of patients, the safety and security of patients, police, health care staff, and the public, and financial issues as between the health and policing systems.

An additional or alternative option would be to amend section 16 to delete the statutory obligation of police to remain at the place of the medical examination and to retain custody of the person until it is complete, or to specify the maximum number of hours during which the police are under the obligation

to remain and retain custody. If the latter course is chosen, we favour the New Brunswick approach that limits police attendance to a certain number of hours, may be appropriate.

The time-frame for detaining a person for an involuntary psychiatric assessment is, on its face, an important protection in *IPTA*. As discussed, we heard different views about whether 72 hours is the appropriate length of time and many concerns that practical difficulties in meeting the time-frame cause psychiatrists and the system more generally to err on the side of admission. It is important to collect data about the number of patients who are admitted as involuntary patients after an involuntary psychiatric assessment with a view to determining if the 72-hour limit for an involuntary psychiatric assessment is leading to more patients being involuntarily admitted than would be admitted if the assessment period was longer or longer in particular circumstances.

We think it is clear in the legislation that the 72-hour involuntary psychiatric assessment begins when the certificate for involuntary psychiatric assessment is completed. However, it is clear to us that there is an uncertainty in the system about when this critical time period commences and so steps should be taken to address this. In our view, the fact that there would be uncertainty on this important but relatively simple issue vividly demonstrates the need for a more organized approach to the implementation of the Act on a provincial level, including with training on the Act.

The confusion about the relevance of capacity and the application of the *Hospitals Act* to the medical examination is understandable. There should be more clarity than there is as to how capacity is relevant to the medical examination required under *IPTA.* Our understanding is that its relevance is related to the treatment that can be provided during the examination and that the applicable law in that respect is the *Hospitals Act,* not *IPTA*.

We believe that a common test for capacity would assist with the confusion. We do not believe it makes sense for capacity assessments at different stages of the operation of the Act to be made on the basis of different standards in relation to the same patient during the same episode. As concluded earlier, a common test may in any event be required by the *Charter of Rights and Freedoms* and would avoid the stigmatization implications of having two different tests. If there was one test for mental health and physical health patients, it would be clear that the same test applied to both examinations and assessments under *IPTA*. If two separate tests are retained, the system should be brought to a clear and common understanding on how the law of informed consent applies to an examination conducted under section 8.

2.2.3.6. Section 13: Judicial order for examination

2.2.3.6.1. Overview

Under section 13, anyone may ask a judge to order a medical examination of another person by a physician. The judge may order the police or someone else to take the person for the medical examination where the judge believes the person:

- has a mental disorder;
- will not consent to the medical examination; and
- as a result of the mental disorder, is threatening to or has caused serious harm to anyone (including himself or herself) or the person will likely suffer serious physical impairment or serious mental deterioration.

The court's order is valid for seven days.

2.2.3.6.2. Issues

We heard that this section of the Act is infrequently used by families and mental health professionals. We requested statistics from the Department of Justice with respect to the frequency of applications under section 13 but we did not receive that information. Families who applied under this section with the hope of facilitating a medical examination of their loved one reported that the process was difficult and intimidating. They reported that judges did not always understand the provisions in *IPTA* or issues about mental illness. They encouraged judicial training. We heard a plea for assistance to family members to help them navigate the judicial process so they could effectively avail themselves of this provision.

There was an assumption expressed that a judicially prescribed medical examination would more likely result in an involuntary psychiatric assessment or admission than a medical examination initiated under police authority. Clinicians credibly told us that the clinical tests are the same regardless of who initiates the medical examination. This appeared to be consistent with the experience of some families' who expressed concern that their loved one was not admitted despite a judicially ordered medical examination.

Section 13 gives authority to a "judge." Judge is defined in section 3 to mean "a judge of the Supreme Court of Nova Scotia (Family Division) or, in an area of the Province where there is no Supreme Court (Family Division), a judge of the Family Court." It was brought to our attention that since 2004, all judges appointed to the Provincial Court have been appointed at the same time as judges of the Family Court. It was said that this meant that many provincial court judges could use their powers as judges of the Family Court under section 13 to order a psychiatric assessment under *IPTA* when presiding in a criminal proceeding. The reason they might do so is that such an assessment would happen at a psychiatric facility designated under *IPTA* rather than at the East Coast Forensic Hospital, as would be the case if a psychiatric evaluation was ordered under the *Criminal Code*. A case was brought to our attention where this was recently done. We were told that in the circumstances of that case, assessment in a psychiatric facility other than the East Coast Forensic Hospital was clearly called for.

As section 13 is currently written, this option would only be available to a Provincial Court Judge who is also a judge of the Family Court where the Judge receives an application under section 13. In the context of a criminal proceeding, this would presumably come from the Crown or defence or both of them.

It was suggested that the relevance of this is that the role that section 13 could play in diverting people with mental illness from the criminal justice system or in ensuring appropriate treatment for those who find themselves in the criminal justice system is underappreciated. It was suggested that the potential may warrant changes to section 13 to make its usefulness in this regard explicit. For example, judges of the Provincial Court might be given the same jurisdiction under section 13 as judges of the Family Court and they might, in that capacity, be given the authority to apply section 13 on their own motion, subject of course, to submissions from the Crown and defence.

We reach no conclusions and make no recommendations in this regard. We simply document the suggestion in case it is one that the appropriate authorities think worthy of further consideration.

2.2.3.6.3. Conclusions

We do not believe that the judicial system is the ideal place to address access to appropriate mental health care. We did not hear enough about this section to recommend removing or amending it. We understand the challenges families face in helping their loved ones get care. We think there are better ways to support families than supporting applications under section 13, particularly where we did not hear evidence that the decision from the medical examination would be different. We feel that efforts to support families in getting care for their loved ones should concentrate on ensuring the effective implementation of *IPTA* within the health care system rather than on facilitating greater use of judicial mechanisms.

In keeping with earlier conclusions that the admission criteria should require a reasonable likelihood of physical impairment or serious deterioration, the same should be required under section 13. We also support the view that education and training on *IPTA* should include education and training for judges. We also think that consideration should be given to the role that section 13 could play in providing an additional option for courts of criminal jurisdiction in diverting people with mental illness from the criminal justice system.

2.2.3.7. Section 14: Powers and Responsibilities of Police

2.2.3.7.1. Overview

As outlined in section 2.2.3.5 of this Report, the police may take a person for a medical examination where certain criteria are satisfied. They must stay with the person while the medical examination is completed. If the person is not recommended for an involuntary psychiatric assessment, the police must take the person back to where the person was taken into custody or some other appropriate place.

The police are also authorized to take a person to a psychiatric facility in a number of circumstance such as the following: where a certificate(s) for involuntary psychiatric assessment has/have been issued; where the person has left a psychiatric facility without permission; where the person is thought to have

breached the conditions for the person's absence from a psychiatric facility; and where the certificate authorizing the person's absence from a psychiatric facility has been cancelled.

The police are also authorized to bring a person to a psychiatrist who issued or renewed a community treatment order for a medical examination where the psychiatrist believes the person has seriously breached the conditions of the community treatment order.

2.2.3.7.2. Issues

As indicated earlier, we received a strong message from family members of those living with schizophrenia and bipolar disorder that full effect is not being given to the deterioration branch of the risk criteria under section 14. Families would like the police to make determinations on the application of the deterioration criterion in a way that is more responsive to the family's experience and assessment of the individual's condition.

We heard a wide variety of comfort levels expressed amongst police with respect to invoking the deterioration branch of the risk criteria. Some were very uncomfortable about their competency to exercise this power while others felt comfortable in exercising it when dealing with an individual they had come to know well over time. We heard contrary views about whether police should have any authority regarding deterioration.

We heard of an evolution taking place in the policing community across the province towards a willingness to take people into custody under the deterioration criterion. Education has played a role in this development. Many call for on-going education, decision-making support, and collaboration with mental health professionals to ensure the police use their discretion in a judicious and appropriate way. Earlier in this Report we discussed some of the work being done in this area between police forces and district health authorities.

In addition to education, it was suggested that *IPTA* should authorize a physician or other health care professional to formally request the police to take a person into custody where the doctor or other health professional thinks the person is likely to seriously deteriorate. We were told about situations where a psychiatrist, for example, knows a patient is deteriorating in the community but the patient will not attend for a visit. It was suggested to us that the psychiatrist's determination should be sufficient authority for the police to bring the person to a hospital for a medical examination.

With respect to the criteria set out under section 14 for the police to take a person into custody where it is not feasible to make an application to a judge for an order for a medical examination under section 13, we were told that this criterion is almost always met or understood to be met. Some felt it should be removed as a criterion for the operation of section 14.

The powers of the police are defined exclusively in terms of the power to take people into custody. We were told by a number of police officers that they try to avoid taking people into custody on mental health calls, because it is better for the person if he or she can be convinced to go to the hospital

willingly. Police officers frequently referred to the Act's guiding principles with regard to treating individuals with "dignity and respect," the preference for voluntary admission and offering services in the "least-restrictive" manner. There is no statutory authorization for the alternative of the police conveying an individual for a medical examination on a voluntary basis. Police officers expressed concern about their authority and their liability where they are transporting an individual who is not in custody. Some asked for explicit recognition in the legislation of a non-coercive option for police to respond to an individual's need for a medical examination.

The issues related to the obligations of the police relative to a medical examination were addressed earlier in the Report under the heading "Sections 8-16: Medical Examination and Involuntary Psychiatric Assessment."

2.2.3.7.3. Conclusions

We believe that the assessment of the deterioration branch of the harm criteria under section 14 is an appropriate discretion for the police to exercise. It has to be emphasized that the police are making this determination for the purpose of having the person examined by doctors for the purpose of determining if they should be assessed by a psychiatrist for possible involuntary admission. We do not minimize the significance of the authority to the police or the individual, but it remains the fact that the ultimate clinical decision is made by doctors. This said, it is critical that the police be supported to the extent possible by the mental health system, including through training and access to clinical advice, such as the crisis line that has recently become available to police throughout the province. Our conclusions regarding the application of this criterion are set out earlier in this Report. In accordance with our earlier conclusion that the deterioration criteria for involuntary admission should require a reasonable likelihood of serious physical impairment or deterioration, the same would apply to section 14.

We support the suggestion that the Act should provide authority for a psychiatrist, doctor, or other appropriate health professional, on behalf of a district health authority, to formally request the assistance of the police in taking custody of an individual where the mental health care system believes the individual is in danger of deterioration. The consideration of this suggestion should, however, take account of the risk that it could become another disincentive to seeking care on a voluntary basis. If the suggestion is adopted, it should be implemented in such a way as to make the request to the police for assistance from the mental health system an additional option. It should not replace the independent authority of the police to make their own assessment in respect of all the criteria set out in section 14.

We have some sympathy for the suggestion to remove the criterion related to the police taking a person into custody where it is not feasible to make an application to a judge for an order for a medical examination under section 13. It would be consistent with our perspective that the judicial system is not the ideal place to address access to appropriate mental health care.

We were impressed with the frequency with which police officers referred to the guiding principles in the Act. We think there is some merit in statutorily authorizing a non-coercive approach for the police

to transport an individual for a medical examination. The Act should make it clear that police do not have to take people into custody to transport them to a hospital for examination under section 8. This may serve to reinforce the guiding principles and provide comfort on liability (legal or otherwise) to the police as they continue to learn and develop appropriate responses to individuals experiencing a mental health crisis.

2.2.3.8. Sections 38-42: Substitute Decision-Making

2.2.3.8.1. Overview

Under *IPTA*, all involuntary hospital patients and patients on community treatment orders have a substitute decision-maker to make decisions on care or treatment on their behalf. The substitute decision-maker is a person chosen by the patient when the person had capacity to make that choice, or a person identified in accordance with a hierarchy of potential substitute decision-makers laid out in section 38 of the Act.

Under section 39 the substitute decision-maker must make decisions in accordance with the informed wishes the patient expressed when he or she was capable unless following those wishes would endanger the health or safety of the patient or someone else. If following the wishes of the patient would endanger the health or safety of the patient or someone else or if the substitute decision-maker does not know of the patient's wishes, then he or she may make the decision that he or she believes is in the patient's best interests. Above we set out our views to the effect that section 39 may be doubtful constitutionally and questionable from a policy perspective because of the broad grounds on which it requires prior informed capable wishes to be disregarded and its failure to require the substitute decision-maker to give any weight to the known values or beliefs of the patient. Here we discuss issues relating to the role of substitute decision-makers that remain relevant even if our recommendations to replace or at least modify section 39 were accepted and implemented

2.2.3.8.2. Issues

As with so many areas related to *IPTA*, we heard about the need for education with respect to the role of substitute decision-makers. Many substitute decision-makers expressed frustration with the lack of information available to help them understand their role and responsibilities under the Act. We heard mixed comments about the role that patient advisors play in this regard. Some family members said that the system could be expected to at least provide a pamphlet to substitute decision-makers describing the basic operation of the Act in simple terms and their role and responsibilities as a substitute decision-maker.

Families expressed concern that police and clinicians do not listen enough to "collateral information" provided by family members or place appropriate weight on what family can tell them about the individual and their behaviours.

We were told about the practical difficulties in getting the substitute decision-maker's written statement required under clause 38(4)(d). We heard that the requirement causes difficulty because many substitute decision-makers are initially contacted by phone. It was suggested that a verbal confirmation, witnessed by district health authority staff, would serve the same goal, help administratively, and would serve patient interests by speeding up the process.

The topic of advance directives came up frequently. We have discussed the issues that arise under section 39 earlier in this Report with respect to overriding a patient's prior capable informed expressed wishes. It is worth noting some of the related issues we heard. We were told that some district health authorities encourage or plan to start encouraging patients to complete a personal directive when they are well. Patients, while capable, are or would be encouraged to choose their substitute decision-maker or express wishes about their treatment and care should they become incapable later.

Some stakeholders were concerned that the use of personal directives could cause administrative burdens where a patient may want to make a new directive with each admission. We heard scepticism from some mental health professionals as to whether the directives of patients involuntarily admitted would be respected, expressing the view that many would question the patient's capacity to have made the directive. Some family members expressed concern that loved ones who lack insight into their illness would make decisions that are against their own best interests. There was concern that such individuals may appoint an acquaintance to be the substitute decision-maker, excluding family who support and care for the individual. It should, of course, be noted that the *Personal Directives Act* is available to people with mental illness as it is to everyone else and further, that *IPTA* places a person authorised by the patient under the *Personal Directives Act* at the top of the substitute decision-maker hierarchy.[165]

Family members shared with us the difficulty they face in performing the role of substitute decision-maker and at the same time maintaining their relationship with their loved one, often an adult son or daughter. Many family members expressed concern that their role as substitute decision-maker can damage or further damage their relationship with the patient who often sees them as responsible for their involuntary treatment. We heard differing views about whether the procedures involved in implementing a community treatment order created a unique strain on the relationship. In particular, some felt the requirement to sign the order in front of the patient was particularly damaging to the familial relationship. Others, however, expressed the view that it was important for the patient to be aware of the decision-making authority and felt the process was no more damaging than the process for involuntary admission.

As we have already discussed, the matter of the scope of decision-making was raised with us. Concern was expressed that the substitute decision-making around "treatment" was limited to medications and not seen to include issues around other therapies. In this regard, the difference in wording between the definition of "substitute decision-maker" under the Act and the basis for a decision under section 39 was highlighted. The definition reads:

[165] *Personal Directives Act*, SNS 2008, c 8.

"substitute decision-maker" means a person who is given the authority to make care or treatment decisions on behalf of an involuntary patient. [emphasis added]

In contrast, section 39 states that "the substitute decision-maker shall make the decision in relation to specified psychiatric treatment and other related medical treatment." [emphasis added] It was suggested that the language in section 39 should be changed to reflect the breadth of decision-making identified in the definition for "substitute decision-maker."

Many participants in our consultations suggested it would be valuable for the Review Board to have broader authority to review decisions made by substitute decision-makers. Section 42 limits the Review Board's authority regarding the provision or refusal of consent by a substitute decision-maker to whether the substitute decision-maker rendered a "capable informed consent." It was suggested that it is important to link the Review Board's authority to the legislated decision-making criteria. We note that the Review Board has interpreted section 42 to permit this basis of review. The Review Board's Annual Report for 2009-2010 states: "The test for whether or not the SDM made a capable, informed consent or refusal is that the decision must be in accordance with the patient's 'prior capable informed expressed wishes' or in the absence of this (or if this would endanger the patient or another person) that the decision be in the patient's 'best interests'."[166]

2.2.3.8.3. Conclusions

We encourage mental health professionals and the mental health system more generally to actively consider where steps can be taken in the administration of the Act to minimize the conflict that the role of the substitute decision-maker can cause in the relationship between substitute decision-makers and patients. A holistic approach to including family in the treatment process may help to minimize conflict between the substitute decision-maker and the patient. In considering these approaches, the importance of documenting the consent or refusals by substitute decision-makers and the necessity that the decisions be subject to accountability must take priority. We do not feel legislative changes to address the relationship dynamics in this regard are appropriate.

We believe, in fact, that accountability for decision-making needs be strengthened in the Act. The Review Board should have clearer authority to review a substitute decision-maker's decision in relation to the legislated decision-making criteria. This is the approach the Review Board has taken and it is, in our view, a defensible approach. It should however be more clearly supported by the language of the Act.

In addition, if section 39 is retained in its current form, contrary to our recommendation, it is vital that decisions taken on the broad grounds of "best interests" be subject to oversight. Indeed, where legislation requires the disregard of such prior capable informed wishes and requires decisions to be made on broad "best interest" grounds in a psychiatric treatment context, prior approval by the Review Board may be required constitutionally.

[166] Review Board, "Annual Report" (2009-2010) at 3, in Appendix L.

With respect to the scope of the substitute decision-maker's involvement under the Act, we believe the language needs to be broad and consistent throughout the Act. The Act should make it clear that the substitute decision-maker is to be involved in all decision-making relating to the patient that would be within the scope of the patient's right to exercise informed consent if the patient was a capable patient.

We are strongly of the view that measures should be undertaken by the district health authorities to ensure that substitute decision-makers: (1) have ready access to the information they need to carry out their roles on behalf of patients, including information about the Act and its operation; (2) are kept informed about the treatment and progress of the patient, including during the discharge planning stage of treatment; and (3) are included in decision-making relating to the full range of treatment options for the patient.

The requirement for a written statement from the substitute decision-maker certifying certain criteria under section 38(4) is consistent with the requirement placed on substitute decision-makers by the *Hospitals Act* and the *Personal Directives Act*. It should be retained unless a broader change is contemplated in all three statutes.

2.2.3.9. Sections 43-46: Certificates of Leave

2.2.3.9.1. Overview

A certificate of leave allows an involuntary patient to live outside of the psychiatric facility after a period of involuntary admission. A certificate can be issued for a period of leave of up to 6 months. The purpose of the certificate is to help an involuntary patient transition from living in the facility to living in the community. The involuntary patient's substitute decision-maker must agree to the certificate and the patient must comply with the treatment plan.

The psychiatrist may cancel the certificate of leave if the patient breaches a condition of the certificate or if the psychiatrist believes: (1) the patient's condition may be a danger to the patient or others; or (2) the patient has failed to report as required by the certificate of leave.

2.2.3.9.2. Issues

We heard that certificates of leave are infrequently used. Some stakeholders were only mildly aware of them and speculated that the controversy surrounding CTOs when the Act came into effect and the educational focus on them during the implementation of the Act may have contributed to their low profile.

Clinicians told us that the absence of a renewal mechanism was a disincentive to using a certificate of leave. We heard that some clinicians view the certificate of leave as a trial run for a community treatment order. We got the impression very few people regard the certificate of leave as an alternative to a community treatment order, i.e., as a mechanism to support transition from hospital to life in the community without involuntary treatment. We were also told that the certificate of leave was used

where the patient did not yet meet the "hospitalization" criteria for a community treatment order under clause 47(3)(iv).

2.2.3.9.3. Conclusions

The reasons for the non-utilization of certificates of leave should be explored. Inquiry should be made into whether they should continue to be provided for in the Act or whether they can play a beneficial role that they are not currently playing. The possible role of certificates of leave in discharge planning should be considered. As explained later, some research on community treatment orders suggests the benefits of involuntary treatment in the community are highest when the involuntary treatment is first ordered. If so, some of the thinking behind the current preference for community treatment orders may require reconsideration.

2.2.3.10. Sections 60-64: Patient Advisor Service and Patient Rights

2.2.3.10.1. Overview

When a person is admitted as an involuntary patient, a patient advisor is assigned to the person. Patient advisors work for the independent Patient Advisor Service. The Empowerment Connection holds the contract to provide these services across the province. Patient advisors are hired based on personal characteristics and experience with persons with mental illness, including family members or their own lived experience. The role of the patient advisor is to help involuntary patients and substitute decision-makers understand the patient's rights under the Act and help them make applications to the Review Board and obtain legal counsel. They also have discretion to offer advice and assistance to a person undergoing an involuntary psychiatric assessment.

The district health authorities must provide notice to the patient advisor service of a decision to admit a person as an involuntary patient, change a person's status, renew an involuntary admission, issue a community treatment order or certificate of leave, and of an application to the Review Board. Patient advisors typically accompany patients to Review Board hearings.

2.2.3.10.2. Issues

We heard many positive things about the role of the patient advisor service and some individual patient advisors in particular. We heard that the service and quality of patient advisors has improved over time. Some expressed the view that the Review Board should have a similar oversight responsibility for patient advisors as they do for substitute decision-makers, particularly in relation to capacity.

We heard different perspectives about whether the service should take on an advocacy role for patients. Most stakeholders, including the patient advisor service, expressed the view that with time and experience they have come to see the value of providing a service that is exclusively an advisory service. We were told that patients found it helpful to receive information about their rights from someone they viewed as separate or independent from the hospital. We heard that the patient interaction with a

patient advisor was often calming and helped the patient feel supported and connected. We heard that hospital staff has come to value the nature of the relationship between the patient advisor and the patient. Over time, hospital staff has developed a level of trust with the patient advisor service and feel that their involvement with the patient is of benefit from a therapeutic perspective. We heard a concern that taking on an advocacy role would likely change the relationship between the patients and advisors and the patient advisory service and the district health authorities, as well as potentially placing the patient advisor in conflict with the substitute decision-maker to whom they also must provide rights advice under the Act.

Section 61 allows the patient-advisor service to offer advice and assistance to a person who is undergoing an involuntary psychiatric assessment. Under section 62, district health authorities are required to provide notice to the patient advisor service on involuntary admission but not on involuntary assessments. Some stakeholders said that patients undergoing an involuntary psychiatric assessment should have mandatory, not discretionary, access to the patient-advisor service under section 61. Others said the district health authorities should have to provide notice of an assessment to ensure the patient advisor had the option of exercising the discretion. Others indicated that the assessment period may generally not be the appropriate time to deliver rights advice for two reasons: (1) the person may not be able to receive the information at a time when they are often in a crisis condition; and (2) it may be confusing to receive rights advice when the person is not involuntarily admitted and may never become an involuntary patient.

At an administrative level, patient advisors expressed concern that they may not always receive the notices from the district health authorities regarding the matters set out in section 62. These matters include notice about the decision to admit a person as an involuntary patient, change a person's status, renew an involuntary admission, issue a community treatment order or certificate of leave, and of an application to the Review Board. We were told that patient advisors sometimes learned about a patient who was entitled to receive their services simply by an advisor's presence on the hospital unit. They worry about the number of patients that may "fall through the cracks" with respect to receiving the service.

We were told that patient advisors usually accompany the patient to Review Board hearings, as authorized by clause 61(2)(g). The patient advisor service reported that for the period from April 1, 2012 to March 31, 2013, of the hearings held, patient advisors attended about 95% of them, at the request of patients. The patient advisor is not, however, listed under subsection 76(1) as one of the individuals who receives a copy of the Review Board decision. It was suggested that the patient advisor should receive a copy of the Review Board's decision or alternatively, notice that the decision has been issued, unless the patient or substitute decision-maker objects. It was suggested that receiving the decision or at least notice of the decision, absent objection from the patient or substitute decision-maker, was consistent with the attendance of the patient advisor at the hearing with the patient. Patient advisors reported that, having attended the hearing at the request of the patient, it placed them in a difficult position when they did not know the substance of the decision or even that a decision had been issued. We were told that sometimes patients and substitute decision-makers assumed the rights

advisor knew the outcome of the hearing and were troubled that the rights advisor had not contacted them to discuss it.

We heard that some patients living in the Cumberland District Health Authority have not had access to the patient advisor service. Cumberland does not have a designated psychiatric facility under the Act. Involuntary patients from that district receive their treatment at facilities located outside of Cumberland County. When these patients return to the area under the authority of a community treatment order, they have a right to access the patient rights service. We heard that the service was not available in the district. Based on conversations that took place during our consultations, we are under the impression that this situation may be in the process of being addressed, which clearly it must be.

A question was raised with us as to the meaning of clause 61(2)(h) which says that the patient-advisor service may offer advice and assistance to "assist in identifying alternative decision-making as outlined in this Act if the patient lacks capacity." The term "alternative decision-making" is not defined and is not used elsewhere in the Act. Because the clause references "alternative decision-making as outlined in this Act," we assume the phrase might mean alternative substitute decision-making, but this is not clearly stated.

The safety of patient advisors in their work was raised with us. We did not receive a lot of detail about the concerns, but we were made aware of two circumstances where the safety of the patient advisor was at risk: one involving an inpatient and one involving an individual on a community treatment order.

2.2.3.10.3. Conclusions

We found the discussion about the value of the advisory role that patient advisors play compelling. We did not hear a compelling case during our consultations for changing the service into an advocacy service. In addition, one must consider the different qualifications and expertise that may be required for the service to shift to an advocacy role.

We do not think the Review Board should have the role of supervising or hearing complaints about patient advisors. Under the Act, the matters reviewable by the Review Board relate to protecting the rights of patients subject to involuntary treatment. We do not believe the quality of individual patient advisors is a matter that is similar to the work the Review Board already does. Other mechanisms, possibly employment and contractual laws, are likely more appropriate ways to address these concerns. Besides, we heard no concerns about the quality or quality of service of patient advisors.

With respect to the current discretion of the patient-advisor service to offer advice and assistance to persons undergoing an involuntary psychiatric assessment, we feel the discretion is appropriate. We accept the suggestions that there are times when it is ineffective and inappropriate to offer rights advice and that timing can contribute to confusion. This is not always the case, so we feel the discretion that currently exists in the Act is appropriate. Absent better information than we have on the frequency with which the service would exercise its discretion to provide advice during an assessment we do not

recommend the Act be amended to require the district health authorities to provide notice of each assessment.

We believe there may be value in the patient advisor service receiving notice that the Review Board has released a decision where the advisor attended the hearing with the patient. We conclude the Act should be amended to allow the Review Board to forward a copy of a written decision to the patient advisor service where the patient advisor attended the hearing and the patient or substitute decision maker does not object.

The Department of Health and Wellness, district health authorities and the patient advisor service should discuss options for ensuring the administrative procedures are in place to ensure notices from the district health authorities are consistently delivered to the patient advisor service.

The meaning of "alternative decision-making" in clause 61(2)(h) should be clarified.

The unavailability of patient advisor services to patients in Cumberland District Health Authority, or to other patients, and their substitute decision-makers is concerning. Measures should be taken to address the situation.

Steps should be taken to ensure the safety of patient advisors as they carry out their responsibilities under *IPTA*. The Patients' Advisors Service and the district health authorities should discuss the safety concerns of patient advisors to identify the nature and extent of the concerns and the specific steps that will be taken to address them.

2.2.3.11. Section 82(1): Privacy and Confidentiality

2.2.3.11.1. Overview

The rules around the confidentiality of personal health information apply to mental health information. *IPTA* does not address rules around the confidentiality of patient information, except to say that the *Personal Health Information Act* (which came into force on June 1, 2013) applies to the records of a patient in a psychiatric facility.[167] Prior to June 1st, 2013 the *Hospitals Act* applied to these records.

Of necessity, the information shared with us about confidentiality of health information was situated in the context of the operation of the provisions on confidentiality of the *Hospitals Act*, which are now superseded by the *Personal Health Information Act*. However, from those who had concern that confidentiality rules hindered the operation of *IPTA* to the disadvantage of patients, we consistently heard they thought their concerns would remain or be accentuated under the *Personal Health Information Act.*

[167] *Supra* note 56. The *Personal Health Information Act* governs the manner in which personal health information may be collected, used, disclosed, and retained within the health care system in Nova Scotia.

2.2.3.11.2. Issues

We were told about and observed a great deal of uncertainty amongst stakeholders about the circumstances when personal health information can or cannot be shared. The uncertainty applies to the sharing of information with people within the health care system as well as persons outside of it. We heard different views about whether the uncertainty or confusion is rooted in the legislation itself or whether it arises from how individuals interpret the legislation. Confidentiality was frequently seen as a barrier to the full engagement of the family in the patient's treatment.

There is apprehension about the effect that the *Personal Health Information Act* will have within the mental health system. There was a perception that this legislation would further restrict appropriate sharing of personal health information.

Many health care providers expressed particular concern about what personal health information they are and are not allowed to share with the police. We heard a common message that it is important for the mental health care system to share some information with police where the police exercise their authority to bring an individual to hospital under *IPTA*. There were different views about the extent of the information that would be appropriate to share. On this issue, we heard:

- Some stakeholders felt that the police should be told whether the person was being admitted under the Act and when the individual was going to be released. Police felt this was important information for them to know in advance of discharge, particularly where the involuntary admission was prompted by a violent incident and the police wish to notify the victim that the person is being released from hospital. We were told that it is also important for the police to know this because they may need to follow up on criminal charges that were pending while the person received psychiatric care.

- Some district health authorities indicated that they considered the police as partners in the administration of *IPTA*. They expressed a desire to maintain this partnership throughout the *IPTA* process, but felt the laws relative to confidentiality prohibited this sort of relationship. Some police and mental health professionals expressed a desire to talk about a decision to admit a patient or not admit a patient as a way of helping the police learn and understand more about how to apply the section 14 criteria. For example, we were told it would be helpful if the clinician could talk with the police officer that brought in the patient about why he or she made a different determination than the police did in relation to the application of the deterioration criterion.

- Some district health authorities expressed an interest in including the police into what is called "the circle of care." Others, including many police officers, indicated that information about diagnosis or treatment was not necessary but that more latitude to share basic information about outcomes (i.e., a decision to discharge or admit, subsequent decision to release, timing of release) would be helpful to the police carrying out their role under section 14.

- We were told that some of the concerns about sharing mental health information with the police are addressed through formal collaboration between mental health professionals and the police involved with mental health crisis teams and police liaison committees. The sharing of information in this context is sanctioned through an authorization from the Minister of Health and Wellness. Some district health authorities expressed concern that these types of authorizations may not be appropriate or feasible where there is no formal crisis team established, thus the current uncertainty about sharing information will continue. Moreover, more sharing may be possible in some parts of the province than others.

We heard cautions and concern about the potential for abuse by third parties where mental health information is shared outside the treating team. Individuals outside the treating team told us about perceived or actual abuse of personal mental health information, particularly in relation to police interactions and domestic relationships. We heard about concern that people with mental illness can be discriminated against and harmed in other ways if their health information is shared with others. We also heard about the anxiety that people living with mental illness feel about the risk that their personal information, particularly their diagnosis, may be used against them in many facets of their lives. This heightened the vulnerability they already feel and experience as persons living with a mental illness.

Concern was expressed that hospital records are not being shared in a timely manner when the patient, through legal counsel, requests them for the purposes of a Review Board hearing. Until June 1, 2013, subsection 71(3) of the *Hospitals Act* allowed a hospital or physician to:

> refuse to make available information from the records or particulars of a person or patient if he has reasonable grounds to believe it would not be in the best interest of the patient to make available that information.

The person requesting the record could challenge the decision by making an application to court. It was suggested that placing the onus on the patient to apply to court for his or her records was inappropriate. We were told that legal counsel commonly experienced delay in accessing the patient's records while they wait for the attending psychiatrist to review them to determine if the criteria in section 71(3) are satisfied. Lawyers told us that the delay in receiving the records was unnecessary and inhibited their ability to prepare to represent the patient at a Review Board hearing. It was suggested that patients should have access to their hospital record unless the physician makes an application to court.

As of June 1st, the *Personal Health Information Act* now applies to this situation. The relevant section reads in part as:

> 72 (1) Notwithstanding Section 71, a custodian may refuse to grant access to an individual's personal health information about that individual if it is reasonable to believe that...
>
> (f) granting the access could reasonably be expected to result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious harm to the mental or physical health of the individual;

It is too soon to assess what will be the effect of this change in wording from the *Hospitals Act*, and of the application of the *Personal Health Information Act* more broadly. It would appear, however, to have narrowed the authority of the physician (or other custodian) to deny access to a patient's records. This does not mean, however, that the difficulty faced by counsel for patients has been resolved.

Finally, we consistently heard a general plea for attention to issues around privacy and confidentiality and for much greater clarity than currently exists. There is a range of opinions about what the rules on confidentiality in mental health should be. There is however, a greater range of opinion on what they are than there should be.

2.2.3.11.3. Conclusions

Like other aspects of law and mental health, the questions about the law of confidentiality and mental health seem to lead to polarized views. Some say that because of the unique vulnerability of mental health patients to abuse of their personal health information, confidentiality protections should be even stronger than for other kinds of patients. Others say that because of the unique aspects of the condition of mental health patients, the confidentiality laws cause greater difficulties in the treatment of mental health patients than they do in the treatment of others.

Confusion about the application of confidentiality principles and legislation was pervasive in our consultations. There is a "hunger" for education about the rights and responsibilities of individuals that are affected by and administer the *Involuntary Psychiatric Treatment Act*. [168]

We are sympathetic to the view of Nova Scotia Legal Aid that patients should have timely access to their records, including through their counsel, for the purposes of preparing for a hearing before the Review Board. This is necessary to procedural fairness and to the effectiveness of the review process. We are not in a position to say that the solution is to change the onus between the patient and the custodian relative to disclosure or withholding. Further consideration of the issue may show that is the appropriate solution. In the meantime, our conclusion is that the matter should be discussed and analysed for the purpose of identifying options that address the valid legislative objective without interfering with the operation of the right to counsel created by *IPTA*.

We are not in a position to respond to the suggestions for legislative amendments we heard, nor do we have the expertise to offer guidance as to the appropriate application of confidentiality legislation and policy in this context. What we can say is that there is a need for clarity in these matters. Education and training is needed for both mental health professionals and the police with respect to their responsibilities and authorities under *IPTA* and the *Personal Health Information Act*.

The Department of Health and Wellness, district health authorities and police organizations should discuss issues that arise in relation to the applicability of confidentiality laws, in particular the *Personal Health Information Act*, to ensure there is a common and clear understanding of what is required and

[168] The importance of improving the sharing of information in the mental health system is emphasized in "Together We Can," *supra* note 2 at 20.

permitted by law. Such a discussion may well confirm there are mistaken impressions at play of what can and cannot be done relative to sharing of information. It may also determine that some of the legal constraints of concern that do apply can be adjusted in sensible ways to better balance the objectives of *IPTA* and the *Personal Health Information Act.* Alternatively, if the discussion validates that some or all of the constraints are appropriate ones, it can help people in mental health better understand the rationale for the constraints.

2.2.3.12. The Forms

2.2.3.12.1. Overview

The Regulations made under *IPTA* set out Forms that must be completed when the Act is being used. The Forms address the following issues:

- Detainment of Voluntary Patient (Form 1)
- Medical Certificate for Involuntary Psychiatric Assessment (Forms 2 and 3)[169]
- Declaration of Involuntary Admission (Form 4)
- Declaration of Renewal of Involuntary Admission (Form 5)
- Declaration of Change of Status (Form 6)
- Certificate of Leave (Form 7)
- Certificate of Cancellation of Leave (Form 8)
- Community Treatment Order (Form 9)
- Renewal of Community Treatment Order (Form 10)
- Revocation of Community Treatment Order (Forms 11A, B, C)[170]
- Request for Review (Form 12)[171]
- Notice of Hearing (Form 13)

2.2.3.12.2. Issues

[169] Section 10 of *IPTA* requires two physicians to each complete a (medical) certificate for involuntary psychiatric assessment to authorize the involuntary psychiatric assessment. Each physician completes a Form 2 – Medical Certificate for Involuntary Psychiatric Assessment Part 1. Section 10(2) states that where compelling circumstances exist and a second physician is not readily available to examine the person and complete the certificate, a single physician may authorize the assessment (i.e., only one Form 2 will be completed). In those circumstances, the single physician must complete Form 3 certifying that compelling circumstances exist and a second physician is not readily available to examine the person and complete the certificate. Form 3 is the Medical Certificate for Involuntary Psychiatric Assessment Part 2.

[170] Form 11A is the revocation of the CTO on the basis that the person no longer meets the CTO criteria. Form 11B is the revocation of the CTO on the basis that the person has failed in a substantial or deleterious manner to comply with their obligations under the order. Form 11C is the revocation of the CTO on the basis that the services required for the CTO are unavailable.

[171] Under section 68, a patient, substitute decision-maker, guardian appointed by law, person who has been authorized to give consent under the *Medical Consent Act*, RSNS 1989, c 279 (no longer in force), a person authorized by the patient to act on the patient's behalf, the chief executive officer of a psychiatric facility, the Minister, or the Review Board may request a hearing.

We consistently heard from psychiatrists and other mental health professionals, including mental health administrators, that the Forms under the Act are confusing, unnecessarily complex, repetitive, and not designed for the administrative systems operating in the district health authorities. For example, we were told that there is no space on the Forms for the label that is placed on all hospital records containing patient information such as demographic information. The use of multiple double negatives in the Forms was mentioned many times.

As explained above in our discussion of qualitative data, we reviewed the Forms completed in seven district health authorities for the year 2012 as a way of supplementing the quantitative data on the functioning of the Act that we anticipated receiving from the Department of Health and Wellness. In the process of reviewing the Forms for that purpose, we noticed what appeared to be a significant level of variation in how the Forms were completed and a certain number of anomalies in either the Forms that were completed or in how they were completed. This may indicate the need for tighter quality control measures within the district health authorities. It may be further illustration of why continuing education and training on the Act is required. It may also be validation of the point we heard from many physicians: the Forms are confusing, complex, and difficult to use.

2.2.3.12.3. Conclusions

It is clear to us that the Forms are an important part of clinical practice. As such, it is important that they be drafted in a way that is accessible to clinicians in their daily work, while still meeting legislative requirements. Based on the number of times concerns were raised with us about the Forms, we believe a task team including the Department of Health and Wellness and district health authority representatives should be established to redraft the Forms or new Forms.

2.3. Future Reviews of *IPTA*

IPTA made important and perhaps fundamental changes in Nova Scotia's law on psychiatric care and more particularly, in the law on involuntary psychiatric treatment. Its adoption was highly controversial and hotly opposed. Many of the arguments were about how the Act would operate once it was put into effect. The legislature responded to these arguments by making an independent review of the Act in its sixth year of operation part of the Act itself. To our knowledge, this is not a typical legislative approach in or beyond Canada when changes in this complex and controversial field of law and health care are made. It is an approach that Nova Scotia should persevere in.

It is true that our review has been constrained by the unavailability of certain quantitative data that would have given us a clearer picture of how the changes made to the law by *IPTA* have been implemented and with what consequence to patients. It has also been constrained by the limited opportunity we have had to analyse the quantitative data that was made available to us late in the review process and by the fact that little of this data has ever been made available to the many stakeholders who participated in the review process. On the other hand, because the review has taken place as required by legislation, it has brought attention to the need for improvement on how the operation of the Act is tracked and analysed through quantitative data on a continuing basis. It has also been able to use the considerable volume of quantitative data that was available to identify a range of questions about the functioning of the Act that call for further inquiry.

The review has also given a diverse range of stakeholders an opportunity to express and exchange their views on the Act and its operations. Our impression is that all stakeholders greatly appreciated having this opportunity, perhaps because consultation processes on health care invariably give limited attention to mental health. As reviewers, we learned a great deal about what people who have considerable experience with the Act think is and is not working. We heard a great deal about what is being done on the ground to address the difficulties and to use the Act to improve the care that is available to patients. We also heard a range of opinions about what cannot be fixed at ground level but requires solutions on a provincial scale.

This qualitative data has brought attention both to concerns about the operation of the Act and opportunities for improvements that are validated – or largely validated – on the basis of qualitative data alone. For example, beyond question, the review has established the urgent need for improvement in the functioning of the Review Board and provided a range of options for making improvement happen.

The review has given those with experience with the Act, as well as experts in mental health legislation, the opportunity to propose many good ideas for improvements to the Act or its operation. This Report endorses many of these ideas, recommends consideration be given to others, and puts others "on the record" so they can be considered and debated in the future as the implementation of the Act and ideas and evidence about mental health legislation continue to evolve.

In each of these respects, this review hopefully validates the wisdom of the legislature's choice in building a review of the Act into the Act itself. In our view, this experience calls for an amendment to ensure that the Act will be independently reviewed in every sixth year of its operation. Accordingly, this is one of our recommendations.

Future reviews should not, however, be discreet events that start and end, like this one, in every sixth year. Instead, the independent reviews of the future should be thought of as culminating events in a process of evaluation and improvement that is continuous and on-going. This depends, however, on acceptance of our recommendations in other areas. Specifically, it depends on acceptance of our recommendations on the role of the Department of Health and Wellness in making the implementation of the Act more of a provincial process that emphasizes continuous improvement through supported and accountable decision-making with a system governed by known and practical standards. It also depends on acceptance of our recommendations on improved collection, analysis and dissemination of data and on the use of the results to improve the functioning of the Act year in and year out.

Future reviews should build on this one in another important respect. We worked hard, with the generous assistance of their advocates and district health authorities, to hear from First Voice in this process. We are pleased with the success we had in this regard: we are deeply appreciative of what we learned through the contributions of those who know the Act through its application to them. We were, however, disappointed that we were not able to hear from more of those who know the Act in this way.

It is now a widely accepted norm that reviews of mental health legislation must fully involve those who live with mental illness.[172] Our experience suggests that making this norm a reality is not straightforward or easy. Based on our experience, we believe that the planning for the next review should start with a consideration of options for ensuring that the review process is enabling as it can be of participation by people with the lived experience of mental illness.

[172] WHO, *supra* note 31; *CRPD, supra* note 10, "Equality, Dignity and Inclusion," *supra* note 9.

3. Review of the Functioning of *IPTA* under Section 59 (Community Treatment Orders)

3.1. Introduction

IPTA authorizes the provision of involuntary psychiatric treatment outside of a psychiatric facility to those who are placed by a psychiatrist on a community treatment order (CTO). When *IPTA* was being debated in the legislature, this was one of its most controversial elements. This reflects the highly contested nature of community treatment orders in the literature on mental health legislation. [173]

Under *IPTA*, a community treatment order may be put in place where a psychiatrist determines:

- the person needs treatment for a mental disorder and the treatment can be provided in the community;
- as a result of the mental disorder, the person is threatening to or has caused serious harm to someone (including himself or herself) or the person will likely suffer serious physical impairment or serious mental deterioration;
- the person does not have the capacity to make treatment decisions
- in the last 2 years, the person
    - has been an involuntary patient in a psychiatric facility for 60+ days;
    - has been an involuntary patient in a psychiatric facility two or more times; or
    - has already been subject to a community treatment order; and
- the services that the person needs are available and will be provided to the person in the community.

Each CTO requires a description of the services that will be provided to the person and the community treatment plan which deals with such matters as how often the person must attend appointments, the responsibilities of the patient and substitute decision-maker, the psychiatrist's responsibilities, and responsibilities of other caregivers and agencies involved in the patient's care.

A community treatment order is valid for 6 months. It may be renewed where it is shown to be effective.

The psychiatrist may cancel a CTO and return the patient to a psychiatric facility for assessment where the patient has seriously failed to comply with the order or where the services required for the CTO are no longer available. The psychiatrist may also cancel the order where he or she determines that the person is able to continue to live in the community without being subject to the order.

[173] See, e.g., R Churchill et al, "International Experiences of Using Community Treatment Orders" (United Kingdom: Department of Health, 2007); John Dawson, "Fault-Lines in Community Treatment Order Legislation" (2009) 29 Int'l J L & Psych 482; Allison M Hunt et al, "Community Treatment Orders in Toronto: The Emerging Data" (2007) 52:10 Can J Psych 647; and Stephen Kisely, "Does compulsory or supervised community treatment reduce 'revolving door' care? Legislation is inconsistent with recent evidence" (2007) Brit J Psych 373.

Our research indicates that the provisions of *IPTA* on CTOs are very similar to those found in the legislation of the five other provinces that provide for CTOs.[174] Although the details differ from one province to another, in general, the authority to place a person under a CTO depends in all but one of these provinces upon the following three factors: (1) whether they meet the criteria for involuntary hospitalization; (2) whether they have experienced a specified duration or frequency of prior involuntary hospitalization; and (3) the availability in the community of the resources that the person will need to live in the community under a CTO.[175]

3.2. Section 59 of *IPTA*

Our mandate confirms that our review of the objectives and functionality of CTOs is to include the matters specified in section 59 of the Act. These matters are: whether CTOs were or were not used during the review period, i.e., the first five years of the Act's operation; the effectiveness of CTOs during the review period; the methods used to evaluate the outcome of any treatment used under community treatment orders; and any further matters prescribed by regulation. There have been no further matters prescribed by regulation.

We have interpreted the requirement to review the effectiveness of CTOs to be equivalent to our mandate from the Minister to review the functionality of *IPTA* relative to its objectives. Therefore, before we turn to the matters specified in section 59, we will address our understanding of the objectives of *IPTA* in authorizing CTOs.

3.3. The Objectives of *IPTA* Relative to CTOs

At one level, the objective of CTOs is obvious: to authorize the involuntary treatment in the community of people with mental illness where treatment in the community is determined under the Act to be possible and appropriate. They are an additional tool for achieving *IPTA*'s broader objective of creating a legislative framework that combines the objective of mental health legislation in protecting individual rights with its objective of enabling involuntary treatment and the benefits it provides to those who would otherwise not have those benefits.

IPTA does not, however, make involuntary treatment in the community and in hospitals interchangeable alternatives. It limits the availability of CTOs to a subset of those who meet the criteria for hospitalization. Specifically, it limits the availability of CTOs to those who have met *IPTA*'s version of what is generally called the "prior hospitalization" criteria in circumstances where the availability of resources is also satisfied. The more specific objective of *IPTA* relative to CTOs is, therefore, to make such orders an option for treating this subset of *IPTA* patients.

---

[174] These provinces are: Alberta, *Mental Health Act*, RSA, 2000, c M-13; Saskatchewan, *Mental Health Services Act*, SS 1984-85-86, c M-13.1; Ontario, *Mental Health Act*, RSO 1990, c M.7; Newfoundland and Labrador, *Mental Health Care and Treatment Act*, SNL 2006, cM-9.1; and Nova Scotia.

[175] Gray, *supra* note 15.

In evaluating the effectiveness of CTOs under *IPTA*, it is important to have a clear understanding of why *IPTA* targets CTOs to this subset of patients. This is because the effectiveness of CTOs can only be evaluated relative to their objectives. If there is not clarity as to the objectives, there cannot be effective evaluation.

Our understanding is that *IPTA* limits the availability of CTOs to those who meet the prior hospitalization criteria because its objective is to reduce or prevent future hospitalizations by persons who have become, or show signs of becoming, so-called "revolving door patients." Although *IPTA* does not say so explicitly, this is generally understood to be the rationale for making prior hospitalization a requirement for a community treatment order. Moreover, this was the rationale given for CTOs when *IPTA* was being debated in the legislature.[176] It is the rationale for CTOs that dominates much of the literature.

Our understanding is that *IPTA* limits the availability of CTOs to situations where the person to be placed on an order will receive the services he or she requires because the objective of *IPTA* is to ensure that CTOs will only be used where the patient who might otherwise be hospitalized is suitably supported while living in the community. On the other hand, we note there is language in *IPTA* suggesting that one of the objectives of CTOs is to ensure that patients living in the community on an order receive the services they need as set out in the community treatment plan which, *IPTA* says, must be completed for every CTO. For example, section 48 references the "obligations" of those who have agreed to provide treatment or care and supervision under the community treatment plan.

These objectives of CTOs, especially that of reducing or preventing further hospitalizations by revolving door patients, were mentioned many times in our discussions with stakeholders. But it was clear that mental health providers, family members, and patients are also evaluating CTOs relative to other objectives. We heard about the role that such orders are playing in improving the lives of the patients who are subject to them in diverse ways. For example, we heard about orders that have made a difference in the ability of patients to secure and keep employment. We heard about the role such orders can play in keeping patients in contact with the mental health system and in facilitating readmission where readmission proves necessary despite the order. We heard about how orders provide a structure for care in the community that becomes a source of continuing social interaction for patients.

These objectives are not at odds with the objective of reducing or preventing further hospitalization. They could be serving that objective in most or at least in many cases. They are not, however, necessarily serving that objective, since patients who are receiving these benefits could still be experiencing readmissions to hospital much as they would have without a CTO. This raises the possibility that community treatment orders are being evaluated on grounds other than the success they are having in meeting the objectives of *IPTA*.

[176] Nova Scotia, Legislative Assembly, *Hansard*, 59th Ass, Sess 1 (17 May 2005) at 7752 & (20 October 2005) at 8595.

This possibility is associated with two further other considerations. The first is that the kind of evaluation that is taking place is not systematic but patient-specific. This kind of evaluation can determine whether specific orders are advancing *IPTA*'s objective of reducing or preventing further hospitalization for specific persons. It cannot, however, tell us if CTOs are generally advancing that objective.

The second associated consideration is that there was a tendency, in some of what we heard, to suggest that CTOs are good because they are less restrictive without regard to whether they are reducing hospitalizations. This contrasts with the view we heard from others: that if CTOs are not reducing hospitalizations, they are adding to and not reducing the deprivations of liberty experienced by those who are placed on them. The related point is that while it may seem intuitive to say that compulsory treatment in the community is less limiting of individual liberty than compulsory treatment in a hospital per se, compulsory treatment in the community is still compulsory treatment that is invasive in different ways. It follows the patient in a way that the loss of liberty while hospitalized cannot. It may also not be subject to the institutional constraints, such as bed availability, that limit involuntary hospitalization.

On the second objective of *IPTA* relative to CTOs – limiting their use to situations in which patients have access to the services they need – what we heard about how the unavailability of resources in the community was limiting the use of CTOs leads us to conclude that, in general, there is little concern about whether this objective of *IPTA* is being met. On the other hand, what we heard also did not suggest that compliance with this objective was being formally evaluated. In addition, although we heard about the role that orders sometimes play in leveraging resources and in organizing them to serve patients on orders in more integrated ways than might otherwise be the case, we did not get the sense that this was generally regarded as one of the objectives of *IPTA*.

As stated above, evaluation of effectiveness requires clarity of objectives. Section 59 indicates that *IPTA* was adopted on the basis that the effectiveness of CTOs would be evaluated. The literature on CTOs makes clear that their effectiveness is a matter of continuing debate among experts on mental health legislation.

Therefore, we think it important that *IPTA* should more clearly state the objectives of making CTOs part of the mental health legislation of Nova Scotia so that on-going evaluation of their efficacy can be more clearly guided by their legislative objectives. The equally important benefit from doing so is to ensure that CTOs are consistently used to serve their intended objectives and not to serve other purposes.

3.4. Use of CTOs

The Department of Health and Wellness provided us with a table of data that set out "Involuntary Treatment Act Metrics." That table set forth the number of CTOs issued after the coming into force of the Act as follows:

	2011-12	2010-11	2009-10	2008-09	2007-08
Community Treatment Orders	37	36	24	10	

We understand that the completeness of this data for 2011-12 is being analysed. As the data comes from the administrative support the Department provides to the Review Board, it may understate the number of CTOs that have been issued given what we have heard about patients on CTOs not coming to the attention of the Review Board. In addition, we know from a presentation we were given on research on CTOs in Capital District that 122 CTOs were issued in that District alone prior to December 31, 2012 – that is 15 more CTOs than included in the data provided to us by the Department of Health and Wellness for the province as a whole. It is important to note that the number of CTOs is not equivalent to the number of patients on CTOs. For example, of the 122 CTOs issued in Capital, 10 were issued for the same person.

The indication that the use of CTOs is growing is consistent with what we heard from our consultations. Specifically, all districts told us that no CTOs were issued in the first year of the Act's operation. Capital District Health Authority told us that use of CTOs started in the second year of the Act's operation and has grown since then, particularly after the appointment in 2010 of a district CTO Coordinator. What we heard in other districts was similar, except that the use of CTOs started later and grew more slowly and modestly than in Capital. In several districts, we were told that their first CTO had been issued very recently or in the past 12 to 18 months. In these districts and in the majority of other districts, our sense is that the total number of CTOs issued is below 10. The exception to this is clearly Capital, where there are more CTOs than in all other districts combined, and perhaps Cape Breton.

In all districts, including Capital, we heard that the use of CTOs was limited by two factors: the amount and complexity of administrative work associated with putting them in place and overseeing them and the limited availability of the community services and resources which must be available before a CTO can be issued. It seems clear, however, that everyone agrees, including those who work in mental health in Capital, that these constraints are greater outside of Capital. The number of CTOs issued in South-West Nova Health Authority is, therefore, of interest. In that district, nine CTOs have been put in place relatively recently. In the other smaller districts, the number is typically much smaller. This may reflect the effort that the South-West Nova Health Authority has invested in making CTOs a feasible option for patients in rural communities.

Growth in the use of CTOs can probably be expected to continue as practitioners and the system gain experience with them. This has been the case in Ontario where a recent review has shown dramatic

growth in the province-wide number of CTOs since their introduction in that province in 2000.[177] What we heard in our consultations was that psychiatrists and other members of the mental health system find the process involved in creating and administering a CTO less daunting once they have been through it several times. In addition, the need for dedicated human and other resources for the administration of CTOs, whether through a coordinator or otherwise, is being recognized. Finally, psychiatrists and other providers are generally positive about the patient outcomes being achieved with CTOs. In combination, all of these factors point to growth in the use of CTOs in the next five years of *IPTA*'s operation.

3.5. Effectiveness of CTOs

Those who participated in the consultations on the basis of experience with CTOs in Nova Scotia were generally positive about their effectiveness. Most of what we heard was broadly consistent with what was heard about the effectiveness of CTOs in the review recently completed in Ontario. [178]

We heard from several patients who were grateful for the stability that being on a CTO had brought to their lives. One told us that because of this stability, she was in a position to get back into the workforce after many years of unemployment and self-harming behaviour. In general what we heard from individuals who had experience with CTOs, or from their advocates, was largely positive or accepting of them. We were also told, however, that this probably reflected who we did and did not have the opportunity to speak with.

Most of the family members who spoke to us about CTOs were positive about the difference a CTO had made to their loved ones. In most cases, these family members were parents of children who were highly vulnerable to self-destructive behaviour before being placed on CTOs. Some of these parents told us about sons and daughters who previously lived on the streets or who were incapable of living on their own, but were now employed and living independently in their own apartments because of the discipline and structure created by a CTO.

Other family members were more sceptical of the value of CTOs. Some told us that the CTO had not resulted in changes to the loved one's behaviours that placed them in danger. The view expressed by some of these family members seemed to be that a CTO was not an effective substitute for hospitalization. For others, the issue appeared to be more a concern that CTOs were not properly organized or monitored or enforced strictly enough. Generally however, families tended to be quite positive about the effectiveness of CTOs, particularly in relation to quality of life for patients as well as the impact on the quality of life for their families.

People in the mental health system were generally positive about the effectiveness of CTOs. We were told that CTOs were preventing recurring hospitalizations of patients. We were provided some empirical support for this generally held view in a presentation on a study completed at the Capital District Health

[177] RA Malatest & Associates, "The Legislated Review of Community Treatment Orders, Final Report" (Prepared for Ontario Ministry of Health and Long-Term Care, 2012) at 20 [Ontario Review].
[178] Ontario Review, *supra* note 173 at 17.

Authority by Dr. Christopher Murphy under the supervision of Dr. Scott Theriault. It showed that 21 of the 44 patients studied were not readmitted to hospital[179] after being placed on a CTO and that 10 of the 23 who were readmitted had only one readmission. This meant that 31 of the 44 patients had less hospitalization after being placed on CTO than their previous medical history suggested would otherwise have been the case. The study also showed that for those who were readmitted, the median length of time for readmission was considerably longer after being placed on a CTO (939 days) than their median length of time between readmissions had been before the issuing of the CTO (153 days). The study also found, however, that the effectiveness of a CTO in this respect seemed to be highest when it was first instituted and that effectiveness declined thereafter.

It should be noted that in addition to being based on a small number of cases, this study is what is called a "mirror image" or "before and after" study. Such studies compare the experience of people on CTOs to their own prior experience. All such studies are subject to certain limitations. In particular, they do not account for confounding temporal effects, i.e., the possibility that improvement reflects a change in circumstances over time other than the presence of the CTO. They are also subject to the phenomenon known as regression to the mean, under which improvement happens because people are placed on CTOs at a low point in their mental illness from which they were likely to improve whether or not they were on a CTO. Nevertheless, the initiative shown by Dr. Murphy and Dr. Theriault in carrying out the only study on the effectiveness of CTOs in Nova Scotia is to be applauded.[180]

We were told that CTOs were generally successful in giving patients sufficient incentive to stay on their medications and that this in turn allowed them to live more successfully in the community than would otherwise be the case. A number of psychiatrists told us that these positive results depend very much on the patients who are placed on a CTO: they work for patients who might otherwise be inclined to comply with a prescribed regime of medication and need reinforcement and incentive to follow through but not for patients who were strongly resistant to their need for medication or for a particular medication. One psychiatrist suggested that for those who were not otherwise inclined to comply, a CTO could only be effective if it imposed the kind of restrictions and control associated with conditional leaves from custody issued by the Criminal Review Board for those found not criminally responsible for criminal acts.

We heard different views from people in mental health about whether CTOs play a useful role in marshalling community resources that would otherwise be difficult to align to meet the needs of a particular individual. In general, we heard that CTOs can play this role within limits, at least if the district health authority has willing partners in the community. The importance of the availability of community partners was demonstrated in a number of ways. For example, in Truro we learned about the important role that the local branch of the Canadian Mental Health Association plays in supporting people with mental illness living in the community, including those on CTOs issued by the Colchester East Hants Health Authority. In Sydney, we met with the impressive multi-disciplinary team that the Cape Breton

[179] One patient died and two moved out of the District or were lost to follow-up.

[180] C Murphy & S Theriault, "Community Treatment Orders at Capital Health: 2007 to 2012" (Report of 21 February 2013).

Health Authority has built to extend the mental health services of the Authority into the community, including for those placed on CTOs.

On the other hand, we heard concerns across the province about the unavailability of shelters and other kinds of residential facilities that are able, or able and willing, to accept a resident under a CTO. We heard that the consequence was to make the option of a CTO unavailable to those who might need it or benefit from it most. This concern was expressed with particular eloquence by a community health nurse we met with in Halifax and by the administrators of a nursing home, a shelter and a residential care facility in Bridgewater.

We also heard different views on the effect that a CTO can have on the relationship between the person on the CTO and the team, which provides them with treatment, support, and services. We heard that continuity of care is improved and that this has real and significant therapeutic value. We also heard that the structure created around the patient by a CTO can ensure the patient has more social interaction than might otherwise be the case, again with good therapeutic benefits. We did, however, also hear a concern from some community mental health workers that the coercive dimensions of CTOs can be a barrier to building and maintaining cooperative relationships with their clients.

We heard different views about what the literature on CTOs said about their effectiveness. Much of this literature assesses the effectiveness of CTOs in reducing hospitalizations. Many of these studies are described as "quasi-experimental" in the recent Ontario review of CTOs in that province.[181] A number, but not all, of these studies show that patients on CTOs have a reduction in hospitalizations, usually as compared to their rate of hospitalization before going on a CTO.[182] One shows the frequency of admission to hospital was significantly lower for persons on CTOs than for those in a comparison group.[183] One study suggests the positive impact of CTOs on time between readmissions is greatest immediately after a CTO is issued. This is consistent with the findings of Dr. Murphy in his study of Capital District Health Authority patients.

In addition to the impact CTOs have on hospitalization, the impact CTOs have on general quality of life, homelessness, participation in community services, and on risk to self and others has also been studied. These studies are reviewed in Ontario's recent review of CTOs. Several report that only a minority of those subject to a CTO were strongly opposed to it and that most saw it as helpful in establishing stability and independence.[184] The same studies, and others,[185] show that patients prefer a CTO when

[181] Ontario Review, *supra* note 177 at 15.

[182] Segal & Burgess, "The utility of extended outpatient civil commitment" (2006) 29:6 Int'l J L Psych 525 [Segal & Burgess, "Utility of Civil Commitment"]; A Hunt et al, "Community Treatment Orders in Toronto: The Emerging Data" (2007) 52:10 Can J Psych 647; and K Kallapiran, A Sankaranarayanan, & T Lewin, "A pilot investigation of the relationship between community treatment orders and hospital utilization rates" (2010) 18:6 Aust Psych 503.

[183] Hunt, *supra* note 182.

[184] Anita Gibbs et al, "How Patients in New Zealand View Community Treatment Orders" (2005) 14:4 J Mental Health 357; Richard L O'Reilly et al, "A qualitative analysis of the use of community treatment orders in saskatchewan" (2006) 29:6 Int'l J L Psych 524.

[185] Marvin Swartz et al, "Assessment of Four Stakeholder Groups' Preferences Concerning Outpatient commitment for Persons with Schizophrenia" (2003) 160:6 Am J Psych 1139; and Krysia Canvin *et al*, "A Bittersweet Pill to

the alternative is hospitalization. Studies suggest that patients who have positive perceptions of CTOs associate them with improved access to support and services, employment and better relationships with family and friends. This research is broadly consistent with what we heard about experience with CTOs in Nova Scotia.

There is, however, research that documents the negative perceptions that patients have of CTOs. Negative perceptions relate to loss of control over one's life and reduced input into decision-making on medication. Patients express concern about community-based stigmatization: a CTO can be experienced and perceived as signalling the person out as mentally ill on a continuing basis. There is research suggesting that resentment about the coercive aspects of CTOs and their stigmatizing effect can have adverse therapeutic effect and lead to an unwillingness to seek help when it is needed.[186]

Some studies have suggested that CTOs reduce episodes of homelessness while the CTO is in effect[187] or increase the use of supportive housing.[188] Research shows that the use of support and services increases when a CTO is in effect,[189] but that those who have been on a CTO use fewer or the same level of services after the CTO expires than those in a comparison group.[190] Research in Australia and in the United States has found a reduction in criminal activity by persons on CTOs when compared to prior history or to a control group.[191] Research in the same two countries has found patients on CTOs had a reduced mortality rate compared to those released from hospital unconditionally.[192]

On the other hand, studies based on randomized controlled trials, the gold standard in health care research, call the effectiveness of CTOs into question. Such studies are difficult to design and implement the evaluation of CTOs due to the legal ethical difficulties associated with studies which evaluate a benefit by giving it to one group and denying it to another.[193] A Cochrane Review based on the two

---

Swallow: Learning from Mental Health Users' Responses to Compulsory Care in England" (2002) 10:5 Health Soc Care Community 361, both as cited in R O'Reilly, R Solomon & JE Gray, "Reforms to Ontario's Mental Health Act: Lessons from the Story of the Man Who Killed Brian Smith" (2012) 9:3 Research Insights 1 at 17.

[186] B Link et al, "Stigma and coercion in the context of outpatient treatment for people with schizophrenia" (2008) 67 Soc Sci Med 409; MS Swartz et al, "Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals" (2003) 21:4 Behav Sci Law 459.

[187] D Muirhead, C Harvey & Graham Ingram, "Effectiveness of community treatment orders for treatment of schizophrenia with oral or depot antipsychotic medication: changes in problem behaviours and social functioning" (2009) 43:11 Aust NZ J Psych 1077.

[188] A O'Brien & S Farrell, "Community Treatment Orders: Profile of a Canadian Experience" (2005) 50:1 Can J Psych 27.

[189] Anne-Marie O'Brien, "Dangerousness or Deterioration: What Criteria are Psychiatrists Using to Issue CTOs?" (Paper delivered at the 31st International Congress on Law and Mental Health, New York, NY, 28 June 2009).

[190] Hunt, *supra* note 182; Segal & Burgess, "Utility of Civil Commitment," *supra* note 182.

[191] GW Hough & KP O'Brien, "The effect of community treatment orders on offending rates" (2005) 12:2 Psychiatry, Psychology and Law 411; Jo C Phelan et al, "Effectiveness and outcomes of assisted outpatient treatment in New York State" (2010) 61:2 Psych Services 137.

[192] Segal & Burgess, "Effect of Conditional Release from Hospitalization on Mortality Risk" (2006) 57:11 Psych Services 1607; Phelan, *supra* note 191.

[193] J Dawson, T Burns, & J Rugkåsa, "Lawfulness of a randomised trial of the new community treatment order regime for England and Wales" (2011) 19:1 Medical Law Reviewer 1.

randomized control trials completed up to 2011 concluded they provided no evidence that people on CTOs experience significant differences over controlled groups in service use (i.e. hospitalization). It also found that randomized controlled trials studies provided no evidence that people on CTOs did significantly better than those in control groups on social functioning or quality of life. It concluded that the studies showed that eighty-five people had to be on CTOs to prevent one hospitalization and that 238 people needed to be on CTOs to prevent one arrest. However, the Review also concluded that people on CTOs were less likely to be victims of crime. [194]

More recently, a randomized control trial conducted in England showed that people released from hospital on a CTO did no better in avoiding subsequent hospitalization over a 12-month period than did patients released under a conditional leave that applied a similar level of involuntary treatment as a CTO but for many fewer days (102 days compared to a median of 255 days for those on CTOs).[195] In both groups, 64% of the members of the group avoided readmission. This study also concluded that clinical outcomes more generally were not different between the patients released under the two different kinds of involuntary treatment in the community.

It has been suggested to us that the limitation of the study is that it does not tell us how persons in both control groups, each of which were under the same level of compulsory treatment for different durations, did in comparison to persons who were not under any compulsory treatment. It seems to us, however, that the study raises questions about whether the benefits that CTOs are thought to yield can justify keeping patients on CTOs for lengthy periods of time. The same questions are raised by the research done in Nova Scotia by Dr. Murphy. In the Nova Scotia context, this perhaps suggests that the more frequent use of CTOs, which can be renewed at 6 months, than of certificates of leave, which cannot be renewed at 6 months, should be reconsidered. In addition, if a 36% readmission rate is a low readmission rate, the study may also suggest that shorter-term continuation of involuntary treatment after discharge in clinically appropriate circumstances can reduce the risk of readmission.

3.6. Methods Used to Evaluate the Outcome of Treatment under CTOs

The clinical team that is responsible for the treatment of a patient under a CTO are responsible for evaluating the effectiveness of the CTO. With the exception of the study completed in Capital District Health Authority by Dr. Murphy, this is the only method of evaluation being used to evaluate the outcome of treatment under CTOs. It operates at the level of each individual patient. Where outcomes are good, the CTO remains in place until it is terminated or allowed to lapse when it is determined that it is no longer required. Where outcomes are poor, the CTO is instead terminated or allowed to lapse for that reason.

[194] S Kisely, LA Campbell & N Preston, "Compulsory community and involuntary outpatient treatment for people with severe mental disorders" (2011) 2 Cochrane Database System Review; HJ Steadman et al, "Randomized controlled trial of outpatient commitment in North Carolina" (2001) 52:3 Psych Services 330; MS Swartz et al, "A randomized controlled trial of outpatient commitment in North Carolina" (1999) 52:3 Psych Services 325.

[195] Tom Burns et al, "Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial" (2013) 381 The Lancet 1627.

It was also clear to us from our discussions with the mental health staffs of the district health authorities that these patient-specific evaluations feed into team discussions about the outcomes generally being observed with patients on CTOs. This is natural given the newness of CTOs and the reality that the making, administration, and monitoring of CTOs requires a team effort, especially as the number of CTOs increases.

These methods of evaluation are, of course, perfectly appropriate. It would be troubling if they were not taking place: they reflect expected clinical practice and *IPTA* provides that a CTO shall not be renewed unless it is determined to have been effective. It seems doubtful, however, that they are the kind of evaluation contemplated by section 59 of *IPTA*. They do not allow quantitative analysis to be applied to determine the general or overall efficacy of treatment under CTOs relative to the legislative objectives they were intended to promote. This requires the kind of study completed by Dr. Murphy at Capital District Health Authority, but on a larger scale and as part of a broader evaluative framework established by the mental health system.

Our understanding is that a proposal to create and implement such a framework was developed by or with the participation of the Nova Scotia Health Research Foundation and a group of researchers shortly before or just after the coming into force of *IPTA*.[196] In light of the minimal evaluation that has taken place of CTO outcomes, it is unfortunate that this proposal or a comparable alternative plan of evaluation was not implemented in 2007 or 2008. On the other hand, even if this had been done, the results may have been inconclusive given the limited use of CTOs until the last few years and the reality that use of CTOs is still very limited or only starting in some districts. Thus, even if a structured, organized, and rigorous evaluative framework at the system level had been implemented, it may have yielded very modest results to date.

As noted above, the use of CTOs is now growing and there is reason to suspect that the growth will continue. Our sense is that CTOs are still regarded as a very new part of the clinical process in Nova Scotia and that many psychiatrists and some entire districts have no or very limited direct experience with them. This may mean that we are not past the point where clinical minds have been made up about CTOs. Together, these considerations suggest it is not too late for Nova Scotia to put in place the kind of evaluative framework for CTOs that it could have done in 2007 but did not. In fact, they suggest the benefits of doing so for the next five years of *IPTA*'s operation may be greater than those that would have been obtained from having done so for the past five years.

We, therefore, reach the following two conclusions. First, *IPTA* should continue to make express provision for targeted evaluation of CTOs by an independent review. This review should however be one that takes place over the next five years, not one that takes place in five years. Our second conclusion is that the effectiveness of this review may depend on it being conducted as an academically rigorous review by qualified health services researchers with expertise in program evaluation who are tasked to produce a peer-reviewed analysis and report. One option for organizing and structuring this

[196] Stephen Kisely, "Psychiatric Evaluation, Response, Treatment & Assessment in Nova Scotia" (2007) [Research Proposal].

kind of review is to assign the task to the Nova Scotia Health Research Foundation, perhaps advised by a mental health system steering committee.[197]

In addition, the discharge abstract data provided to us by the Department of Health and Wellness suggests there is less administrative data being routinely collected on CTOs than there is on involuntary hospitalizations. This does not make sense to us. Persons on CTOs are not hospital patients but they are receiving treatment on an involuntary basis under the authority of the Act. Clearly, they are not in-patients but they are clearly patients. Understanding their experience and also the system's experience with CTOs requires that a comparable level of data with respect to CTOs and patients on CTOs be tracked and analysed on a continuing basis. It can also be important to ensuring that people on CTOs receive appropriate and informed care. At a minimum, the fact that a person is on a CTO needs to be part of the person's health records so that this can be appropriately taken into account in whatever part of the mental health system is called on to provide care and treatment to the person while the CTO is in effect.

3.7. Other Issues relating to CTOs

In stating the criteria for the issuing of a CTO, clause 47(3)(a)(iii) requires a psychiatrist to be of the opinion that, as a result of the mental disorder, the person does not have the full capacity to make treatment decisions. There are at least two difficulties with this language.

The first problem is that it is ambiguous as to meaning. As stated above, in sorting out the criteria for hospitalization, *IPTA* defines capacity as the capacity to "fully" understand and appreciate the nature of their condition, the nature and purpose of the proposed treatment, and the risks and benefits in undergoing and in not undergoing the proposed treatment. In stating the test for capacity relative to a CTO as the absence of "full capacity to make treatment decisions," section 47 is, presumably, intended to indicate that the capacity question for CTOs is the same as the capacity question for involuntary hospitalization. There is, however, a difference between asking whether someone has capacity by asking if they have full understanding and appreciation and asking if they have "full capacity." This difference could result in yet another distinct test for capacity being applied under *IPTA*.

The second problem is that if section 47 means or is interpreted to mean the same thing as capacity as section 18 (the hospitalization test for capacity) it is subject to the same human rights concerns as section 18. It applies a different test to those with mental illness than is applicable to those with physical illness, who fall under the *Hospitals Act*. In doing so, it may reinforce stereotyping and prejudice against people with mental illness. It may also be vulnerable to constitutional challenges under section 15 of the *Charter* (as interpreted and applied in light of the *Convention on the Rights of People with Disabilities*) and section 7 of the *Charter*.

We consistently heard that *IPTA* is complex with respect to CTOs and that the process of designing, issuing and administering a CTO is also complex. We were told this discourages utilization of the CTO option when it might be appropriate. Views were not, however, universal in this regard: several

[197] One of the reviewers, William Lahey, is a member of the Board of Directors of the Health Research Foundation.

psychiatrists expressed the view that the perceived complexity was largely a function of unfamiliarity and that once psychiatrists and mental health teams became more familiar with the process, it would come to be viewed as more manageable.

Another relevant point is that the process for putting a CTO in place becomes more manageable for clinicians when the district health authority is able to put a more standardized administrative framework around the CTO process. This seems to be the lesson to be taken from the appointment of a CTO coordinator in Capital District Health Authority, and from the larger-scale experience with CTO coordinators in Ontario.[198] For smaller districts especially, it may also be the lesson to be taken from the experience of the South-West Nova Health Authority, where, as mentioned above, a larger number of CTOs has been issued than by other small health districts. In addition, an administrative infrastructure for CTOs may have an important role to play in ensuring that CTOs are managed in an organized, coordinated, and effective manner. What we heard about the experiences of those on CTOs leads us to conclude that this can make a difference to the success of a CTO in maintaining the well-being of the person on the CTO.

There are, however, ambiguities in the language of *IPTA* that could cause confusion and make the administration of CTOs more complex and uncertain than it needs to be. The main issue of this nature is the uncertainty the Act creates relative to the allocation of responsibilities among participating psychiatrists. There are several aspects to this.

Subsection 47(2) suggests that any psychiatrist can issue a CTO, but we were told that, in practice, this is always the attending psychiatrist in the hospital. If this is the intention, there may be value in amending *IPTA* to make it explicit.

Section 48 contemplates but does not require the naming of a psychiatrist in the order who has agreed to accept responsibility for general supervision and management of the CTO. Section 53 says the psychiatrist who issues or renews is responsible for general supervision and management of the order, without providing for delegation of this responsibility to another psychiatrist. Together, the two provisions seem to contemplate but not to require the delegation of responsibility for general supervision and management from the in-patient psychiatrist to a treating psychiatrist in the community. They are, however, open to other conflicting interpretations, when read in the context of the rest of the CTO provisions: that all references to psychiatrist are references to the issuing psychiatrist, who will usually be an inpatient psychiatrist, and that at least some references to psychiatrist include the community psychiatrist who accepts a role under the CTO. The result can be confusion as to which psychiatrist has responsibility for general supervision and management and confusion about the authority, if any, of other psychiatrists who may be called on to treat a person on a CTO. We heard about experiences of persons on CTOs suggesting these confusions have occurred in some cases. For example, we were told about a situation where a psychiatrist with no prior involvement or role in relation to a CTO cancelled it upon seeing the person on the CTO for the first time, with no

[198] Ontario Report, *supra* note 177.

consultation with the issuing psychiatrist. We do not think this is contemplated by the current language of *IPTA,* but we think that language is not as clear on the point as it should be.

We, therefore, think the Act should be amended to be clearer on the allocation of responsibility for general supervision and management. One option would be amendments making it clear that the responsibility belongs to the issuing in-patient (attending) psychiatrist *unless* the CTO delegates that responsibility to another psychiatrist named in the CTO. The Act should probably also clarify the effect or permitted scope of authorized delegations. For example, we doubt the intention is to allow delegation of supervision and management responsibilities that can only be discharged by an in-patient psychiatrist. Instead, the intention is probably to permit delegation of some sub-set of the responsibilities of supervision and management that can be better discharged by a psychiatrist working in the community than by a psychiatrist working in a hospital. This should be made more explicit.

Another issue that was raised with us several times was the unavailability of the option of amending a CTO to reflect changes in the condition of the person or in their context that call for amendments, including those that would make a CTO less restrictive. Instead, the only options available under the Act are terminating the CTO, terminating it and issuing a new one, or leaving it in place as originally written. This seems fairly restrictive given the fluid nature of the conditions and the circumstances that a CTO will often be intended to address. The making of a CTO is laborious and the need to fix all problems, no matter the magnitude, by ending one and issuing another CTO can be a disincentive for CTOs or for improving particular CTOs where this would be appropriate. In addition, where these disincentives are overcome, the process of terminating one CTO and issuing another in order to address issues that could have been addressed by amendment may be more stressful for the person on the CTO and their families than an amendment process would be.

As already discussed, a great deal of the discussion we heard about CTOs focused on the unavailability in the community of the services and resources often needed to develop a good community treatment plan, at least if CTOs are to be more than orders to take medications, which *IPTA* clearly implies they are supposed to be. From the discussions, it is clear that unavailability often means that the required resource or service is simply unavailable, either at all or in sufficient quantity, especially in rural Nova Scotia. It is also clear though that unavailability sometimes means that the service or resource cannot be accessed because of organizational or logistical barriers or because of the unwillingness or inability of those who have the resource or the service to make it available to support a person on a CTO. Unavailability may also be caused or accentuated in some circumstances because the health care system is either unwilling or unable to make support available to the organizations beyond the formal health care system that might provide some of the necessary resources or services.

We agree with those who told us that important incremental progress in addressing the systemic barriers to the accessibility of community resources and services can be made through the relationships and networks that are established and developed one CTO at a time. Ultimately, however, addressing these barriers may require a more systemic effort on the part of the mental health care system as whole, working at a systemic level with partners in other parts of the broader mental health system. Particularly important to this broader collaboration are the community-based organizations that work

with people with mental illness and the various kinds of facilities and programs that operate under the mandate of the Department of Community Services. The police may also have a role to play.

Such approaches will provoke concern that services and resources for those living with mental health in the community will be largely dedicated to those living in the community under a CTO. The concern will be that there will be even less support than the inadequate support currently available for those who need it to prevent progression to a stage at which involuntary treatment becomes necessary. There will also be a concern that the availability of services and resources for those on CTOs will become a rationale for placing people on a CTO with the adverse implications this will entail for the broader stigmatization and autonomy of people with mental illness.

These are important concerns not to be lightly dismissed. On balance, however, we take the view that if *IPTA* is to authorize CTOs, the policy and administrative steps to ensure the effectiveness of CTOs to the well-being of those placed on CTOs should also be taken. In addition, we are influenced by the discussions we heard in the Cape Breton Health Authority and in the focus groups we held at the end of our process, where the view was expressed that people placed on CTOs should have some priority in accessing available resources and services since they are those in the community who have the greatest clinical need for those resources and services. We note however that for this to be true, the criteria for community treatment orders must continue to limit CTOs to those who are the persons in the community with the greatest clinical need. In a rough way, this is what the "prior hospitalization" criterion presumably does.

This is one of the reasons we are not persuaded by the suggestion made to us by some that the "hospitalization criteria" should be deleted to make a CTO, as a less-restrictive alternative to hospitalization, available whether or not the patient has been previously hospitalized. We are aware that this is the approach in many of the countries that have introduced CTOs and that it is the approach in Alberta. It rests however on the assumption that CTOs result in less hospitalization than would otherwise occur and, as we have reviewed above, we do not think this assumption has been validated. In addition, our understanding of *IPTA* is that it introduced CTOs on the understanding that their performance *in Nova Scotia* relative to this key assumption would be systematically monitored and evaluated. Despite the good work of Drs. Murphy and Theriault, this monitoring and evaluation has not occurred to date. We therefore have no basis to recommend the expanded use of CTOs.

On the other hand, we are sympathetic to the view of those who told us that there should be recognition in legislation of the least restrictive alternative of voluntary care in the community. In our own view, this would create symmetry in what the Act says about hospital treatment and in what it says about treatment in the community. It currently provides a framework for both voluntary and involuntary treatment in hospital. It only deals with treatment in the community when it is provided on an involuntary basis.[199]

[199] We note that the legislative framework for voluntary treatment in the community could also be created in broader mental health legislation, should such legislation be adopted.

We heard a recurring concern about the functioning of the Review Board relative to persons on CTOs. Specifically, we heard that some persons on CTOs are not receiving the reviews of their CTO, or the opportunity for such a review, to which *IPTA* entitles them. It seems that this happens because documentation on CTOs is not going automatically to the Department or from the Department to the Review Board. Obviously, these problems have to be immediately fixed.

Somewhat similarly, we heard of persons on CTOs in Cumberland District Health Authority who were not receiving advice from the Patients' Advisory Service. Like other distinctive difficulties being experienced with the functioning of the Act in that district, this seems to relate to its status as one of two districts that does not have an in-patient unit for involuntary patients, the result being that CTOs for persons in the district get issued in another district, usually Colchester. Again, this is a problem that obviously needs to be fixed, which we are told is happening.

Finally, at several district health authorities, we were told that a serious problem for many people who are or might be placed on a CTO is the cost of the medications they are or would be required to take. This is an important reminder that the people in question are almost by definition living in poverty and that the medications in question are almost by definition expensive. It also reminds us that although the lack of insight into their illness is often discussed as the primary or even the only reason for the unwillingness of some patients to take prescribed medicine once they are discharged from hospital, other factors are also at play, including poverty. We think this issue needs to be addressed.

Part 3 Recommendations

1. Introduction

The third part of our mandate requires us to provide advice on "Whether amendments should be made to the Act or associated legislation; or changes should be made in the administration of the Act or of associated legislation" with a view to improving or strengthening the functioning of the Act "relative to its proper objectives, patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives as articulated in Nova Scotia's mental health strategy." It also requires us to provide advice on "the nature and the objective" of the legislative amendments or the administrative changes that we recommend. Our advice on the nature and the objective of our recommendations are found in Part 2 of this Report.

We first lay out the recommendations that arise from our review of the whole of *IPTA* under section 84. In doing so, we first address recommendations from the first part of our mandate dealing with the question of whether the objectives of *IPTA* require revisions, clarification or strengthening. We then deal with our recommendations from the second part of our mandate, in which we considered whether *IPTA* was effectively meeting its current objectives and "patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, as articulated in Nova Scotia's mental health and addictions strategy."

We then address our recommendations from our review of community treatment orders under section 59 of *IPTA*.

2. Recommendations Pertaining to the Objectives of *IPTA*

2.1. Recommendations on Guiding Principles

Recommendation 1

The guiding principles should be expanded to include a guiding principle on cultural safety.

Recommendation 2

The guiding principles should be expanded to include a guiding principle on equality between people with mental and physical health issues and between people with different mental health issues.

Recommendation 3

A separate provision should be added to the Act, perhaps as a subsection to section 2, confirming that the Act should be read and applied consistently with Canada's accepted obligations under the *Convention on the Rights of Persons with Disabilities*.

Recommendation 4

The opening words of section 2, which currently make the guiding principles relevant to "dealing with mental health issues," should be amended to read to make the guiding principles relevant to "dealing with mental health issues, *including the interpretation and administration of this Act.*"

Recommendation 5

The guiding principle in 2(h), which currently says that "any declaration of involuntary admission or declaration of incapacity is made on the basis of evidence," should be amended to read: "*any certificate for involuntary psychiatric assessment*, declaration of involuntary admission, declaration of incapacity *or community treatment order*, is made on the basis of evidence."

2.2. Recommendations on Rights of Patients under Involuntary Evaluation, Assessment, and Treatment

Recommendation 6

Provisions should be added to *IPTA* providing more extensive and more explicit protection to the rights of patients detained under the Act. In that regard, consideration should be given to addressing issues related to control measures such as restraint and seclusion, certain treatments such as psychosurgery, protection of private communications, and other specific patients' rights that are consistent with administration of the Act in accordance with the guiding principles.

2.3. Recommendations on the Expansion of *IPTA* to Deal with Mental Health More Generally

Recommendation 7

The Act should continue to be focused on psychiatric treatment.

Recommendation 8

Consideration should be given to the development and adoption of legislation that complements *IPTA* and the Health Authorities Act by providing a statutory framework for development and implementation of the Nova Scotia's mental health strategy, as amended from time to time, building on the release of Nova Scotia's first mental health strategy in 2012. Such legislation, which could be called the Mental Health and Addictions Care Planning Act, could:

a) set the goals of the mental health system, or authorize the setting of these goals;

b) define the mental health system of Nova Scotia to include the health, community services, education and justice systems, to the extent that each has a role to play in mental health;

c) create a framework for collaboration and coordinated effort on mental health by the Ministers of health, community services, education and justice, their departments and the systems within their respective jurisdictions;

d) make the same ministers and their departments collectively responsible for the ongoing development of the province's mental health strategy and individually responsible, with appropriate and necessary collaboration, for implementation of the strategy within their respective spheres of responsibility, in accordance with relevant legislation, such as the *Health Authorities Act* in the case of the health care system;

e) outline a framework for evidence-based decision-making and continuing public participation in the process of developing the province's mental health strategy; and

f) require evaluation and public reporting on the results of evaluation on the implementation of the mental health strategy and progress towards the goals set out in the legislation and the strategy.

3. Recommendations Pertaining to the Functioning of *IPTA*

3.1. Recommendations Relating to the Overall Functioning of the Act

Recommendation 9

The Act should be amended to more explicitly and extensively define the mandate of the Minister of Health and Wellness with respect to the overall functioning of the Act. The new provision (or provisions) should be consistent with the division of functions and responsibilities between the Minister and the district health authorities set out in the Health Authorities Act. Within that framework, the new provision(s) should lay out the responsibilities and powers of the Minister to lead, guide and oversee the general administration of the Act. The Minister's responsibilities should include education about the Act, the development and implementation of supports for interpreting and administering the Act, and either the process or the authority of the Minister to create the process to identify, disseminate and ensure compliance with best practices in the interpretation and administration of the Act. For example, the Minister's responsibilities and authority should be framed to include the authority to:

- ensure that each district has effective procedures in place for guiding and overseeing the effective and consistent administration and interpretation of the provisions of the Act;

- ensure there is appropriate consistency across districts in the administration and interpretation of the provisions dealing with the provision of psychiatric treatment, recognizing the importance of context to the administration and interpretation of these provisions;

- ensure the implementation of *IPTA* is supported by systems and processes that will ensure the Act is effectively implemented throughout the Province, including decision-support tools on the interpretation and application of key concepts such as serious deterioration and capacity;

- ensure that districts have in place an effective program of education on voluntary and involuntary psychiatric treatment and *IPTA* for their employees and physicians, mental health patients, their families (with specific attention to the role of substitute decision-makers), and the public; and

- ensure that the efforts of the districts in the area of educating and informing patients, families and the public about voluntary and involuntary psychiatric treatment and *IPTA*, are supported by effective and accurate educative efforts at the provincial level;

- ensure that appropriate data on the functioning of *IPTA* is effectively tracked, monitored, analysed and applied to inform and improve the functioning of *IPTA* relative to its objectives.

Recommendation 10

The Department of Health and Wellness, together with the district health authorities, should make inquiries into the apparent variations in how *IPTA* is being implemented, as indicated by existing data, so as to identify and understand the causes of the variations and to ensure that steps are taken to address variations attributable to unwarranted differences in how *IPTA* is being interpreted and administered.

Recommendation 11

The Department of Health and Wellness and the district health authorities should work together to identify additional data relevant to understanding the functioning of the Act that should be tracked at the provincial level. They should also work together to identify and implement better procedures and processes for the regular sharing of data between the Department and the districts to support decision-making in the districts and regular discussions between the Department and the districts about the data and its operational significance.

Recommendation 12

The Department of Health and Wellness should track data that will contribute to better understanding of the functioning of the Act in the following respects:

- the timing of changes in status of patients relative to the timing for Review Board hearings, or, to the extent applicable, other requirements of the Act;

- the potential causal relationship between the requirement that involuntary psychiatric assessments must be completed within 72 hours and the percentage of assessed patients who are involuntarily admitted;

- the median duration of involuntary psychiatric assessments for patients who are and who are not involuntarily admitted;

- the percentage of patients being admitted under the harm criterion and under the deterioration criterion or under both criteria, both at the medical examination stage of the *IPTA* process and the involuntary psychiatric assessment stage of the *IPTA* process;

- the number of voluntary patients who are incapable, the duration of their hospitalization, and changes in their patient status;

- the percentage of section 8 medical examinations that result in a psychiatric assessment, including:

    - the percentage of people brought to emergency rooms for a medical examination at the direction of a court order issued pursuant to section 13 of *IPTA* who are detained for an involuntary psychiatric assessment;
    - The percentage of people brought to emergency rooms for a medical examination by police who are detained for an involuntary psychiatric assessment;
- the volume of "mental health calls" being fielded by police and the percentage of these that result in the exercise of the authority of the police under *IPTA*; and,

- other information agreed to by the Departments of Health and Justice, the district health authorities and the policing services to be important in understanding the evolving role of the police under *IPTA*.

Recommendation 13

The Department of Health and Wellness should take a leadership role in using data to improve the functioning of *IPTA* and address inter-district practice variations or variations in the interpretation of the Act.

Recommendation 14

Amendments to *IPTA* to further define the responsibilities of the Department of Health and Wellness for the overall functioning of the Act should make it clear that the Department of Health and Wellness is responsible for both tracking data relevant to the functioning of the Act or for analysing the data on a

continuing basis to identify patterns or trends that warrant inquiry and deeper analysis. The Act should give the Department clear authority to make such inquiries or to make sure they happen.

Recommendation 15

A more cohesive and integrated process or system for collecting, analysing, presenting and applying the various sources of data relative to the functioning of *IPTA* should be designed and implemented under the leadership of the Department of Health and Wellness with the active participation of the district health authorities, the police forces, the Department of Justice and other relevant stakeholders.

Recommendation 16

Subject to applicable laws and reasonable cost and feasibility considerations, the Department of Health and Wellness and the district health authorities should take the necessary steps to ensure that information which is relevant and useful to understanding and informed discussion of the functioning of *IPTA* is made available to the public on a regular basis, and that this information is kept current.

Recommendation 17

The Department of Health and Wellness should acquire and maintain the information systems and human resources capacity needed to ensure that the administration of *IPTA* is evidence-based on an on-going basis.

3.1.1. Recommendations on Overall Functioning of the Act Relative to Patient Well-Being

Recommendation 18

Consideration should be given to identifying and developing options for reducing the health care system's reliance on the police in the operation of the Act in respect of: decision-making relative to people in the community who may need to be examined under *IPTA* and transporting people for the purposes of examination, assessment or treatment under *IPTA* from the community to hospitals, between hospitals and from hospitals to the community.

Recommendation 19

Efforts should continue to reduce waiting in emergency rooms for people who come or are brought to hospitals for examination under *IPTA* and to minimize or eliminate periods of waiting for such patients in public waiting rooms when they are under the custody of police. Policies and procedures should be reviewed and modified to the extent possible to limit the unnecessary use of police in providing security in emergency rooms relative to *IPTA* patients.

Recommendation 20

Measures should be taken to provide support to health workers in emergency rooms and throughout the health care system generally relative to their roles in providing care to patients who may come

under the authority of *IPTA*. These efforts should include education and training to ensure all who play a role under *IPTA* understand the Act and its objectives, including the Act's guiding principles. They should also include education on mental illness which addresses issues such as stigmatization and the critical role played by health care providers in mental illness prevention, promotion, treatment, recovery and rehabilitation.

Recommendation 21

Efforts should be made to ensure the language in the Act is not constraining, or interpreted to constrain, the range of mental health care services available to *IPTA* patients. To the extent necessary to prevent the language of *IPTA* from having this effect, appropriate amendments to *IPTA* should be made.

Recommendation 22

District health authorities and the mental health care system more generally should commit to making comprehensive discharge planning available to all *IPTA* patients, with appropriate involvement of family members and community supports.

Recommendation 23

District health authorities should continue their efforts to identify and implement options for improving the experience of patients who are treated under *IPTA*, for example, by ensuring patients have appropriate leisure and recreational opportunities and that limits on the opportunity patients have to enjoy their past times, hobbies, and other interests are not unnecessarily restrictive.

Recommendation 24

The elimination of stereotyping assumptions about people determined to lack capacity relative to treatment for mental illness, such that they lack capacity in all respects, or that they cannot be believed, or that they have nothing to contribute to their treatment and care, needs to be a priority for everyone involved in the functioning of *IPTA*. It should be a central element of education and training on *IPTA*.

Recommendation 25

All district health authorities should ensure that their physical facilities, policies, procedures and practices relative to treatment of *IPTA* patients, including in the application of restraint and seclusion measures, are in accordance with *IPTA*'s guiding principles, including the entitlement of each person to be "treated with dignity and respect" and in "the least-restrictive manner and environment." The Department of Health and Wellness should ensure this recommendation is observed on a continuing basis.

3.1.2. Recommendations on the Overall Functioning of the Act Relative to Applicable Human Rights Principles

Recommendation 26

Measures should be taken to bring greater clarity to what serious deterioration means and how it should be evaluated in particular circumstances.

Recommendation 27

The deterioration component of the risk criteria as set out in clauses 8(a), 13(c), 14(d), 17(c), and 47(3)(a)(ii) should be amended to apply where it is determined that the person being assessed is "*reasonably* likely to suffer serious physical impairment or serious mental deterioration, or both," instead of "likely to suffer serious physical impairment or serious mental deterioration, or both."

Recommendation 28

Measures should be taken to ensure *IPTA*'s criteria for admission to a psychiatric facility are properly understood and applied in all districts and by all providers. These measures could be part of the measures recommended for improved efforts to educate people about the Act, for development and implementation of decision-support tools and for a systematic process of accountability to ensure best practices are developed, identified, shared and consistently used in the interpretation and administration of the Act.

Recommendation 29

The obligation of a substitute decision-maker under section 39 of *IPTA* not to follow the prior capable informed expressed wishes of the patient on the basis that it would "endanger the physical or mental health or safety of the patient or another person", should be replaced with a provision that gives greater protection and weight to the prior capable informed expressed wishes of the patient. To the extent the revised provision requires substitute decision-makers not to follow prior capable informed expressed wishes, it should require the substitute decision-maker to take account of the known values and beliefs of the patient. The new provision should be the same as the parallel obligation of substitute decision-makers governed by the *Hospitals Act* unless a specific rationale for imposing a different obligation on the substitute decision-makers of mentally ill patients can be identified that is consistent with applicable guarantees of equality for people with mental illness and disability.

Recommendation 30

If section 39 is retained in its current form or if it is replaced by a provision on the obligation of substitute decision-makers not to follow prior capable informed expressed wishes that does not require the substitute decision-maker to respect known values and beliefs, decisions contrary to prior capable informed wishes of patients being treated under *IPTA* should be subject to review by the Review Board before they are implemented.

Recommendation 31

The word “fully” should be deleted wherever it appears in section 18 of *IPTA*.

Recommendation 32

To address the equality problems that currently exist with section 18, and to reduce or eliminate the confusion that currently exists as to which “test” for capacity applies to which decisions under *IPTA*, consideration should be given to creating a common definition of capacity that applies under *IPTA* and the *Hospitals Act*.

Recommendation 33

The idea of supported or assisted decision-making as an emerging alternative to substitute decision-making should be examined for possible introduction in the longer-term.

Recommendation 34

The problems that exist with the administrative functioning of the Review Board should be addressed as an immediate priority, including by implementing the specific recommendations that follow.

Recommendation 35

IPTA should be amended to authorize Review Board members to continue to serve as members of the Board beyond the expiry of their term of office until they are reappointed or replaced by another person duly appointed to take their place.

Recommendation 36

IPTA should provide for the appointment of a Vice-Chair and provide the Vice-Chair with authority to exercise all of the powers of the Chair when the Chair is unavailable or the position of Chair is vacant.

Recommendation 37

IPTA should be amended to give the Chair of the Review Board clear responsibilities for the overall administration of the Review Board. Guidance should be taken from the legislation that establishes other quasi-judicial tribunals in Nova Scotia or from the legislation that establishes the equivalent of the Review Board in other provinces.

Recommendation 38

IPTA should be amended to give the Chair the authority and responsibility for exercising the discretion to refuse to review a patient file under subsection 68(3).

Recommendation 39

The Review Board and the Department of Health and Wellness should put in place a succession plan and a recruitment plan for the Review Board. The Review Board and the Department should work together to keep both plans current. The recruitment plan should identify and address the factors currently limiting recruitment efforts.

Recommendation 40

As an immediate priority, the Review Board, the Department of Health and Wellness and the district health authorities should work together to identify the flow of information between the districts and the Review Board that is necessary to the Review Board's ability to discharge its responsibilities in accordance with *IPTA*. They should then work together to develop and implement a dependable process to ensure that the Department, Review Board and the districts each receive the information they need to ensure the Review Board's ability to discharge its responsibilities and the predictable and dependable functioning of the review process for patients, substitute decision-makers, districts, counsel, patient advisors, and psychiatrists.

Recommendation 41

The Department of Health and Wellness should provide the Review Board with the administrative support it requires to carry out its important and time-sensitive quasi-judicial responsibilities. This support includes but is not limited to:

- appropriate administrative staff;
- a database for indexing, filing and storing decisions so they can be retrieved and used by Board members and counsel;
- other methods for ensuring awareness amongst Board members of prior Board decisions on specific issues as required;
- an efficient scheduling system;
- other technology and services that are required to ensure the efficient and dependable functioning of the Board; and
- support for training and related activities that the Board may undertake to ensure Board members have appropriate training and knowledge to carry out their responsibilities as a tribunal with specialized expertise.

Recommendation 42

The Review Board, the Department of Health and Wellness, the district health authorities, the Nova Scotia Legal Aid Commission and the Patients' Advisory Service should hold discussions to identify

scheduling and other process options for addressing the constraints the Review Board currently faces due to factors such as the competing schedules of attending psychiatrists and legal aid lawyers.

Recommendation 43

Consideration should be given to alternative processes for scheduling Review Board hearings, including instituting a system of scheduling built around pre-determined and fixed "Review Board hearing days," for example, every Thursday or every second Thursday, supplemented by case-specific scheduling of hearings for cases that cannot be accommodated on the fixed days.

Recommendation 44

Recognizing that *IPTA* gives those involuntarily admitted to a psychiatric facility a right to counsel, options for increasing the capacity of the Legal Aid Commission to provide counsel to *IPTA* patients on a timely basis should be explored by the Legal Aid Commission and the Province of Nova Scotia.

Recommendation 45

The Review Board should invite the Department of Health and Wellness, the district health authorities, the Legal Aid Commission and the Patients' Advisory Services into discussions on options for improving the hearing process, including options for ensuring that hearings are not unnecessarily adversarial, and options for proceeding when a patient does not attend a hearing.

Recommendation 46

The Review Board, with the necessary administrative, technical and financial support of the Department of Health and Wellness, should implement a system for recording Review Board hearings.

Recommendation 47

More generally, the Review Board should explore options for taking a more organized and cohesive approach to its functions as a quasi-judicial tribunal that plays a critical role in protecting the rights of a vulnerable population.

Recommendation 48

Consideration should be given to options for making Review Board decisions, with patient-identifying information avoided or removed, accessible to the public and therefor to counsel on the same basis as everyone else. The experience in other provinces, including Ontario, should be taken into account. Available options for ensuring privacy and confidentiality other than the current practice of not releasing decisions to the public should be fully explored on the understanding that patient privacy and confidentiality must be assured.

Recommendation 49

Consideration should be given to amending *IPTA* to give the Review Board a broader remedial discretion to deal with cases in which there has been non-compliance with the Act that is not relevant to the central questions that the Board is mandated to decided, i.e. whether the prerequisites for involuntary admission or for a community treatment order were met or continue to be met or are met at the time of hearing (where they were not met at the time of admission). The remedial discretion could include the authority to require a district health authority to take such steps as are necessary in the opinion of the Review Board to prevent reoccurrence of the non-compliance in subsequent cases.

Recommendation 50

The Act should be amended to reflect a consistent authority of the Review Board with respect to certificates of leave. Specifically, clauses 68(1)(e) and 76(2)(d) should be reviewed.

Recommendation 51

The inconsistency of language between subsection 36(1), which refers to a *request* for a review by the patient entitled to a review under the Act, and subsection 45(1), which refers to an *application* for a review, should be addressed by amending the Act using language that is consistent with the patient's entitlement to a review.

3.1.3. Recommendations on the Overall Functioning of the Act Relative to the Mental Health System

Recommendation 52

The regulation designating the hospitals that have psychiatric facilities as defined in the Act should be amended to address the incongruity between these regulations, which say that the Aberdeen Hospital is a designated hospital, and the situation on the ground, which is that the Aberdeen Hospital does not have an involuntary inpatient unit.

Recommendation 53

Each district health authority should be served by a psychiatric facility that is designated as the facility for that district, whether it is in the district or another district.

Recommendation 54

IPTA should be amended or otherwise clarified as it relates to the roles and responsibilities of the chief executive officer of a district health authority that does not have a designated psychiatric facility.

Recommendation 55

Consideration should be given to whether patient care under *IPTA* could be improved by a provincial framework for acute mental health care, and perhaps for mental health care more generally, that more

clearly differentiates the services to be available in all districts; the services to be provided in regional centres for multiple districts; the services to be provided at the provincial level; and the coordination and integration of services at each tier of the system and between and across the tiers of the system.

3.2. Recommendations Relating to Specific Sections or to Related Sections

3.2.1. Recommendations on the Title of the Act

Recommendation 56

If *IPTA*, as recommended, is retained as a separate statute dealing with the psychiatric treatment component of mental health, it should be renamed the *Psychiatric Treatment Act* to better accord with the objectives of the Act as stated in the guiding principles and the scope of the Act.

3.2.2. Recommendations on Interpretation

Recommendation 57

Consideration should be given to whether the Act should better reflect the roles played by physicians who are not psychiatrists and other kinds of health care professionals, relative to responsibilities that are currently defined as exclusively the role of psychiatrists.

3.2.3. Recommendations on Voluntary Patients

Recommendation 58

Consideration should be given to the question of whether the Review Board should have jurisdiction to, on its own motion or otherwise, to review the involuntary admission of a patient whose status as an involuntary patient is changed to that of a voluntary patient prior to the patient's hearing at the Review Board.

Recommendation 59

IPTA should be amended to give the Review Board a jurisdiction and responsibility to periodically review the status of all patients held as "voluntary incapable" patients on a schedule specified in the Act. Guidance on the design of the appropriate legislative provisions may be found in the mental health legislation of other jurisdictions that have given this role to their equivalent of the Review Board.

3.2.4. Recommendations on Medical Examination and Involuntary Psychiatric Assessment

Recommendation 60

The recommended efforts to ensure a better and more consistent understanding of the Act on the part of everyone who works with, or may be called on to contribute to the functioning of the Act should

address the uncertainty or different understandings that currently exist as to the purpose and scope of a medical examination under section 8 of the Act.

Recommendation 61

Consideration should be given to amending *IPTA* to give a less generic and more descriptive name to the clinical evaluation that happens under section 8 of the Act.

Recommendation 62

Whether through legislative amendments, education and training efforts, or other interventions, the system should be brought to a clear and common understanding on how the law of informed consent applies to an examination conducted under section 8. Similarly, greater clarity and a common understanding should be achieved on the test for capacity that applies to the determination to be made under section 8, which is whether to issue a certificate for involuntary psychiatric assessment.

Recommendation 63

There should be no legislative change to the law of informed consent as it relates to the treatment of a patient under examination under section 8.

Recommendation 64

There should be an examination of the operation of the requirement that detaining a patient for involuntary psychiatric assessment generally requires the certificates of two physicians with a view to making sure it operates as an effective safeguard for patients, as contemplated by *IPTA*.

Recommendation 65

The Department of Health and Wellness and district health authorities should carry out the analysis needed to determine if the 72-hour limit for an involuntary psychiatric assessment is leading to more patients being involuntarily admitted than would be admitted if the assessment period was longer or longer in particular circumstances. Based on the outcomes of the analysis, legislative amendments or other appropriate steps should be taken either to ensure assessments are appropriately completed in less than 72 hours or to adjust the maximum time period for an assessment to ensure that assessments are properly completed for all patients.

Recommendation 66

Education and training about the Act should ensure it is widely understood that the duration of an involuntary psychiatric assessment is not “for 72 hours” but is “for <u>up to</u> 72 hours.”

Recommendation 67

The Act should be amended to clarify the meaning of “medical certificate” in subsection 10(2).

Recommendation 68

Time periods set forth in the Act and the Forms in the regulations should be expressed consistently. Consideration should be given to amending the Act to express the time period relative to the initial admission in terms of 30 days rather than a month to minimize the risk of error in the calculation and to ensure consistent time periods for all patients.

Recommendation 69

IPTA should be amended or other steps taken to ensure there is clarity in the mental health care system as to when the 72 hours for an involuntary psychiatric assessment commences.

3.2.5. Recommendations on Judicial Orders for Examination

Recommendation 70

Efforts to support families in getting care for their loved ones should concentrate on ensuring the effective implementation of *IPTA* within the health care system, not on facilitating greater use of the option of applying for a judicially ordered medical examination under section 13.

Recommendation 71

Education and training on *IPTA* should include education and training for judges.

3.2.6. Recommendations on Powers and Responsibilities of Police

Recommendation 72

IPTA should be amended to make it clear that police do not have to take people into custody to transport them to a hospital for examination under section 8.

Recommendation 73

Consideration should be given to an amendment to *IPTA* that would authorize the issuing of a Form on behalf of a district health authority which would authorize the police to use their authority under section 14. The Form should be valid if issued on behalf of a district health authority by a health care provider in a prescribed profession.

Recommendation 74

The health and justice systems should develop a memorandum of understanding on how Section 16 of the Act will be generally implemented, subject to mutually agreed variation at the district level, to allow both the mental health care system and the policing system to effectively achieve their respective objectives and responsibilities. Specifically, the Memorandum of Understanding should address:

- The well-being and safety and security of patients;
- The safety and security of police, health care staff and members of the public; and
- The human and financial resource management implications of section 16 for the policing service and the health care system.

Recommendation 75

Section 16 of *IPTA* should be amended as required to reflect and to implement the Memorandum of Understanding developed in accordance with the previous recommendation. In the alternative, section 16 should be amended either to delete the statutory obligation of police to remain at the place of the medical examination and to retain custody of the person until the medical examination is completed, or to specify the maximum number of hours during which the police will remain under the obligation to remain and retain custody. If the latter course is chosen, Nova Scotia should consider the New Brunswick approach, which says that police are required to stay for three hours.

3.2.7. Recommendations on Substitute Decision-Makers

Recommendation 76

IPTA should be amended to make clear that substitute decision-makers are to be involved in all decision-making relating to the patient that would be within the scope of the patient's right to exercise informed consent if the patient was a capable patient. In this regard, and to address consistency, amendment should be considered in relation to clause 2(z) which refers to "care or treatment decisions," section 39 which refers to "specified psychiatric treatment and other related medical treatment" and section 38 which references "consent."

Recommendation 77

IPTA should be amended to expressly authorize the Review Board to review the consistency of a decision of substitute decision-makers with the criteria for substitute decision-making set out in the Act.

Recommendation 78

Measures should be undertaken by the district health authorities to ensure that substitute decision-makers: (1) have ready access to the information they need to carry out their roles on behalf of patients, including information about the Act and its operation; (2) are kept informed about the treatment and progress of the patient, including during the discharge planning stage of treatment; and (3) are provided

opportunity to participate in decision-making relating to the full range of treatment options for the patient, including discharge planning.

3.2.8. Recommendations on Certificates of Leave

Recommendation 79

The reasons for non-utilization of certificates of leave should be explored for the purpose of determining: (a) whether the Act should continue to provide for certificates of leave; or (b) whether certificates of leave can play a beneficial role that they are not currently playing. The possible role of certificates of leave in discharge planning should be considered.

3.2.9. Recommendations on Patient Advisor Service and Patient Rights

Recommendation 80

Measures should be taken to ensure that the unavailability of patient advisor services to patients on community treatment orders who live in Cumberland District Health Authority, and their substitute decision-makers, is being effectively addressed. At the same time, an analysis should be carried out to ensure that patient advisor services are otherwise being made available to all patients in accordance with the Act.

Recommendation 81

Steps should be taken to ensure the safety of patient advisors as they carry out their responsibilities under *IPTA*. The Patients' Advisors Service and the district health authorities should discuss the safety concerns of patient advisors to identify the nature and extent of the concerns and the specific steps that will be taken to address them.

Recommendation 82

IPTA should be amended to allow the Review Board to forward a copy of a written decision to the patient advisor service where the patient advisor attended the hearing and the patient or substitute decision maker does not object.

Recommendation 83

The Minister, district health authorities and the patient advisor service should discuss options for ensuring the administrative procedures are in place to ensure notice of involuntary admissions from the district health authorities to the patient advisor service is consistently delivered.

Recommendation 84

The meaning of "alternative decision-making" in clause 61(2)(h) should be clarified.

Recommendation 85

The role of patient advisors should continue to be to advise patients and substitute decision-makers on patient rights under *IPTA*.

3.2.10. Recommendations on Privacy and Confidentiality

Recommendation 86

The Department of Health and Wellness should initiate discussions with Nova Scotia Legal Aid Commission, the district health authorities, and the Review Board to identify options for ensuring timely and effective access by patients and their counsel to patient records, for the purpose of preparing for Review Board Hearings.

Recommendation 87

The Department of Health and Wellness, district health authorities, and police organizations should discuss issues that arise in relation to the interaction of the *Personal Health Information Act* and *IPTA* to ensure there is a common and clear understanding of what is required and permitted by law and to identify options for ensuring that the interaction of *IPTA* and the *Personal Health Information Act* effectively addresses and protects the rights and interests of mental health patients under both statutes.

3.2.11. Recommendations on Forms

Recommendation 88

A task team that includes psychiatrists and district health authority representatives should be established to re-design the Forms set out in the *IPTA* Regulations.

4. Recommendations on Future Reviews of *IPTA*

Recommendation 89

IPTA should be amended to provide for an independent review in every sixth year of the Act's operation. Future reviews should be structured as culminating events in the process of continuous evaluation and improvement to be created by acceptance of other recommendations.

Recommendation 90

Planning for future reviews of *IPTA* should start with identification and consideration of options for ensuring that each review process will be as enabling of participation by people with the lived experience of mental health as it can be.

5. Recommendations on Functioning of *IPTA* Under Section 59 (Community Treatment Orders)

Recommendation 91

To ensure (a) CTOs are used when it is consistent with their rationale and not to serve other purposes and (2) that the effectiveness of CTOs is evaluated against their intended objectives, *IPTA* should clearly state the statutory objectives of making community treatment orders part of the mental health legislation of Nova Scotia.

Recommendation 92

IPTA should continue to make express provision for targeted evaluation of CTOs by an independent review. This review should be structured as one that takes place over the next five years, not one that takes place in five years. It should be conducted as an academically rigorous review by qualified health services researchers with expertise in program evaluation who are tasked to produce a peer-reviewed analysis and report.

Recommendation 93

The Department of Health and Wellness should collect administrative data for CTOs that is comparable to the administrative data that is collected for patients treated under *IPTA* in hospital.

Recommendation 94

The word "full" should be deleted from clause 47. The test for capacity for the purposes of applying the criteria for community treatment orders, like the test of capacity for involuntary hospitalization, should be a test that is the same for those with mental illness and those with physical illness.

Recommendation 95

IPTA should be amended to make it clear that the responsibility of general supervision and management of a CTO belongs to the issuing in-patient (attending) psychiatrist *unless and to the extent* the CTO delegates that responsibility to another psychiatrist named in the CTO. *IPTA* should also be amended to more clearly delimit the supervision and management responsibilities that can be delegated and those that remain with the issuing in-patient (attending psychiatrist).

Recommendation 96

IPTA should be amended to permit the amendment of CTOs.

Recommendation 97

The mental health care system should undertake a systematic effort, working in collaboration with partners in the broader mental health system, to address the barriers that prevent community services and resources from being available to persons under a CTO.

Recommendation 98

The availability of CTOs should continue to be limited by the “prior hospitalization criteria” set out in in clause 47(3)(a)(iv) of *IPTA*.

Recommendation 99

A legislative framework for the provision of psychiatric treatment in the community on a voluntary basis that is symmetrical with and proportionate to the framework that *IPTA* currently creates for voluntary treatment in hospital should be added to *IPTA*.

Recommendation 100

The causes for the absence of review of CTOs by the Review Board in accordance with the Act, including in Cumberland District Health Authority, should be identified and fixed as an immediate priority.

Recommendation 101

Consideration should be given to addressing the issue of the cost of medications for people on community treatment orders

Selected References

Legislation

Nova Scotia

Adult Protection Act, RSNS 1989, c 2.

Children and Family Services Act, SNS 1990, c 5.

Freedom of Information and Protection of Privacy Act, SNS 1993, c 5.

Health Authorities Act, SNS 2000, c 6.

Health Research Foundation Act, SNS 1998, c 14.

Hospitals Act, RSNS 1989, c 208.

Human Rights Act, RSNS 1989, c 214.

Incompetent Persons Act, RSNS 1989, c 218.

Inebriates' Guardianship Act, RSNS 1989, c 227.

Involuntary Psychiatric Treatment Act, SNS 2005, c 42.

Medical Consent Act, RSNS 1989, c 279.

Narcotic Drug Addicts Act, RSNS, c 307.

Ombudsman's Act, RSNS 1989, c 327.

Personal Directives Act, SNS 2008, c 8.

Personal Health Information Act, SNS 2010, c 41.

Protection for Persons in Care Act, SNS 2004, c 33.

Canada

An Act respecting the protection of persons whose mental state presents a danger to themselves or to others, RSQ, c P-38.001.

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

Civil Code of Quebec, SC 1991, ss 1-41.

Mental Health Act, RSA, 2000, c M-13.

Mental Health Act, RSBC 1996, c 288.

Mental Health Act, CCSM, c M110.

Mental Health Act, SNB 1973, c M-10.

Mental Health Services Act, RSNB 2011, c 190.

Mental Health Act, RSNWT (Nu) 1988, c M-10.

Mental Health Act, RSO 1990, c M.7.

Mental Health Care and Treatment Act, SNL 2006, cM-9.1.

Mental Health Act, RSNWT 1988, c M-10.

Mental Health Act, RSPEI 1994, c M-6.1.

Mental Health Services Act, SS 1984-85-86, c M-13.1.

Mental Health Act, RSY 2022, c 150.

Uniform Mental Health Act, Uniform Law Conference of Canada, adopted 1987.

International

Australia, Northern Territory: *Mental Health and Related Services Act 2002* (NT), online: http://www.health.wa.gov.au/mhareview/resources/legislation/NT_Mental_Health_Act.pdf.

New Zealand: *Mental Health (Compulsory Assessment and Treatment) Act 1992,* (NZ) 1992/46, online: http://www.legislation.govt.nz/act/public/1992/0046/latest/DLM262176.html?search=ts_act_mental+health_resel&p=1&sr=1.

Norway: *Mental Health Care Act,* (Act No. 62/1999) (s.1-1a) (translated from Norwegian), online: http://www.ub.uio.no/ujur/ulovdata/lov-19990702-062-eng.pdf.

South Africa: *Mental Health Care Act*, No 17 of 2002, online: http://www.justice.gov.za/legislation/acts/2002-017_mentalhealthcare.pdf.

United Kingdom: *Mental Health Act 2007* (UK)*,* c 12. http://www.legislation.gov.uk/ukpga/1983/20/contents.

United Nations:

Convention on the Rights of Persons with Disabilities and Optional Protocol, 13 December 2006, 2515 UNTS 3, online: http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf.

International Covenant on Civil and Political Rights, GA Res 2200A (21), UNGAOR Supp No 16 (1966) 52.

Universal Declaration of Human Rights, GA Res 217 (111), UNGAOR, 3d Sess, Supp No 13, UN Doc A/810, (1948) 71.

United States, Ohio: *Ohio Revised Code*, Chapter 5119, online: http://codes.ohio.gov/orc/5119.

United States, Massachusetts: *Massachusetts Laws*, Chapters 19 and 123, online: http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123 and http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter19/.

Case law

Canada

Canadian Foundation for Children, Youth and the Law v Canada (Attorney General), [2004] 1 SCR 76.

R v Kapp, 2008 SCC 41

R v Oakes, [1986] 1 SCR 103.

Suresh v Canada (Minister of Citizenship and Immigration, 2002 SCC 1.

United States v Burns, [2001] 1 SCR 283.

Alberta

Alberta (Office of the Public Trustee) v HB, 2012 ABQB 590.

Alberta v Hutterian Brethren of Wilson Colony, 2009 SCC 37.

BT v Alberta Hospital, [1997] AJ No 894.

E v Board of the Foothills General Hospital, 2003 ABQB 1031.

EW v Alberta Hospital (Edmonton), 1999 ABQB 566.

M v Alberta (1985), 61 AR 14, 15 WCB 54.

MB v Alberta, 149 DLR (4th) 363.

Mr. C v Rockyview General Hospital, 2003 ABQB 366.

Rogerson v Alberta Hospital (Edmonton), 1999 ABQB 412.

Russell v Calgary General Hospital, 2004 ABQB 102.

British Columbia

Andrews v Law Society of British Columbia, [1989] 1 SCR 143.

Chang v Vancouver Coastal Health Authority, 2006 BCSC 2056.

Franks v Ruddiman, 2004 BCSC 632.

Hopkins v Hislop (1981), 121 DLR (3d) 337, 26 BCLR 165.

McCorkell v Riverview Hospital (1993), 104 DLR (4th) 391, [1993] 8 WWR 169.

Mullins v Levy, 2009 BCCA 6.

Nelson v Ontario, 2012 ONSC 1021.

Ness v Geagea, 2012 ONSC 700.

NT v Facility, 2012 BCSC 1162.

Re BC Motor Vehicle Act, [1985] 2 SCR 486.

Robinson v Kirby, [1984] BCJ No 1127.

Scherba v Riverview Hospital, [1981] BCJ No 915.

Manitoba

Bobbie v Health Sciences Center, [1989] 2 WWR 153.

Bruederlin v Parker, 2012 MQBQ 121.

Kotello v Manitoba, 2004 MBQB 172.

R v JJL, 2001 MBCA 21.

Thwaites v Health Sciences Center Psychiatric Facility (1988), 48 DLR (4th) 338.

Wisner v Wisner, [1991] 4 WWR 331.

New Brunswick

Frothingham v Regional Health Authority B (cob Horizon Health Network), 2013 NBQB 104.

Leyco Holdings Limited v McKie, [1982] NBJ No 57, 37 NBR (2d) 357.

Newfoundland and Labrador

Farrell v Eastern Health, 2011 NLTD(G) 75.

PH v Eastern Regional Integrated Health Authority, 2010 NLTD 34.

Northwest Territories & Nunavut

Northwest Territories (Ministry of Health) v EK, [1998] NWTJ No 54.

Re K(S), [1990] NWTJ No 58.

Nova Scotia

Nova Scotia v Moore (1995), 143 NSR (2d) 369.

Nova Scotia v Rankin, 2005 NSSC 74.

Nova Scotia (Minister of Health) v CR, 2006 NSSC 138.

Nova Scotia (Minister of Health) v VS (Litigation Guardian of), (2006) NSCA 122.

Nova Scotia (Minister of Social Services) v PDE (1986), 74 NSR (2d) 351, [1986] NSJ No 568.

Ocean v Economical Mutual Insurance Co, 2009 NSCA 81.

R v Fisher, 2006 NSSC 206.

R v KAS, [2007] NSJ No 504 (NSCA).

R v Phillips, 2006 NSCA 135.

R v S(RD), [1997] 3 SCR 484.

Re Boudreau (1980), 114 DLR (3d) 756, 43 NSR (2d) 212.

Re Crewe, [2007] NSJ No 450 (NSSC (Fam Div)).

Re JJ, 2001 NSSF 12, 193 NSR (2d) 13.

Ontario

Blakely v Kingston Psychiatric Hospital, [1995] OJ No 2837.

Centre for Addiction and Mental Health v Al-Sherewadi, [2011] OJ No 1755 (OSCJ).

CL v Hurdalek (1997), 33 OTC 388, [1997] OJ No 2572.

Daugherty v Stall, [2002] OTC 944, 48 ETR (2d) 8.

Fleming v Reid (1991), 4 OR (3d) 74, 82 DLR (4th) 298.

Geiger v Dua, [1994] OJ No 3175.

Giecewicz v Hastings, 2007 ONCA 890.

Gordon v Cameron, [1994] OJ No 523.

Haugan v Whelan (2003), 64 OR (3d) 713, [2003] OTCA 299.

Hung Dung (Philip) Tran v Dr. Ginsberg, 2011 ONSC 927, [2011] OJ No 706.

Khan v St. Thomas Psychiatric Hospital (1992), 7 OR (3d) 303.

Lavallie v Kingston Psychiatric Hospital, [1999] OJ No 4306.

Lavallie v Kingston Psychiatric Hospital (2000), 136 OAC 334, 35 ETR (2d) 250.

Level v Bali, 2012 ONSC 5136.

MG v Whelan, 2012 ONSC 1771.

Middel v Adams, [1993] OJ No 2861.

R v Stanley, 2010 ONSC 324.

Re Warner, 2013 ONCA 181.

Roy v Furst, [1999] OJ No 1490.

Sawatsky v Norris (1992), 10 OR (3d) 67, 93 DLR (4th) 238.

Sevels v Cameron, [1995] OJ No 381.

Singh v de Souza, [2009] OJ No 3490, 179 ACWS (3d) 1197.

SMT v Abouelnasr, [2008] OJ No 1298, 166 ACWS (3d) 569.

Sousa v Klukach, [2003] OJ No 779.

Starnaman v Penetanguishene Mental Health Centre, [1994] OJ No 1958.

Starson v *Swayze*, [2003] 1 SCR 722.

Taylor v Penetanguishene Mental Health Centre, [1993] OJ No 3090.

Tortis v Adam, [2008] OJ No 368.

Tran v Ralyea, [1993] OJ No 2861.

TS v O'Dea, [2003] OTCA 399, 64 OF (3d) 713.

Van Es v Dunn, 2011 ONSC 950.

<u>Prince Edward Island</u>

MacDonald v MacDonald, 2002 PESCTD 84.

Re R (M) (1991), 96 Nfld & PEIR 236.

Québec

Centre hospitalier Robert-Giffard c JG, [2005] JQ No 19533.

Centre hospitalier universitaire de Sherbrooke – Hôtel Dieu c CR, 2011 QCCS 5991.

Centre hospitalier universitaire de Sherbrooke – Hôtel Dieu c JB, 2009 QCCS 223.

Centre hospitalier universitaire de Sherbrooke – Hôtel Dieu c KC, 2009 QCCS 6384.

Centre hospitalier universitaire de Sherbrooke – Hôtel Dieu c RC, 2008 QCCS 6001.

Centre de santé et de services sociaux d'Arthabaska-et-de-l'Érable c DT, 2010 QCCS 6742.

Centre de santé et de services sociaux de Beauce c IR, [2005] JQ No 8809.

Centre de santé et de services sociaux de Beauce – services hospitaliers c DS, 2011 QCCS 3977.

Centre de santé et de services sociaux de Beauce – services hospitaliers c FR, 2011 QCCS 2708.

Centre de santé et de services sociaux des Etchemins c JN, 2011 QCCS 1581.

Centre de santé et de services sociaux du Haut-Richelieu-Rouville c A, 2006 QCCS 5764.

Centre de santé et de services sociaux de Lac-St-Jean-Est c MT, 2011 QCCQ 15932.

Centre de santé et de services sociaux de l'Ouest-de-l'Île c RR, 2012 QCCS 1899.

Centre de santé et de services sociaux de Richelieu-Yamaska c CH, 2010 QCCS 2300.

Centre de santé et de services sociaux de Rimouski-Neigette c CF, 2011 QCCS 3550.

Centre de santé et de services sociaux de Rimouski-Neigette c JT, 2008 QCCQ 8215.

Centre de santé et de services sociaux de Rimouski-Neigette c LL, 2008 QCCQ 8319.

Centre de santé et de services sociaux du Suroît c CG, [2005] JQ No 15748.

Chagnon c SL, [2005] JQ No 3012.

Ford v Quebec, [2002] 2 SCR 712.

Grizenko c X, [2000] RJQ 2123.

Guèvremont c AS, [2004] RDF 467.

Hôpital Maisonneuve-Rosemont c JJ, 2010 QCCS 2301.

Hôpital Maisonneuve-Rosemont c MH, 2013 QCCS 974.

Hôpital de Sacré-Coeur de Montréal c DB, 2011 QCCS 6013.

Institut Philip Pinel de Montréal c Gharavy, [1994] RJQ 2523.

Institut Philip Pinel de Montréal c HM, [2005] JQ No 17707.

Institut Philip Pinel de Montréal c Wong, [1997] RL 265.

Institut universitaire en santé mentale de Québec c OR, 2011 QCCS 2222.

Institut universitaire en santé mentale de Québec c PG, 2010 QSSC 1258.

Institut universitaire en santé mentale de Québec c WK, 2011 QCCS 6900.

JMW c SCW, [1996] RJQ 229.

JR c Centre hospitalier de L'Université de Montréal, 2009 QCCA 480.

L (CHA) c B (TI) (2001), JE 653, REJB 23156.

Luyet c RS, 2006 QCCS 909.

MB c Centre hospitalier Pierre-Le-Gardeur, [2004] RJQ 792, (2004) 238 DLR (4th) 312.

MC c Service professional du Centre de santé et de services sociaux d'Arthabaska-et-de-l'Érable, 2010 QCCA 1114.

Portnoy c LG, 2009 QCCS 5390.

Saskatchewan

Clinton v Regina District Health Board (1998), 171 Sask R 44.

Hedlund v Ringlein, 2006 SKQB 311.

Mental Health In Patient Services v AG, 2011 SKQB 475.

Regina Qu'appelle Health Region (Mental Health Inpatient Services, Director) v AB, 2012 SKQB 422.

Regina Qu'appelle Health Region (Mental Health Inpatient Services, Director) v PD, 2012 SKQB 136.

Regina Qu'appelle Health Region (Mental Health Inpatient Services) v WD, 2012 SKQB 299.

Saskatoon Regional Health Authority v AB, 2005 SKQB 153.

Saskatoon Regional Health Authority v Okemahwasin, 2009 SKQB 417.

Saskatoon Regional Health Authority v Oman, 2007 SKQB 239.

Willis v Saskatchewan Region Health Authority, 2003 SKQB 102.

Yukon

Whitehorse General Hospital (Executive Director) v Blasdell, [1991] YJ No 196.

Whitehorse General Hospital v Kerr, [1986] YJ No 53.

Whitehorse General Hospital v Marshall, [1986] YJ No 88.

International Jurisprudence

Australia, Victoria

AB, [1988] VMHRB 1.

ALB, [1989] VMHRB 10.

BC, [1987] VMHRB 4.

DAC, [1992] VMHRB 1.

GW, [1990] VMHRB 4.

HL, [1997] VMHRB 17.

KMC, [1989] VMHRB 13.

MF, [1995] VMHRB 4.

MW, [1987] VMHRB 3.

RG, [1993] VMHRB 9.

RH, [1991] VMHRB 2.

Wilson v DHS, [2000] VCAT 2052.

01-039, [2000] VMHRB 1.

03-057, [2002] VMHRB 11.

99-467, [1998] VMHRB 15.

Ireland

B v Mental Health (Criminal Law) Review Board & Ors, [2008] IEHC 303.

C v Clinical Director of St. Patrick's Hospital, [2009] IEHC 47.

L v Kennedy, [2010] IEHC 195.

M v Mental Health commissioner & Ors, [2008] IEHC 441.

McN & Anor v HSE, [2009] IEHC 236.

OD v Kennedy & Ors, [2007] IEHC 129.

R(M) v Byrne & Ors, [2007] IEHC 73.

Re: X, Judicial Review, [2009] NIQB 2.

New Zealand

Applicant 09/130, [2010] NZMHRT 35.

Applicant 11/019, [2011] NZMHRT 19.

Applicant 11/040, [2011] NZMHT 40.

Attorney-General v Moroney, [2001] 2 NZLR 652.

KJ, [2012] NZMHT 117.

PS v North Shore Family Court HC Auckland, [2011] 2 NZLR 781.

R v Warren, [2009] NZHC 907.

V 12/020, [2012] NZMHRT 20.

Waitemata Health v Attorney General, [2001] NZCA 312.

X 13 / 047, [2013] NZMHRT 47.

Scotland

Beattie v Dunbar (Mental Health Officers), [2006] ScotSC 108.

City of Edinburgh Council v D, 2010 Scot D 10/10

Di Mascio v Mental Health Tribunal for Scotland, 2008 GWD 37-559.

Henderson v Mental Health Tribunal, 2011 SCLR 129.

Krol v Craig, 1999 SCLR 67, [1998] UKHL 44.

Laurie v Mental Health Tribunal for Scotland, 2007 GWD 32-555.

Reid v Secretary of State for Scotland, [1998] UKHL 43.

Reid (Alexander Lewis Hutchinson) v Her Majesty's Advocate, [2012] HCJAC 150.

The Scottish Ministers v A Decision of the Mental Health Tribunal for Scotland and Anor, [2009] CSIH 66.

The Scottish Ministers v Decisions of the Mental Health Tribunal for Scotland, [2009] CSIH 33.

The Scottish Ministers v Decision of the Mental Health Tribunal, [2011] CSIH 76.

The Scottish Ministers v The Mental Health Tribunal in the case of JK, [2009] CSIH 9.

The Scottish Ministers v The Mental Health Tribunal, 2012 SLT 560, [2012] CSIH 18.

South Africa

G v Sixty-Six Others, [2008] ZAKZHC 37.

S v Mabena & Another, 2007 (1) SACR 482 (SCA).

United Kingdom

AA v Cheshire and Wirral Partnership NHS Foundation Trust, [2009] UKUT 195 (AAC).

Barker v Barking, Havering and Brentwood Community Healthcare NHS Trust (Warley Hospital) and another, [1999] 1 FLR 160.

CNWL NHS Foundation Trust v H-JH, [2012] UKUT 210 (AAC).

DL-H v Devon Partnership NHS Trust v Secretary of State for Justice, [2010] UKUT 102 (AAC).

G(TJ), [2010] EWHC 3005 (COP).

HL v United Kingdom, [2004] ECHR 471.

Holloway, R (on the application of) v Oxfordshire Country Council & Ors, [2007] EWHC 776 (Admin).

In Re F, [1991] UKHL 1.

Masterman-Lister v Brutton & Co, [2002] EQCA Civ 1889.

MH v Secretary for the Department of Health, [2005] UKHL 60.

NHS Trust v T, [2004] EWHC 1279 (Fam).

PS, R (On the application of) v Responsible Medical Officer & Anor, [2003] EWHC 2335 (Admin).

R v Canons Park Mental Health Review Tribunal, Ex parte A, [1995] QB 60.

R v Hallstrom, *Ex parte W; R v Gardiner, Ex parte L*, [1986] QB 1090.

R v Merseyside Mental Health Review Tribunal, Ex parte K, [1990] 1 All ER 694.

R v Wilson and another ex parte Williamson, [1996] COD 42.

R (CS) v MHRT, [2004] Mental Health Law Reports 355.

R (DR) v Mersey Care NHS Trust, [2002] Mental Health Law Reports 386.

R (Wilkinson) v Broadmoor Hospital, [2001] EWCA 1545 (Civ).

Re: C, [1994] 1 All ER 819.

Re: L, [1998] UKHL 24.

Regina v Achworthy Hospital Authority, ex parte B, [2005] UKHL 20.

Regina v Ashworth Hospital Authority (now Mersey Care National Health Service), ex parte Munjaz, [2005] UKHL 58.

S v Airedale National Health Trust Service, [2002] EWHC 1780 (Admin).

Secretary of State v RB, [2010] UKUT 454 (AAC).

Secretary of State for the Home Department v Mental Health Review Tribunal 'PH', [2002] EWCA 1868 (Civ).

Secretary of State for Justice v MP and Nottinghamshire Healthcare NHS Trust, [2013] UKUT 25 (AAC).

SH v Cornwall Partnership NHS Trust, [2012] UKUT 290 (AAC).

Smith, R v Mental Health Review Tribunal for South Thames Region, [1998] EWHC 832 (Admin).

St. George's Healthcare NHS Trust v S, R v Collins and others, Ex parte S, [1998] 3 All ER 673.

Secondary Sources

Books, Papers, Chapters, Articles

Peter Bartlett, "The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria" (2003) 11 Medical Law Review 326-352.

J Brink *et al,* "A study of how people with mental illness perceive and interact with the police" (Calgary, Alberta: Mental Health Commission of Canada, 2011) online: http://www.mentalhealthcommission.ca.

K Brown & E Murphy, "Falling Through the Cracks: The Quebec Mental Health System" (2000) 45 McGill LJ 1037.

Philip Burgess *et al*, "Do Community Treatment Orders for Mental Illness Reduce Readmission to Hospital" (2006) 41 Social Psychiatry and Psychiatric Epidemiology 574.

Tom Burns & J Dawson, "Community Treatment Orders: How ethical without experimental evidence" (2009) Psychological Medicine.

Tom Burns et al, "Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial" (2013) 381 The Lancet 1627.

Krysia Canvin et al, “A Bittersweet Pill to Swallow: Learning from Mental Health Users’ Responded to Compulsory Care in England” (2002) 10:5 Health Soc Care Community 361.

Peter J Carver, “Mental Health Law in Canada” in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds, *Canadian Health Law and Policy*, Fourth Edition (Markham: LexisNexis Canada, 2011) at 341-383.

R Churchill et al, “International Experiences of Using Community Treatment Orders” (United Kingdom: Department of Health, 2007) online: http://www.dh/gov/eb/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_072730.

Craig M Coldwell & William S Bender, “The Effectiveness of Assertive Community Treatment for Homeless Populations with Severe Mental Illness: A Meta-Analysis” (2007) 164 Am J Psychiatry 393.

Frank B Cross, “The Error of Positive Rights” (2000-2001) 48 UCLA L Rev 857.

Mary Cullen-Drill & Kathleen Schilling, “The case for mandatory outpatient treatment” (2008) 46:2 J Psychosocial Nursing 33.

Simon Davis, “The Legal and Ethical Context of Mental Health Practice” in *Community Mental Health in Canada: Policy, Theory, and Practice* (Vancouver: UBC Press, 2006) at 270-293.

John Dawson, “Fault-Lines in Community Treatment Order Legislation” (2009) 29 Int’l J L & Psych 482.

J Dawson, T Burns, & J Rugkåsa, “Lawfulness of a randomised trial of the new community treatment order regime for England and Wales” (2011) 19:1 Medical Law Reviewer 1.

Colleen M Flood, Lance Gable & Lawrence O Gostin, “Introduction – Legislating and Litigating Health Care Rights Around the World” (2005) Wayne State University Law School Legal Studies Research Paper Series, No 08-29.

Daniel Frank et al, “Effects of compulsory treatment orders on time to hospital readmission” (2005) 56:7 Psych Services 867.

EC Fistein et al, “A comparison of mental health legislation from diverse Commonwealth jurisdictions” (2009) 32 International Journal of Law and Psychiatry 147-155.

A Gibbs et al, “How patients in New Zealand view community treatment orders (2005) 14:4 J Mental Health 357.

Kris Gledhil, “Community Treatment Orders” (2007) J Mental Health L 149.

Siri Glopped, “Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health” (2008) 10:2 Health and Human Rights Journal 21.

John E Gray, Margaret A Shone & Peter F Liddle, *Canadian Mental Health Law and Policy*, Second Edition (Markham: LexisNexis Canada Inc, 2008).

Jude Hall, “Frontline Providers of Mental Healthcare: The Role of Police Officers in Involuntary Psychiatric Assessments Under the Mental Health Care and Treatment Act” (2010) 19 Dalhousie

J Legal Stud 107.

GW Hough & KP O'Brien, "The effect of community treatment orders on offending rates" (2005) 12:2 Psychiatry, Psychology & L 411.

Allison M Hunt et al, "Community Treatment Orders in Toronto: The Emerging Data" (2007) 52:10 Can J Psych 647.

H Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health LJ 139-194.

H Archibald Kaiser, "Health Law in the 21st Century: Imagining an Equality Promoting Alternative to the Status Quo of Canadian Mental Health Law" (2003) Health LJ 185.

H Archibald Kaiser, "Law and Psychiatry in the Age of the Convention on the Rights of Persons with Disabilities" in Hy Bloom & Richard Schneider, eds, *Law and Mental Disorder: A comprehensive and practical approach to mental disorder and the law* (Toronto: Irwin Law and Centre for Addiction and Mental Health, forthcoming).

H Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, Second Edition (Markham and Vancouver: Butterworths Canada, 2002) at 251-330.

H Archibald Kaiser, "Restraint and Seclusion in Canadian Mental Health Facilities: Assessing the Prospects for Improved Access to Justice" (2001) 19 Windsor YB Access Just 391.

K Kallapiran, A Sankaranarayanan & T Lewin, "A pilot investigation of the relationship between community treatment orders and hospital utilization rates" (2010) 18:6 Australasian Psych 503.

Bendan D Kelly, "Mental health legislation and human rights in England, Wales and the Republic of Ireland" (2011) 34 Int'l J L Psych 439

Stephen Kisely, "Does compulsory or supervised community treatment reduce 'revolving door' care? Legislation is inconsistent with recent evidence" (2007) Brit J Psych 373.

Stephen Kisely & Leslie Campbell, "Community treatment orders for psychiatric patients: the emperor with no clothes" (2006) 51:11 Can J Psych 683.

Stephen Kisely, Leslie Campbell & Neil Preston, "Compulsory community and involuntary outpatient treatment for people with severe mental disorders" (2011) 2 Cochrane Database of Systematic Reviews.

Stephen Kisely et al, "A comparison of health service use in two jurisdictions with and without compulsory community treatment" (2005) 35:9 Psych Med 1357.

Stephen Kisely et al, "A Controlled Before-and-After Evaluation of a Mobile Crisis Partnership Between Mental Health and Police Services in Nova Scotia" (2010) 55:10 Can J Psychiatry 662.

Stephen Kisely et al, "An eleven-year evaluation of the effect of community treatment orders on changes in mental health service use" (2013) 47 J Psych Research 650.

Stephen Kisely et al, "Impact of Community Treatment on Admission Rates" (2004) 184 Brit J Psych 432.

Stephen Kisely et al, “Randomized and non-randomized evidence for the effect of compulsory community and involuntary out-patient treatment on health service use: systematic review and meta analysis” (2007) 37:1 Psych Med 3.

GV La Forest, “May the Provinces Legislate in Violation of International Law?” (1961) 39:1 Can Bar Rev 78.

Tim J Lambert, Bruce S Singh & Maxine X Patel, “Community Treatment Orders and Antipsychotic Long-Acting Injections” (2009) 52 British J of Psych Supplement 57.

BG Link, D Castille & J Stuber, “Stigma and Coercion in the Context of Outpatient Treatment for People with Mental Illnesses” (2008) 67 Social Science and Medicine 409.

BG Link et al, “Arrest outcomes associated with outpatient commitment in New York State” (2011) 62:5 Psych Services.

B Link et al, “Stigma and coercion in the context of outpatient treatment for people with schizophrenia” (2008) 67 Soc Sci Med 409.

Leslie London, “What is a Human Rights Based Approach to Health and Does it Matter?” (2008) 10:1 Health and Human Rights Journal 65.

Nawaf Madi, Helen Chao & Jerry Fang Li, “CIHI Survey: Hospital Readmissions for Patients with Mental Illness in Canada(2007) 10:2 Healthcare Quarterly 30.

Right Honourable Beverley McLachlin, PC, Chief Justice of Canada, “Medicine and the Law: the Challenge of Mental Illness” (2005) online: http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp.

B McSherry & P Weller, eds, *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010).

Adam Miller, “Health in the hoosegow” (21 January 2013) online: CMAJ http://www.cmaj.ca.

David Muirhead, Carol Harvey & Graham Ingram, “Effectiveness of community treatment orders for treatment of schizophrenia with oral or depot antipsychotic medication: clinical outcomes” (2006) 40 Aust NZ J Psych 596.

Richard Mullen, John Dawson & Anita Gibbs, “Dilemmas for clinicians in use of community treatment orders” (2006) 29 Int’l JL & Psych 535.

C Murphy & S Theriault, “Community Treatment Orders at Capital Health: 2007 to 2012” (Presentation given 21 February 2013).

Anne-Marie O’Brien, “Dangerousness or Deterioration: What Criteria are Psychiatrists Using to Issue CTOs?” (Paper delivered at the 31st International Congress on Law and Mental Health, New York, NY, 28 June 2009).

Anthony O’Brien, Brian McKenna & Robert Kydd, “Compulsory community mental health treatment: literature review” (2009) 46 Int’l J Nursing Studies 1245.

A O’Brien & S Farrell, “Community treatment orders: Profile of a Canadian Experience (2005) 501 Can J

Psych 27.

D Okai et al, “Mental capacity in psychiatric patients: systematic review” (2007) 191 British Journal of Psychiatry 291.

Richard O’Reilly et al, “Principles Underlying Mental health Legislation” (2010) 55:10 Can J. Psychiatry 1-5 [also published as a Position Paper for the Canadian Psychiatric Association].

Richard O’Reilly et al, “A qualitative analysis of the use of community treatment orders in Saskatchewan” (2006) 29 Int’l JL & Psych 516.

Richard O’Reilly, Robert Solomon & John E Gray, “Reforms to Ontario’s Mental Health Act: Lessons from the story of the man who killed Brian Smith” (2012) 9:3 Research Insight: Regional Mental Health Care London and St. Thomas 1.

Susan M Paddock, “Measuring changes in client-level treatment process in the therapeutic community (TC) with the Dimensions of Change Instrument (DCI)” (2007) 33:4 American Journal of Drug and Alcohol Abuse 537.

Gunvant Patel, “Community treatment orders in Victoria: A clinic-ethical perspective” (2008) 16 Aus Psych 340.

Lora Patton, “These Regulations Aren’t Just Here to Annoy You: The Myth of Statutory Safeguards, Patient Rights and Charter Values in Ontario’s Mental Health System” (2008) 25 WRLSI 9.

John Petrila & Annette Christy, “Florida’s outpatient commitment law: a lesson in failed reform?” (2007) 59:1 Psych Services 21.

Jo C Phelan et al, “Effectiveness and outcomes of assisted outpatient treatment in New York State” (2010) 61:2 Psych Services 137.

Ed Ratushny, *Conduct of Public Inquiries: Law, Policy and Practice* (Toronto: Irwin Law, 2009).

G Roberts & K Grimes, “Return on Investment: Mental Health Promotion and Mental Illness Prevention” (Canadian Policy Network at the University of Western Ontario, 2011).

Gerald Robertson, *Mental Disability and the Law in Canada*, Second Edition (Scarborough, Ontario: Thomson Canada Limited, 1994).

Barbara J Russell, “How research ethics’ protections can contribute to public policy: the case of community treatment orders” (2011) 34:5 Int’l. J. L. & Psych. 349.

Becky Rynor, “Value of community treatment orders remains at issue” (2010) 182:8 CMAJ E337.

Karen Schwartz et al, “Community Treatment Orders: The Service User Speaks. Exploring the Lived Experience of Community Treatment Orders” (2010) 15:1 International Journal of Psychosocial Rehabilitation 39-50.

Steven P Segal & Philip Burgess, “Conditional release: a less restrictive alternative to hospitalization” (2006) 57: 11 Psych Services 1600.

Steven P Segal & Philip Burgess, “Effect of Conditional Release from Hospitalization to Mortality Risk”

(2006) 57:11 Psych Services 1607.

Steven P Segal & Philip Burgess, "The utility of extended outpatient civil commitment" (2006) 29:6 Int'l JL & Psych 525.

A Sen, *The Idea of Justice* (London: Allen Lane, 2009).

Jacquelyn Shaw, "One Step Forward, Two Steps Back: a Charter Analysis of s.39 of Nova Scotia's *Involuntary Psychiatric Treatment Act*" (2009) 4:2 JEMH 1.

Alexander Simpson, "Mental Health Law in Ontario: Challenges for Reform" (2011) 31:3 Health Law in Canada 65-80.

HJ Steadman et al, "Randomized controlled trial of outpatient commitment in North Carolina" (2001) 52:3 Psych Services 330.

Martin Swartz et al, "A randomized controlled trial of outpatient commitment in North Carolina" (1999) 52:3 Psych Services 325.

Martin Swartz et al, "Assessing outcomes for consumers in New York's Assisted Outpatient Treatment Program" (2010) 61:10 Psych Services.

Marvin Swartz et al, "Assessment of Four Stakeholder Groups' Preferences Concerning Outpatient commitment for Persons with Schizophrenia" (2003) 160:6 Am J Psych 1139.

Martin Swartz et al, "Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals" (2003) 21:4 Behav Sci Law 459.

Martin Swartz et al, "Use of outpatient commitment or related civil court treatment orders in five US communities" (2006) 57:3 Psych Services 343.

George Szmuckler & Paul S Appelbaum, "Treatment pressures, leverage, coercion, and compulsion in mental health care" (2008) J Mental Health 233.

Shelley Trueman, "Community Treatment Orders and Nova Scotia – The Least Restrictive Alternative?" (2003) 11 Health LJ 1-34.

Anita G Wandzura, "Community Treatment Orders in Saskatchewan: What Went Wrong?" (2008) 71 Sask L Rev 269-306.

Sheila Wildeman, "Access to Treatment of Serious Mental Illness: Enabling Choice or Enabling Treatment?" in C Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006).

Sheila Wildeman, "Insight revisited: a relational approach to the status of capacity to make treatment decisions in involuntary psychiatric hospital settings" in J Downie & J Llewellyn, eds, *Being relational : reflections on relational theory and health law* (Vancouver: UBC Press, 2011).

Robyn Williams, "Cultural safety - what does it mean for our work practice?" (1999) 23:2 Australian and New Zealand Journal of Public Health 213.

Michael Woody, "Community Crisis Intervention Team" undated. Copy provided at Police Mental Health Liaison Conference, Halifax, June 13, 2011.

Guido R Zanni & Paul F Stavis, "The effectiveness and ethical justification of psychiatric outpatient commitment" (2006) 7:11 Am J Bioethics 31.

Position papers

Canadian Mental Health Association, "An Act to Promote Mental Health and Community Participation in Nova Scotia: A Discussion Paper" (Ratified 26 January 2005).

Canadian Psychiatric Association, "Mandatory Outpatient Treatment, Position Paper," approved 2 June 2009, http://publications.cpa-apc.org/media.php?mid=912.

Canadian Psychiatric Association, "Principles Underlying Mental Health Legislation, Position Paper," approved June 2010.

Reports

Mark Asbridge et al, "Mental Health and Addictions Epidemiological & Demographic Analysis" (September 2011) [Prepared for the Nova Scotia Mental Health and Addictions Strategy Project.]

Auditor General, Nova Scotia, "Health: Mental Health Services" in *Report of the Auditor General* (June 2010) 49 (ch 4).

Roger Bland & Brian Dufton, *Mental Health: A Time for Action* (31 May 2000) [Submitted to the Deputy Minister of Health, Province of Nova Scotia – Dr. T Ward.]

"Canadian Human Rights Act Review Panel Report, Promoting Equality: A New Vision" (2000) (Chair: Honourable Gérard V La Forest) http://publications.gc.ca/collections/Collection/J2-168-2000E.pdf.

Nicole Chammartin, Christine Ogaranko, Beverly Froese, "Equality, Dignity and Inclusion: Legislation that Enhances Human Rights for People Living with Mental Illness: Final Report" (30 November 2011) submitted to Evaluation Project Committee, Mental Health and the Law Advisory Committee, Mental Health Commission of Canada.

"Come Together: Report and Recommendations of the Mental Health and Addictions Strategy Advisory Committee" (March 2012) http://www.gov.ns.ca/health/mhs/reports/MHAS_2012_Full.pdf

Commission on the Future of Health Care in Canada, "Building on Values: The Future of Health Case in Canada – Final Report" (2002) http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf.

Commission on the Review of Federal Labour Standards, "Fairness at Work: Federal Labour Standards for the 21st Century: Review of the Canada Labour Code Part III" (2006) Chair: Harry W Arthurs) http://www.hrsdc.gc.ca/eng/labour/employment_standards/fls/pdf/final_report.pdf.

Dreezer & Dreezer Inc., "Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act, For the Ontario Ministry of Health and Long-Term Care" (December 2005) http://www.health.gov.on.ca/english/public/pub/ministry_reports/dreezer/dreezer.pdf.

International Financial Consulting, "The Legislative Review of Export Development Canada" (2008) http://www.international.gc.ca/commerce/assets/pdfs/edc-eng.pdf.

Law Commission of Ontario, "The Law as it Affects Persons with Disabilities: Consultation Paper" (September 2011) http://www.lco-cdo.org/en/disabilities-consultation-paper.

Law Reform Commission of Canada, "The criminal process and mental disorder," Working Paper No. 14 (1975).

Law Reform Commission of Nova Scotia, *Mental Health Provisions of the Hospitals Act*, Discussion Paper (September 2000) http://www.lawreform.ns.ca/Downloads/Hospitals_Act_DIS.pdf.

Law Reform Commission of Nova Scotia, *Mental Health Provisions of the Hospitals Act*, Final Report (February 2002) http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf.

RA Malatest & Associates, "The Legislated Review of Community Treatment Orders, Final Report" (Prepared for the Ontario Ministry of Health and Long-Term Care, 2012).

Mary Pat MacKinnon, Sonia Pitre & Judy Watling, "Matching Methods with Policy Purpose: Two Case Examples of Public Engagement" (2007) http://cprn.org/documents/47131_en.pdf.

Nova Scotia, "Building Bridges: Improving Care in Custody for People Living with Mental Illness" (December 2012) http://gov.ns.ca/just/global_docs/Building_Bridges_Hyde_Report.pdf.

Nova Scotia, "Together We Can: The plan to improve mental health and addictions care for Nova Scotians" (2012) online: http://www.gov.ns.ca/health/mhs/reports/together_we_can.pdf. [Response to "Come Together," Report of the Mental Health and Addictions Strategy Advisory Committee.]

Nova Scotia, "Together We Can: The plan to improve mental health and addictions care for Nova Scotians, Our First Year" (2013) Progress Report on the Nova Scotia Mental Health Strategy, online: http://gov.ns.ca/health/mhs/reports/MHS-Together-We-Can-One-Year-Update.pdf

Nova Scotia, Department of Health and Wellness, "Involuntary Psychiatric Treatment Act- Fact Sheet" (June 2007) http://www.gov.ns.ca/health.

Nova Scotia, Department of Health and Wellness, Department of Justice & Capital District Health Authority, "Joint Review of the East Coast Forensic Hospital's Community Access Privileges" (September 2012).

Nova Scotia, Department of Health and Wellness, "Possible Mental Health Indicators" (2011) Slides.

Nova Scotia, Department of the Environment, "Nova Scotia's Environment Act, legislative review process 2000: committee report" (Halifax: Nova Scotia, Department of the Environment, 2000).

Nova Scotia, Department of the Environment, "Proposed changes to the Nova Scotia Environment Act: A

discussion paper" (2011) online: http://www.gov.ns.ca/nse/dept/docs/env.act.review.2011.pdf.

Nova Scotia Department of Health, "Better Care Sooner: the plan to improve emergency care" (December 2010).

Nova Scotia Health Research Foundation, "Mental Health and Addictions Strategy: Consultation Results and Evidence from Other Sources" (2011) [Submitted to the Department of Health and Wellness].

Nova Scotia Health Research Foundation, "Nova Scotia Mental Health and Addictions Strategy Working Document" (2011).

Nova Scotia Mental Health Strategy Advisory Committee, Nova Scotia Health Research Foundation, "Mental Health Strategy Background Document: A summary of the current state of mental health and addictions services in Nova Scotia" (24 June 2011) online: http://www.nshrf.ca/sites/default/files/mental_health_and_addictions_summary_document_09.14.11.pdf.

Christine Ogaranko, Beverly Froese & Nicole Chammartin, "Equality, Dignity and Inclusion: Legislation that Enhances Human Rights for People Living with Mental Illness: Mental Health and Human Rights Evaluation Instrument" (30 November 2011) Report to the Canadian Mental Health Association.

"Report of the Fatality Inquiry into the Death of Howard Hyde" (30 November 2010) (Chair: Anne S. Derrick, Provincial Court Judge) online: http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf.

Review Board under the *Hospitals Act* and the *Involuntary Psychiatric Treatment Act*, *Annual Reports* (Nova Scotia, 1979-2010).

Roy J Romanow, "Building on Values: The Future of Health Care in Canada – Final Report" (2002) online: http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf.

Dr. John Ross, "Emergency Care in Nova Scotia: Interim Report" (April 2010).

Dr. John Ross, "The Patient Journey Through Emergency Care in Nova Scotia: A Prescription for New Medicine" (October 2010) online: http://www.gov.ns.ca/health/emergencycarereport/docs/Dr-Ross-The-Patient-Journey-Through-Emergency-Care-in-Nova-Scotia.pdf.

Royal College of Psychiatrists, "Second Reading Briefing on the Mental Health Bill, 2006" (United Kingdom: House of Commons, 2007).

Senate Standing Committee on Social Affairs, Science and Technology, "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada" (2006) online: http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/rep02may06-e.htm#FOREWORD.

International documents

Office of the United Nations High Commissioner for Human Rights & World Health Organization, *The*

Right to Health, Fact Sheet No 31 (2008) online: http://www.ohchr.org/Documents/Publications/Factsheet31.pdf.

World Health Organization, "Mental Health Information Systems" (2005) http://www.who.int/mental_health/policy/mnh_info_sys.pdf.

World Health Organization, "Mental Health Legislation and Human Rights: Mental Health Policy and Service Guidance Package" (2003) online: http://www.who.int/mental_health/resources/en/Legislation.pdf.

World Health Organisation, *WHO Resource Book on Mental Health, Human Rights and Legislation* (2005) online: http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf.

Other

Alberta Health Services, "Regional Capacity Assessment Team – Mental Health," online: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1009095.

Canadian Institute for the Administration of Justice, "'Ambiguous Crossroads': Persons with Mental Health Problems and the Criminal Justice System" (1 February 2013) Attended conference held at Schulich School of Law, Dalhousie University, Halifax, Nova Scotia.

Canadian Institute for Health Information, online: www.cihi.ca

Canadian Institute for Health Information, "Ontario Mental Health Reporting System Resource Manual, 2011-2012" (Module 1 – Clinical Coding and Module 2 - Technical Specifications and Data Submission).

Canadian Mental Health Association, online: www.cmha.ca

Health Information Standards Committee for Alberta, "Mental Health Reporting Requirements: Inpatient Interval Reporting Data Set" (11 February 2010) http://www.health.alberta.ca/documents/HISCA-Mental-Health-IIR.pdf

Stephen Kisely, "Psychiatric Evaluation, Response, Treatment & Assessment in Nova Scotia" (2007) [Research Proposal].

Mental Health Commission of Canada, online: http://www.mentalhealthcommission.ca/english/pages/default.aspx

Nova Scotia, Legislative Assembly, *Hansard*, 59th Ass, Sess 1 (17 May 2005) at 7752 & (20 October 2005) at 8595.

Nova Scotia Health Research Foundation website regarding Mental Health Strategy Project, online: http://www.nshrf.ca/initiatives/initiatives/mental-health-strategy/mental-health-strategy-background-document.

National Institute of Mental Health, Series FN No 10, "Data Standards for Mental Health Decision Support Systems" (Washington DC: Supt Of Docs, US Govt Print Off, 1989). DHHS Publications No (ADM) 89-1589.1989.

Police Mental Health Liaison Conference, Halifax, 13 June 2011.

Population Health Research Unit, Dalhousie University, data fields in Research Data Repository, http://metadata.phru.dal.ca/.

United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, "Decision Support 2000+, Draft Requirements Analysis of Decision Support 2000+, Background Statement" (undated) www.mhsip.org/ds2000/backgroundstatment1.pdf

World Health Organization website regarding Mental Health http://www.who.int/topics/mental_health/en/.

Meetings with Justice La Forest, 2011

Stephen Ayer, Executive Director, Schizophrenia Society of Nova Scotia

Dr. John Campbell, Director Mental Health Services, Annapolis Valley Health

Sharon Davis-Murdoch, Health Association of African Canadians

Joe Denny, Executive Director, Native Alcohol and Drug Abuse Counselling Association of Nova Scotia

Dr. David Elliott, Nova Scotia Department of Health and Wellness

Gail Gardiner, Executive Director, Canadian Mental Health Association, Nova Scotia

Jean Hughes, Associate Professor, Dalhousie School of Nursing

Involuntary Psychiatric Treatment Act Liaison Group established by the Nova Scotia Department of Health and Wellness as a resource for Justice La Forest's work. Members include: Dr. John Campbell, Dr. Ruth Carter, Susan Hare, Avai Kochanoff, Dr. Herb Orlik, Dr. Michael Teehan, Dr. Scott Theriault.

Anne Jackman, Chair, *Involuntary Psychiatric Treatment Act* Review Board

Malcolm Jeffcock, Nova Scotia Legal Aid

Arlene Johnson, Acting Executive Director, Mi'kmaw Family & Children's Services of Nova Scotia

H Archibald Kaiser, Professor, Schulich School of Law

Lana MacLean, Health Association of African Canadians

Lesley McKee, Program Manager for Child Protection Services, Mi'kmaw Family & Children's Services of Nova Scotia

Judith McPhee, Executive Director, Policy and Information Management, Nova Scotia Department of Justice

Mental Health Directors, Chiefs of Psychiatry and Vice-Presidents Community Mental Health for the

District Health Authorities

Superintendent William (Bill) Moore, Halifax Regional Police

Patricia Murray, Nova Scotia Department of Health and Wellness

Don Roper, Empowerment Connections

Ken Scott, Nova Scotia Department of Health and Wellness

Donna Smith, Co-Chair, Health Association of African Canadians

Terry Taylor, Nova Scotia Mental Health and Addictions Strategy

Dr. Scott Theriault, Clinical Director, Adult Specialty Services and Forensic Services, Capital District Health Authority

Ida Vincent, Executive Director, Tawaak Housing

Sheila Wildeman, Assistant Professor, Schulich School of Law

Ken Winch, Executive Director, Court Services, Department of Justice

Other Contacts

Eileen Allen, Health Information Services, Capital District Health Authority

Mark Asbridge, Community Health & Epidemiology, Dalhousie University

Lynn Cheek, Nova Scotia Department of Health and Wellness

Tina Hall, Nova Scotia Department of Health and Wellness

Michelle MacDonald, Nova Scotia Department of Health and Wellness

Lorna MacPherson, Nova Scotia Department of Community Services

Peter Nestman, Community Health & Epidemiology, Dalhousie University

Denice Nicholson, Nova Scotia Department of Health and Wellness

Connie Paris, Program Lead, Mental Health & Addictions, Canadian Institute for Health Information

Mary Pyche, Acting Program Leader, Crisis/Emergency Services, Capital Health Mental Health Program

Carrie Ricker, Legal Counsel, Capital District Health Authority

The Honourable Mr. Justice Richard D. Schneider**,** Ontario Court of Justice

Charlotte Smith, Colchester East Hants Health Authority

Jennifer Thorne, Nova Scotia Department of Health and Wellness

Appendix A

Statement of Work

STATEMENT OF WORK

Independent Review pursuant to Sections 59 and 84 of the *Involuntary Psychiatric Treatment Act.*

Purpose

The *Involuntary Psychiatric Treatment Act* Section 84 requires an independent review of the entire Act during the year commencing July 3, 2012. The Act, pursuant to Section 59, also requires that the Minister of Health and Wellness undertake a review of community treatment orders during the year commencing July 3, 2012, and specifically, whether community treatment orders were or were not used during the review period; the effectiveness of community treatment orders during the review period; and the methods used to evaluate the outcome of any treatment used under community treatment orders.

Structure of the Review

The reviews required under Sections 59 and 84 of the *Involuntary Psychiatric Treatment Act* will be conducted as a single, independent review. The review shall be referred to as the Independent Review pursuant to Sections 59 and 84 of the *Involuntary Psychiatric Treatment Act.*

Attached as Schedule A are metrics under the *Involuntary Psychiatric Treatment Act* since it came into force in July 2007.

A sole reviewer or reviewers shall be appointed by the Minister to conduct the review. The reviewer or reviewers shall be a person who is independent from the Department of Health and Wellness. The reviewer or reviewers are to report to and be accountable to the Minister.

Scope

The review shall comprehensively review the functioning of the *Involuntary Psychiatric Treatment Act.* The review will include, but is not restricted to, consideration of:

(1) The direct functioning of the legislative provisions;

(2) The contextual factors that may directly or indirectly affect the operation of the Act as it applies to those impacted or potentially impacted by its functioning; and

(3) The effect of significant developments in provincial, national and international law and policy as related to mental health, including the Nova Scotia Mental Health Strategy announced by the Department of Health and Wellness in 2012;

For the purpose of clarity, the comprehensive review must explicitly include the matters set out in Section 59 of the Act.

Deliverables

The review will provide advice to the Minister that is reasonable and able to be implemented within the current fiscal reality on the following matters:

(1) Whether the objectives of the Act continue to be the right objectives or whether they should be revised, clarified or strengthened;

(2) Whether the Act is effectively meeting its current objectives and is otherwise functioning effectively and appropriately or whether the functioning of the Act is in need of improvement, in specific areas or more generally;

(3) Whether:

- amendments should be made to the Act or to associated legislation; or
- changes should be made in the administration of the Act or of associated legislation;

to improve or strengthen the functioning of the Act relative to its proper objectives, patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, including as articulated in Nova Scotia's mental health strategy ("Together We Can The plan to improve mental health and addictions care in Nova Scotia"); and

(4) In the event and to the extent amendments to the Act or associated legislation or changes in administration are recommended, the nature and the objective of the legislative amendments or the administrative changes that the review would recommend.

Document deliverables:

- A work plan by November 7, 2012
- An interim report by January 31, 2013
- A final report by July 2, 2013

Process

The review will proceed by considering relevant information pertaining to the current functioning of the Act and literature on mental health and mental health legislation that is relevant to the mandate of the review. The review will conduct focused discussions with stakeholders and experts who are able to provide perspectives, information and advice that are relevant to the mandate of the review. The review will build upon but

seek to avoid duplicating the consultations and other work completed in the development of Nova Scotia's mental health strategy ("Together We Can The plan to improve mental health and addictions care in Nova Scotia"). The review will also consider the report of January 2012 of Honourable Justice Gerard La Forest and the associated work which underpins the report.

Tenure and Reporting of Results

The reviewer or reviewers to be appointed in Summer 2012 for a term to end on July 2, 2013. The reviewer or reviewers shall submit a report to the Minister regarding the findings of the review on or before July 2, 2013. The reviewer or reviewers shall prepare a work plan by no later than November 7, 2012 for submission to the Minister. Additionally, an interim report shall be submitted to the Minister by January 31, 2013.

Schedule A
I*nvoluntary Psychiatric Treatment Act* Metrics

	2011-12	2010-11	2009-10	2008-09	2007-08
Community Treatment Orders	37	36	24	10	
Certificate of Leave	5	2	5	4	
Hearing-review of Involuntary Admission	47	53	55	38	23
Hearing Cancelled by Patient	3	7	5	13	13
Patient changed to Voluntary Status before Hearing held	57	62	53	1	19
Hearing Requests	140	133	121	115	60

Community Treatment Order:
Patient has agreed to meet the conditions to be treated in the community.

Certificate of Leave:
Short term leave from the hospital; maximum time is 6 months.

Involuntary Psychiatric Treatment Act came in force in July, 2007.

Appendix B

Report of Justice La Forest, January 2012

FINAL REPORT FOR PLANNING FOR THE REVIEW OF THE *INVOLUNTARY PSYCHIATRIC TREATMENT ACT*

Submitted to the Nova Scotia Department of Health and Wellness

Prepared by the Honourable Justice Gérard V. La Forest

January 26, 2012

TABLE OF CONTENTS

I. Executive Summary 3

II. Summary of Recommendations 5

III. Current Mandate 7

IV. Process for Developing Recommendations 8

V. The Reviews 9

VI. Suggested Structure for the Review.....10

VII. Suggested Mandate for the Review 17

VIII. Suggested Terms of Reference.....22

APPENDICES

A. Terms of engagement for Justice Gérard La Forest for planning for the review of the *Involuntary Psychiatric Treatment Act* 24

B. Terms of engagement for the Dalhousie Health Law Institute for planning for the review of the *Involuntary Psychiatric Treatment Act* 25

C. Work plan for stage 2 of planning for the review of the *Involuntary Psychiatric Treatment Act*, submitted to the Nova Scotia Department of Health and Wellness by the Honourable Justice Gérard La Forest, dated February 11, 2011.....26

D. Letter to Kevin McNamara, Deputy Minister of the Department of Health and Wellness, from the Honourable Justice Gérard La Forest, dated October 25, 2011 66

SELECTED REFERENCES 74

MEETINGS.....82

I. EXECUTIVE SUMMARY

Background

The *Involuntary Psychiatric Treatment Act* has been in operation since July 2007 and is to undergo mandated legislative review during the year beginning July 3, 2012. The Act requires review of the legislation generally and reviews of certain matters pertaining to community treatment orders.

The Department of Health and Wellness engaged my services, with the support of the Dalhousie Health Law Institute, to provide advice and recommendations regarding the mandate and approach to be taken to the legislative reviews.

A list of my recommendations follows this Executive Summary.

The reviews

The *Involuntary Psychiatric Treatment Act* refers to two legislative reviews. Section 84 of the Act requires an independent review of the entire Act. Section 59 requires that the Minister of Health and Wellness undertake a review of whether community treatment orders were or were not used; the effectiveness of community treatment orders; and the methods used to evaluate the outcome of any treatment used under community treatment orders. For the purposes of this review, the Minister must use data collected on community treatment orders for the entire five-year period during which the Act has been in operation. There is no mention of the need for independence for this aspect of the review.

Considering the potential duplication of efforts that could be involved in conducting the reviews under section 84 and section 59 separately, I recommend that the reviews be conducted as a single, independent review.

Suggested structure for the review

I recommend that a single, independent reviewer be appointed to conduct the review. There are several advantages in engaging a single reviewer, including: the difficulty in choosing a stakeholder representative review team that is fully representative of the many perspectives regarding the issues; the nature of a review of legislation as opposed to a review of mental health policy in the abstract; the efficiencies and economies of a single reviewer model; the need to be driven by evidence to determine what is in the best interests of patients; and the need to focus on the evidence, accounting for contextual factors, and the conclusions that can be drawn from the evidence.

The advantages of the single reviewer model are highly dependent on the selection of the right individual. The attributes of the reviewer would ideally include impartiality, experience in evaluating and drawing conclusions from evidence, in conducting reviews, and in working on the development, interpretation and administration of legislation, as well as a background in human rights.

The success of the review, whether it is conducted by a single reviewer or a panel, is also heavily dependent upon access to a robust support system. These supports should include: a research director; access to advisors with technical or substantive expertise; administrative and secretarial assistance; technology, equipment, supplies and space; and associated expenses.

Suggested mandate for the review

The review cannot be merely technical in nature. The Act functions in a wider context that needs to be accounted for and understood as part of the review. As such, the reviewer needs to consider three interrelated matters: the direct functioning of the Act; its contextual functioning; and significant developments that have happened since the Act came into force.

Under the direct functioning of the Act, the reviewer needs to consider how the Act operates throughout the province and the policy underlying its provisions. The reviewer should consider the impact of the legislation on a constellation of stakeholders and the roles they play under the Act. Such stakeholders should include patients, substitute decision-makers, health care providers, police, patient advisors and the Review Board.

As part of the contextual functioning of the Act, the reviewer should consider such factors as the availability of support services, social context (including homelessness, poverty, racism, social isolation and oppression), the Aboriginal experience, criminalization and interaction with other legislation. In an effort to understand these and other contextual factors, the reviewer should consider engaging a diverse group of stakeholders, including those identified in the previous paragraph as well as family members, social supports officials, advocacy organizations, cultural organizations, administrators, legal professionals, court officials, academics and the public.

There have been a number of significant developments that need to be considered as the review takes place. These include: the ongoing work of the Mental Health Commission of Canada; Canada's ratification of the Convention on the Rights of Persons with Disabilities; the Report of the Fatality Inquiry into the Death of Howard Hyde; the passage of Nova Scotia legislation, including the *Personal Directives Act* and the *Personal Health Information Act*; the Better Care Sooner plan, including the upcoming recommendations from the Advisory Committee appointed by the Minister to develop recommendations regarding a Mental Health and Addictions Strategy for the province.

I recommend that the review's mandate should be to conduct a comprehensive examination of the functioning of the Act. This comprehensive review should include contextual factors that may directly or indirectly affect the operation of the Act as it applies to those impacted or potentially impacted by its functioning. The effect of significant developments in provincial, national and international law and policy as it relates to mental health should also be considered.

II. SUMMARY OF RECOMMENDATIONS

The following is a list of recommendations contained in this report.

Recommendation # 1

I recommend that a single, independent review of the *Involuntary Psychiatric Treatment Act* be undertaken and that the review include in its scope the matters cited in sections 59 and 84 of the Act.

Recommendation # 2

I recommend that the single review suggested above be referred to as the "Independent Review pursuant to sections 59 and 84 of the *Involuntary Psychiatric Treatment Act*."

Recommendation #3

I recommend that a single reviewer be appointed to conduct the review pursuant to sections 59 and 84 of the Act.

Recommendation #4

The ideal attributes of the reviewer should include: impartiality, experience in evaluating and drawing conclusions from evidence, in conducting reviews, in working on the development, interpretation, and administration of legislation; as well as a background in human rights.

Recommendation #5

I recommend that support provided for the review include:

(a) a research director, with assistance as needed;
(b) access to advisors with technical or substantive expertise, as needed;
(c) administrative and secretarial assistance;
(d) the provision of necessary technology, equipment, supplies and space;
(e) associated expenses.

Recommendation #6

Access to data required for the conduct of the review, both from within the Department of Health and Wellness and from external organizations, should be facilitated by the Department.

Recommendation #7

The mandate for the review should be to conduct a comprehensive examination of the functioning of the legislation, which should include discussion of the following matters:

(1) the direct functioning of the legislative provisions;
(2) the contextual factors that may directly or indirectly affect the operation of the Act as it applies to those impacted or potentially impacted by its functioning; and
(3) the effect of significant developments in provincial, national and international law and policy as it relates to mental health.

For the purpose of clarity, the review must explicitly include the matters set out in section 59 of the Act.

III. CURRENT MANDATE

The *Involuntary Psychiatric Treatment Act* has been in operation since July 2007 and is due to undergo mandated legislative review during the year beginning July 3, 2012. The Act requires review of the legislation generally and review of certain matters pertaining to community treatment orders.

The Department of Health and Wellness engaged my services, with the support of the Dalhousie Health Law Institute, to provide advice and recommendations regarding the approach to be taken to the legislative reviews and their conduct. In the discharge of my mandate, the project was divided into two stages. The terms of my engagement are attached as Appendix A. The terms of engagement for the Dalhousie Health Law Institute are attached as Appendix B.

During the first stage, I developed a work plan for the second stage of the project. The work plan, attached as Appendix C to this report, was submitted on February 11, 2001.

In the second stage of the project I was to prepare one or more reports on the approach to be taken to the reviews and their conduct; terms of reference and procedure for each review; and recommendations on actions to be taken by the Department of Health and Wellness and the mental health system of Nova Scotia to prepare for the conduct of the reviews. This report, which includes a number of recommendations and the suggested terms of reference, fulfills the requirements of the second stage of my mandate. In addition, in a letter to the Deputy Minister dated October 25, 2011, I made interim recommendations regarding the collection of data that would be necessary or helpful to the conduct of the reviews, (attached as Appendix D). On November 21, 2011, at the Department's request, I met with Departmental staff to discuss the interim recommendations.

IV. PROCESS FOR DEVELOPING RECOMMENDATIONS

The stage one work plan (Appendix C) sets out the tasks which I agreed to undertake for the purpose of developing recommendations regarding the conduct of the statutory reviews. The identified tasks have been completed.

The research and work done during stage two was tailored to my mandate of preparing recommendations respecting the proposed conduct of the pending reviews. As such, my focus has been on identifying issues that are relevant to reviewing the Act, and considering how those issues influence the structure of the review. The work done was three-fold. It involved (1) reviewing documents including academic literature, reports, legislation, international documents, database information, websites, and a range of government-mandated reviews in Canada; (2) talking informally with a variety of individuals and organizations; and (3) preparing this report and terms of reference.

The issues raised, both in documents and in conversation, have ranged from broad philosophical approaches to mental health legislation generally to specific concerns about technical aspects of the Act. The recommended structure and mandate of the review are shaped by consideration of philosophical, legal, practical and technical issues. The relevance of these issues in guiding my recommendations is discussed throughout this report.

V. THE REVIEWS

The *Involuntary Psychiatric Treatment Act* requires two types of legislative reviews.

Section 84 of the Act requires an independent review of the entire Act. The legislation does not set out specifics about who should conduct the review, nor does it identify how it should be conducted or particular issues to be addressed. It is clear from use of the word 'independent' that the entire Act is to be reviewed by a person or persons at arm's-length from the Department of Health and Wellness.

Section 59 of the Act also requires that the Minister of Health and Wellness review three matters specific to community treatment orders. The Minister must undertake a review of whether community treatment orders were or were not used; the effectiveness of community treatment orders; and the methods used to evaluate the outcome of any treatment used under community treatment orders. For the purposes of this review, the Minister must use data collected on community treatment orders for the entire five-year period during which the Act has been in operation. There is no mention of the need for independence for the review under section 59.

As earlier mentioned, the independent review applies to the whole Act. As such, it is appropriate to interpret it as including matters related to community treatment orders. This raises the potential that the independent review may duplicate some of the work that would be done for the Minister's review under section 59. The potential duplication of efforts has implications for the costs associated with the conduct of the reviews. It also potentially places an unreasonable burden on stakeholders who may be called upon by both the independent review and the ministerial review to share their experiences and perspectives about community treatment orders and other aspects of the Act. It therefore makes sense for the independent review to incorporate within its scope the matters identified for reviewing community treatment orders. Doing so will enable the review to consider issues concerning community treatment orders in the broader context of the Act and avoid duplication of efforts.

There is no restriction on the Minister's power to delegate the work for the ministerial review. The legislative requirement is that she undertake a review of specific matters. This undertaking could take the form of engaging an external person to conduct the review.

Recommendation # 1

I recommend that a single, independent review of the *Involuntary Psychiatric Treatment Act* be undertaken and that it include within its scope the matters cited in sections 59 and 84 of the Act.

Recommendation # 2

I recommend that the single review suggested above be referred to as the "Independent Review pursuant to sections 59 and 84 of the *Involuntary Psychiatric Treatment Act.*"

VI. SUGGESTED STRUCTURE FOR THE REVIEW

The appropriate structure for the proposed review is heavily influenced by the substantive issues respecting the Act and mental health generally. In coming to the recommendations regarding the structure for the review, I have been influenced by a variety of considerations, including the complexity of the issues, the diversity of stakeholders and perspectives, and the importance of an evidence-based analysis in health care generally. This section discusses these and other considerations under the following headings: composition of the review team, attributes of the reviewer, supports for the reviewer, and the gathering of evidence.

(1) Composition of the review team

My examination of Canadian government-mandated reviews suggests that there are three general frameworks for structuring review teams: individual; expert panel; and consulting firm. Given the considerable challenge in choosing a stakeholder-representative review team that is fully representative of the many perspectives, and the nature of the mandate, I have come to the conclusion that a single reviewer is best positioned to account for the variety of perspectives in the conduct of the review, and particularly in the context of the evidence as it emerges during the review. A single reviewer is well-situated to be driven by, and focus on, the evidence, accounting for contextual factors, to enable the development of conclusions and recommendations as to the best interests of persons with mental disorder.[1] There are also efficiencies and economies to be gained by having a single individual conduct the review. I will address each of these factors in turn, while acknowledging that they are interconnected and not discrete topics.

(a) Perspectives

There is a wide range of perspectives about mental disorder generally and about mental health legislation more specifically. At a simplistic level, two conceptualizations may be described. A medical model views mental disorder as a medical condition for which treatment is needed. A human rights model views mental disorder as a disability for which societal barriers disable the individual more than the mental condition. The dichotomous characterization described above may be seen as representing ends of a spectrum and there is much nuance and variation of perspectives existing along the continuum.

It will be important for the review to be informed by the different perspectives about the Act and about mental health issues generally. This could be achieved through representation of differing perspectives on the review team, or through the evidence-gathering process. These two structural methods of engaging differing perspectives reflect either a consensus model or, alternatively, an arms-length analysis model. A consensus model aims at finding common ground, while an arms-length model aims at a more substantive-based examination.

[1] This terminology is taken from the *Involuntary Psychiatric Treatment Act*. There are various terms that could be used, such as person living with mental disability or patient, but this report adopts the wording from the Act.

Given the diversity of perspectives, it would be very difficult to ensure that all perspectives are represented on a panel in such a way that a consensus model could effectively support an efficient review of the legislation. The consensus model is generally more effective in two contexts: when the perspectives are able to be clearly delineated and the goal is to find common ground, and where the review is of a broad policy nature. While, as will be seen in the discussion about mandate, the Act's review should not be a strictly technical review, on the spectrum of policy reviews versus substantive-based reviews, it leans more towards the latter. I also note that the province has just completed a mental health policy review that was structured around a multi-stakeholder committee. The nature of the development of the provincial mental health and addictions strategy is different from that of a legislative review, and those differences should be reflected in the structural composition for the processes.

(b) Evidence

As important as are a wide range of perspectives about the Act and mental health, the core value for the review is the individual's well-being. The varying perspectives are relevant in determining this and providing context, but evidence, situated in a broader context, will be critical for the review.

Not all reviews are conducted by a single reviewer, and appropriately so. Interestingly, in two evidence-based reviews in which strong ideological differences were present amongst stakeholders,[2] the federal government chose a single reviewer model. In the context of the review of the *Involuntary Psychiatric Treatment Act*, a single reviewer would help to ensure that the analysis will be informed by the evidence as opposed to the individual views members of the panel may hold. The mandate of the review, as will be seen later, is focused on how the Act functions. As such, evidence will need to be collected and analyzed to assess its functioning in the context of how it operates, how its operation is influenced by contextual factors, and how it meets its policy goals. A single reviewer is well-positioned to be directed by the evidence to draw conclusions and make recommendations concerning the best interests of patients.

(c) Efficiency and economy

The one-year timeframe for the review influences several factors about the review, including the choice of whether a single reviewer or a panel should conduct it.

As discussed earlier, it would be challenging to choose a review team that is fully representative of the many perspectives about the Act. If such a team were assembled, time would be a factor in simply calling meetings and reviewing documents. It would also be a factor in having discussion and working on consensus.

In addition to time efficiencies, appointing a single reviewer may lead to cost efficiencies. For example, as will be seen later in this section, stakeholder consultation should be a key

[2] See Commission on the Future of Health Care in Canada, 2002, led by Roy Romanow. See also Fairness at Work: Federal Labour Standards for the 21st Century: Review of the Canada Labour Code Part III, 2006 led by Harry Arthurs.

component of the review. Some of the costs associated with completing tasks, such as stakeholder consultation, increase per person involved. Additionally, the time factors involved in working with a large review team will impact upon budget. Budgetary considerations should not be the primary motivation for appointing a single reviewer, rather the other advantages discussed above should receive greater weight in assessing the options.

(d) Summary

There are several advantages in engaging a single reviewer for the review, including: the difficulty in choosing a stakeholder representative review team that is fully representative of the many perspectives; the nature of a review of legislation as opposed to a review of mental health policy in the abstract; the efficiencies and economies of a single reviewer model; the need to be driven by evidence to determine what is in the best interests of patients; and the need to focus on the evidence, accounting for contextual factors, and the conclusions that can be drawn from the evidence.

(2) Attributes of the reviewer

The advantages of the single reviewer model are highly dependent on the selection of the right individual. The attributes of the reviewer would ideally include impartiality, experience in evaluating and drawing conclusions from evidence, in conducting reviews, in working on the development, and in the interpretation and administration of legislation, as well as a background in human rights. Each of these attributes is discussed below.

Impartiality is a crucial characteristic for the reviewer. Impartiality, to paraphrase the Canadian Judicial Council[3], does not require that the person have no sympathies or opinions, as we are all products of our social experience, education, and general background. It is sufficient that the person must be seen to be able to consider different points of views with an open mind. It is important that the reviewer not be seen to be an advocate for a particular approach to mental health legislation.

Appointing a reviewer who has experience and a background in evaluating evidence and drawing conclusions therefrom will be important for ensuring that the review is driven by evidence. It will also be important that the reviewer have experience conducting reviews, as well as a background in working on the development, interpretation and administration of legislation. Not only will this background facilitate the smooth conduct and operation of the review, but it will lend credibility to its fair conduct and to the ultimate report and recommendations. The expertise that the reviewer would bring to the review, then, may not necessarily be subject-matter knowledge but rather process expertise and experience.

The issue of human rights and the Canadian Charter of Rights and Freedoms is interwoven with issues relating to mental health, regardless of the perspective one may hold with respect to mental disorder and mental health legislation. The relationship between human rights and

---

[3] Canadian Judicial Council, Commentaries on Judicial Conduct (1991) at p. 12 as quoted in para 35 of R. v. S. (R.D.), [1997] 3 S.C.R. 484

mental health legislation is well-recognized internationally[4] and nationally.[5] Issues around discrimination and stigma are broad themes that affect people experiencing mental disorder. More specifically, detainment, consent, treatment, and procedural protections are examples of issues that impact upon the experience of people with mental disorder from a human rights perspective. It will be helpful for the reviewer to have a solid grounding in human rights issues.

When the Act was developed, there was strong advocacy by people with varying perspectives about the legislation generally and about specific provisions. As I understand it, one reason for the inclusion of the requirement for an independent review of the Act was to address the concerns raised by competing perspectives about the legislation. The credibility of the review will be strengthened if its structure is seen to support openness to hearing and understanding various perspectives, understanding contextual factors and an ability to be driven by the evidence to evaluate the legislation.

Recommendation #3

I recommend that a single reviewer be appointed to conduct the review pursuant to sections 59 and 84 of the Act.

Recommendation #4

The ideal attributes of the reviewer should include: impartiality; experience in evaluating and drawing conclusions from evidence; experience in conducting reviews; experience in working on the development, interpretation and administration of legislation; as well as a background in human rights.

(3) **Supports for review team**

The success of any review, whether conducted by a single reviewer or a panel, is heavily dependent upon access to a robust support system. An examination of other Canadian government-mandated reviews indicates that, regardless of the composition of the review structure, access to research support, substantive and technical expertise, and administrative support are necessary to achieving the mandate of the review. In this section, I discuss each of these components.

---

[4] See for example: World Health Organization, Department of Mental Health and Substance Dependence, "The Role of International Human Rights in National Mental Health Legislation" 2004 http://www.who.int/mental_health/policy/international_hr_in_national_mhlegislation.pdf

[5] See for example: the work of the Mental Health Commission of Canada http://www.mentalhealthcommission.ca/english/pages/default.aspx ; John E. Gray, Margaret A. Shone and Peter F. Liddle, *Canadian Mental Health Law and Policy*, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 400-401 and elsewhere; H. Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L.J. 139-194.

(a) Research support

The review will require research to be conducted. The research will of necessity take various forms, including documentary review, collection of quantitative and qualitative evidence, and analysis of each of these components.

(i) Documentary research

My work to date indicates that there is much knowledge to be gained through the review and analysis of existing literature, reports, informal publications, and case law. This sort of research could be used to prepare background materials to stimulate discussion and solicit input from stakeholders. It also provides a solid foundation for understanding the broader contextual and policy considerations in which the Act operates, thus providing a backdrop for interpreting the evidence as it emerges during the review.

As the research and evidence unfolds, it may be necessary to commission one or more papers as a means of filling a gap in the necessary information with which to evaluate the functioning of the Act. It would be premature to predict whether an expert would need to be engaged to address an issue. However, my preliminary work indicates that the influence of socio-economic and socio-cultural factors on the operation of the Act may be such an area. I recommend that the reviewer identify potential issues that require commissioned research early in his or her mandate.

The background documentary research is important and requires resources to compile it, but the key role for the review is to determine how the Act operates in the province. Consequently, a strong emphasis should be placed on the collection and analysis of both quantitative and qualitative information.

(ii) Quantitative research

With respect to quantitative research, the reviewer will need to gather and analyze raw data. There will be challenges in this regard, as the mental health data that should inform the review is dispersed, fragmented and complex. It is collected by multiple organizations, both inside and outside the health system. It exists in paper-based and electronic formats. It is located in patient records and in provincial databases. There are technical challenges in linking certain data because, even if electronic, it is stored in information systems that operate on differing technical standards.

Pursuant to my discussion with Departmental officials on November 21, 2011 in follow-up to the recommendations set out in my letter to the Deputy Minister dated October 25, 2011, the information contained in the forms prescribed in the *Involuntary Psychiatric Treatment Act* regulations will be an important source of data for the reviewer. I am pleased that the Department is taking steps to collect this information. It will also be important to access information about how police across the province exercise their functions under the Act. I understand that the Department is in the process of determining what information police collect in this regard and how it might be made available to the reviewer. It will also be important to obtain data about the exercise of the courts' powers under the Act.

As discussed in the next sub-section, the reviewer may need to access technical advice. The issue of quantitative data is complex and a field of study unto itself. It is likely that the reviewer will need to seek technical advice about collecting and interpreting data that address the review's mandate, as well as what data linkages may be of particular relevance. Access to data, both from within the Department of Health and Wellness and from external organizations, is critical for the review and should be facilitated by the Department.

(iii) Qualitative research

A third form of research is qualitative in nature. It involves engaging with the public and stakeholders to hear about their experiences with and perspectives about the Act. Citizen engagement is a critical aspect to any review. Historically, public consultations demonstrate that citizens "have the capacity and sophistication to tackle complex policy issues in a meaningful way."[6] Both the public and stakeholders make important contributions to the course of a review. Reports for government mandated reviews usually include commentary about the usefulness of public and stakeholder input.

There are many different categories of people with varying experiences with the operation of the Act. They include patients, families, and health care providers, policing officials, social supports officials, advocacy organizations, cultural organizations, clinicians, administrators, legal professionals, court officials, academics and the public. Engaging this diverse group of stakeholders will require a range of approaches. Different issues and sensitivities are relevant to different stakeholders. Of particular importance are the issues of stigma and privacy for persons with a mental disorder.

Providing a range of methods for sharing opinions and information about the operation of the Act will be essential to gaining helpful stakeholder input. Some people prefer to provide written feedback; others prefer conversation. Some stakeholders are relatively vulnerable, some relatively privileged. A variety of options should be offered to participate in the review process, including written input, public meetings, website materials, a toll-free message system, and targeted meetings. Similarly, a range of methods should be employed to ensure that the public and different communities are aware of the review and encouraged to participate in a way that is meaningful and relevant to them, as well as to the review. The budget should include allowance for expenses incidental to the engagement of stakeholders.

As is the case with quantitative research, the reviewer may need to access the services of someone with expertise in research methods regarding the collection and analysis of stakeholder input.

(iv) Summary

A considerable amount of work will be involved in coordinating the documentary review, the collection of evidence in its many forms, and the analysis of these components. I suggest that it

[6] Mary Pat MacKinnon, Sonia Pitre, Judy Watling, "Matching Methods with Policy Purpose: Two Case Examples of Public Engagement" Canadian Policy Research Networks, 2007, http://www.cprn.org/documents/47131_en.pdf.

will be efficient and economical for the reviewer to have ongoing, continuous support of a research director to assist with the coordination and analysis of the evidence. The research director may engage research assistance should that be considered efficient and economical.

(b) Technical expertise

All of the reviews considered in preparing this report relied on substantive and technical expertise, but the expertise was accessed through different mechanisms. Sometimes the committee members themselves had the necessary expertise; sometimes it came from commissioning papers; sometimes from the support systems put in place for the review team; and at other times from discussions with different stakeholders. These various options were not mutually exclusive.

Different types of technical expertise will likely be needed at different times during the review. The reviewer should have access to advisors with relevant expertise, dependent upon where the evidence and analysis leads the reviewer. As already suggested, an example may be the need for advice from someone competent in statistical analysis and epidemiological methodologies to help formulate and interpret the informational needs for the review in a manner that addresses the capabilities of existing information systems, the availability of data and analytical methods.

(c) Administrative support

In addition to the research and technical supports required for the review, administrative supports will be important for the smooth and efficient operation of the review. The reviewer should have access to office support to assist with such matters as file management, website maintenance and stakeholder meeting arrangements.

The reviewer should also be supported through access to appropriate technology, equipment, supplies and space.

Recommendation #5

I recommend that the support provided for the review include:
(a) a research director, with assistance as needed;
(b) access to advisors with technical or substantive expertise, as needed;
(c) administrative and secretarial assistance;
(d) the provision of necessary technology, equipment, supplies and space; and
(e) associated expenses.

Recommendation #6

Access to data required for the conduct of the review, both from within the Department of Health and Wellness and from external organizations, should be facilitated by the Department.

VII. SUGGESTED MANDATE FOR THE REVIEW

The approach taken to the stage one work plan was broad. As indicated earlier, it was important to understand the environment within which the legislation operates in order to appreciate the factors and issues that must be addressed when recommending the structure and the mandate for the review. My work to date has demonstrated that the operation of the Act is affected not only by matters specific to the wording of the legislation, but also by the operation of the legislation in the context of the environment in which it operates. As such, the mandate for the review must address both internal and contextual factors. This requires consideration of three matters, all of which are interrelated: the direct functioning of the Act; its contextual functioning; and significant developments that have occurred since the Act came into force. I will address each matter in turn.

(1) Direct functioning of the Act

A review cannot occur without consideration of the relevant legislative provisions. The review, however, cannot be merely technical in nature. The Act operates in a context that must be accounted for and understood as part of the review. The operation of the Act throughout the province must be reviewed and the policy underlying its provisions should be examined as needed.

The mandate must be considered in the context of the statutory one-year timeframe to conduct the review. It is not possible to consider every issue relevant to the Act. The reviewer will need to prioritize issues as the evidence emerges from the analysis that flows from the evidence. It will be important for the reviewer to make decisions in the context of the review to focus the issues. It would be presumptuous of me to identify what those priority issues may be based upon the limited sampling of information I have gathered. However, my work to date indicates that the review may need to consider a number of the issues highlighted below.

These issues are arranged around the constellation of stakeholders upon whom the Act has a direct impact or who are required to interpret, evaluate and apply specific terminology and criteria when making decisions. Sometimes suggestions are made, which I trust will be helpful, but the reviewer should not be bound by these suggestions.

(a) Impact on Patient

(i) **Categories of admission**

a. Voluntary and capable
b. Voluntary and incapable
c. Involuntary

Within this broad category, one of the issues identified to date is that there may be inappropriate changes in patient status. These may impact on apparent rights protections of patients.

(ii) Criteria for examination, assessment and involuntary status

The changes in criteria between the Hospitals Act and the Involuntary Psychiatric Treatment Act should be reviewed, including the definition of mental disorder, the requirement for incapacity, and the addition of the factor of deterioration. The new criteria should be reviewed in the context of the entire process and criteria concerning involuntary examination, assessment and admission.

(iii) Confidentiality, access and disclosure

Preliminary work to date indicates that issues concerning confidentiality and access to information in the context of the Act may not be well-understood by professionals who work in the mental health and legal systems. The findings of Judge Derrick in the Hyde Report regarding the sharing of information further supports the need to review the situation in the context of the Act and the Personal Health Information Act which I understand is expected to come into force in the fall of 2012.

(iv) Community treatment orders

Section 59 of the Act requires review of three matters relating to community treatment orders: whether they were or were not used; their effectiveness; and the methods used to evaluate the outcome of any treatment used under them.

As indicated earlier, community treatment orders should be reviewed as part of the wider functioning of the legislation.

(v) Certificates of leave

Certificates of leave are another community treatment option under the Act. My preliminary work indicates that it may be of value to review why they were or were not used as an alternative to community treatment orders.

(vi) Restraint and seclusion

Some provincial statutes include provisions addressing the issues of restraint and seclusion. The Involuntary Psychiatric Treatment Act does not include such provisions and it may thus be appropriate to consider these issues in the context of the functioning of the legislation.

(b) Role of Substitute Decision-Makers

(i) How substituted consent operates under the Act
(ii) Advance directives (including the *Personal Directives Act*)

(c) Role of Health Care Providers

(d) Role of the Police

It will be important to examine how and why police make decisions to direct an individual towards the Involuntary Psychiatric Treatment Act regime as opposed to the criminal justice regime.

It will also be important to understand how, and to what extent the police exercise their authorities under the Act.

(e) Role of Patient Advisors

The position of patient advisor is new to the Act. It did not exist under the former Hospitals Act regime. As such, it will be important to evaluate the role in the context of the functioning of the legislation.

(f) Role of Review Board

(g) Other

As indicated earlier, it is not possible to review all aspects of the functioning of the Act in a one-year timeframe. As such, consideration should be given to whether it would be appropriate to mandate an ongoing or periodic review of the Act.

It will also be important to consider the interaction of other legislation with the Involuntary Psychiatric Treatment Act.

(2) <u>Contextual functioning of the Act</u>

As indicated earlier, the Act's functioning is highly dependent upon external factors. The direct functioning of the Act must be considered in its relevant context. It will be important for the reviewer to consider contextual factors that may directly or indirectly affect the operation of the Act as it applies to those impacted or potentially impacted by its functioning.

The reviewer should consider the extent to which contextual factors should be examined as the evidence unfolds. My preliminary work indicates that the issues surrounding the availability of support services, social context, Aboriginal experience, criminalization and interaction with other legislation are all factors that merit reflection. These categories are interrelated such that an individual may be impacted by multiple contextual factors. These suggestions are not directive; as indicated earlier, the reviewer must have the flexibility to focus the issues as the evidence unfolds.

The availability of support services for individuals living with a mental health disorder in the community may have an impact upon the need or propensity to engage the Act. It will be important for the reviewer to consider the availability of community resources across the province as it relates to the Act's functioning.

Social context is germane to how individuals and communities experience the Act throughout the province. Social context addresses issues relevant to vulnerable populations, including those experiencing homelessness, poverty, racism, social isolation, family isolation, and oppression. The reviewer should be attentive to the cultural contexts of different communities, including immigrant communities, African Nova Scotian communities, Aboriginal communities and Acadian and other francophone communities.

With respect to the experience of Aboriginal communities, my preliminary work suggests the challenges they face separate and apart from issues pertaining to the Act, are immense. Such issues as poverty, geographical isolation and the impact of residential schools complicate their experience with the mental health system. As part of the review, the larger challenges that Aboriginal peoples in Nova Scotia face need to be taken into account in relation to the challenges that they face in the mental health system.

The Hyde Report highlighted the concern "that people having problems with their mental health in the community often find themselves "drawn into the justice system"."[7] The reviewer should consider how the operation of the Act may bear on the criminalization of people living with mental disorder.

The Act functions not only in a societal context; it also functions in a legislative context. Consideration should be given to how it interacts with the operation of other legislation, such as the *Adult Protection Act*, the *Incompetent Persons Act*, the *Personal Directives Act* and the *Personal Health Information Act* (not yet in force).

(3) <u>Significant developments</u>

There are a number of key developments that have occurred since the Act came into force in July 2007. They include:

The Mental Health Commission of Canada has been working since March 2007 on a number of research projects that aim to improve the mental health system in Canada. The research projects are diverse, ranging from the impact of mental health issues on different demographics to the ways in which legal and service systems impact upon people living with mental illness. The Commission is in the process of developing both the Mental Health Strategy for Canada and its report and evaluation instrument for the Human Rights Evaluation Project. Both are anticipated to be available for the review.

Canada ratified the Convention on the Rights of Persons with Disabilities on March 22, 2010, which aims to *"promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their*

---

[7] Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf at 313.

inherent dignity." The Convention includes persons with mental impairments within the meaning of 'persons with disabilities.'

In November 2010, Judge Anne Derrick issued her *Report of the Fatality Inquiry into the Death of Howard Hyde*. In her report, Judge Derrick details extensive evidence relevant to the interaction between the criminal justice system and the mental health system. She also addresses issues concerning the potential invocation of the *Involuntary Psychiatric Treatment Act* in Mr. Hyde's situation. However, because the Act was not invoked, Judge Derrick did not have the evidentiary basis to conduct a detailed examination of the legislation. Her recommendations touch on general issues relevant to the Act as well as specific recommendations for it and for the mandate of the review.

Since the Act came into force, the Nova Scotia legislature passed a number of statutes that are relevant to its operation. Specifically, the *Personal Directives Act* was passed in 2008 and came into force on April 1, 2010, and the *Personal Health Information Act* was passed in 2010, though it has not yet come into force.

The Minister of Health and Wellness has been taking steps toward the provision of better mental health services. The Better Care Sooner plan to improve emergency care, released December 2010, identifies the objective of providing people with mental illness emergency care better suited to their needs. The plan identifies two actions under this objective. An advisory committee was appointed by the Minister to develop recommendations regarding a mental health and addictions strategy for the province. Its report is expected to be disseminated prior to commencement of the review. The second action under the plan addresses collaborative work between emergency departments, mental health programs, and the police to provide a crisis response to mental health emergencies.

Recommendation #7

The mandate for the review should be to conduct a comprehensive examination of the functioning of the legislation which should include discussion of the following matters:

(1) the direct functioning of the legislative provisions;

(2) the contextual factors that may directly or indirectly affect the operation of the Act as it applies to those impacted or potentially impacted by its functioning; and

(3) the effect of significant developments in provincial, national and international law and policy as it relates to mental health.

For the purpose of clarity, the review must explicitly include the matters set out in section 59 of the Act.

VIII. SUGGESTED TERMS OF REFERENCE

TERMS OF REFERENCE

Independent Review pursuant to sections 59 and 84 of the *Involuntary Psychiatric Treatment Act*

Purpose

The *Involuntary Psychiatric Treatment Act* section 84 requires an independent review of the entire Act during the year commencing July 3, 2012. The Act, pursuant to section 59, also requires that the Minister of Health and Wellness undertake a review of community treatment orders during the year commencing July 3, 2012, and specifically: whether community treatment orders were or were not used during the review period; the effectiveness of community treatment orders during the review period; and the methods used to evaluate the outcome of any treatment used under community treatment orders.

Structure of the review

The reviews required under sections 59 and 84 of the *Involuntary Psychiatric Treatment Act* will be conducted as a single, independent review. The review shall be referred to as the Independent Review pursuant to sections 59 and 84 of the *Involuntary Psychiatric Treatment Act*.

A sole reviewer shall be appointed by the Minister to conduct the review. The reviewer shall be a person who is independent from the Department of Health and Wellness. The reviewer is to report to and be accountable to the Minister.

The reviewer will be supported by the provision of appropriate resources, including: a research director with appropriate assistance; access to advisors with technical or substantive expertise as needed; administrative and secretarial assistance; technology, equipment, supplies and space; and associated expenses.

Mandate

The review shall comprehensively review the functioning of the *Involuntary Psychiatric Treatment Act*. The review will include, but is not restricted to, consideration of:

(1) The direct functioning of the legislative provisions;
(2) The contextual factors that may directly or indirectly affect the operation of the Act as it applies to those impacted or potentially impacted by its functioning; and
(3) The effect of significant developments in provincial, national and international law and policy as related to mental health;

For the purpose of clarity, the comprehensive review must explicitly include the matters set out in section 59 of the Act.

The review will consider background documentary research, quantitative evidence, and qualitative evidence. The reviewer will consult with stakeholders as appropriate, including members of the public, patients, families, health care providers, policing officials, social supports officials, advocacy organizations, cultural organizations, clinicians, administrators, legal professionals, court officials and academics.

Tenure and reporting of results

The reviewer is to be appointed at the latest by July 3, 2012 for a term to end on July 2, 2013. He or she shall submit a report to the Minister regarding the findings of the review by July 2, 2013.

APPENDIX A

Terms of engagement for Justice Gérard La Forest for
planning for the review of the *Involuntary Psychiatric Treatment Act*

The Consultant shall provide the following services:

1. Development of a work plan, including terms of reference, by February 15, 2011.

2. Preparation of one or more reports to the Minister of Health on the approach to be taken to the reviews and their conduct, including a detailed plan for the conduct of the reviews after the date specified in the *Involuntary Psychiatric Treatment Act*; terms of reference and procedure for each review; and recommendations on actions to be taken by the Department and/or the mental health system of Nova Scotia to prepare for the conduct of the reviews by January 30, 2012.

The Consultant shall have access to research and secretariat services from the Health Law Institute of Dalhousie University. Such services will be detailed in a contract between the Institute and the Department.

APPENDIX B

Terms of engagement for the Dalhousie Health Law Institute for planning for the review of the *Involuntary Psychiatric Treatment Act*

The Institute shall

- generally support the Reviewer in the discharge of his mandate to prepare for and to conduct the reviews; and
- provide research and secretariat services to the Reviewer in respect of the following two distinct stages of the Reviewer's mandate:

1. Development of a work plan, including terms of reference, by February 15, 2011.

2. Preparation of one or more reports to the Minister of Health on the approach to be taken to the reviews and their conduct, including a detailed plan for the conduct of the reviews after the date specified in the *Involuntary Psychiatric Treatment Act*; terms of reference and procedure for each review; and recommendations on actions to be taken by the Department and/or the mental health system of Nova Scotia to prepare for the conduct of the reviews by January 30, 2012.

Institute services were provided by:

Elaine Gibson, Associate Professor
William Lahey, Associate Professor
Leah Hutt, Senior Research Associate
Nayha Acharya, Research Associate
Charlotte Edwards, Research Assistant
Barbara Carter, Administrative Assistant

APPENDIX C

Work Plan for Stage 2 of Planning for the Review of the *Involuntary Psychiatric Treatment Act*

Submitted to the Nova Scotia Department of Health and Wellness

Prepared by The Honourable Justice Gérard V. La Forest

February 11, 2011

Table of Contents

BACKGROUND 4

WORK PLAN 5

Section A. Work Plan Outline 6

Section B. High-level Preliminary Issues Identification 7

I. **"BIG-PICTURE"** 7

- Focus of the statute 7
- Human rights 8
- Community supports 10
- Resource allocation 11
- Geographical context 12
- Interaction between the Involuntary Psychiatric Treatment Act and the criminal justice system..... 13

II. **IMPACT ON PATIENT** 15

- Categories of admission (voluntary/capable; voluntary/incapable; involuntary) 15
- Criteria for examination, assessment and involuntary status 16
  - Definition of mental disorder 17
  - Dangerousness 19
  - Need for treatment 20
  - Capacity 21
- Consent to treatment 22
- Confidentiality/access 25
- Repetitive admissions 27
- Community options (community treatment orders, leave certificates) 28

III. **ROLE OF SUBSTITUTE DECISION-MAKER** 29

- Voluntary/incapable
- Involuntary

IV. **ROLE OF HEALTH CARE PROVIDER** 31

- Institution
- Psychiatrists
- Other health care providers

V. **ROLE OF PATIENT ADVISOR** 32

- Advisor vs. advocate
- Funding

VI. **ROLE OF POLICE** 33

- Apprehension
- Criminalization of mental illness

VII. **ROLE OF REVIEW BOARD** 35

- Substantive
- Procedural

VIII. **OTHER** 37

- Time frames

REFERENCES 39

BACKGROUND

The *Involuntary Psychiatric Treatment Act* (IPTA) requires the Minister of Health and Wellness to undertake a review of community treatment orders and table a report in the House of Assembly. The Act also requires the Minister of Health and Wellness to have an independent review of the entire Act completed and table the review in the House of Assembly. Both reviews must be undertaken during the year beginning July 3, 2012, being the sixth year after the date when the Act came into force.

The requirements for these reviews are set out in the Act as follows:

> ***Review by Minister***
>
> *59 (1) The Minister shall undertake a review of the following matters:*
>
> *(a) whether community treatment orders were or were not used during the review period;*
>
> *(b) the effectiveness of community treatment orders during the review period;*
>
> *(c) the methods used to evaluate the outcome of any treatment used under community treatment orders; and*
>
> *(d) any further matters prescribed by the regulations.*
>
> *(2) The review must be undertaken during the sixth year after the date on which Sections 47 to 59 come into force utilizing data collected on community treatment orders for the entire five-year period.*
>
> *(3) The Minister shall make available to the public for inspection and table, in the House of Assembly, the written report of the review completed under subsection (1).*
>
> ***Independent review of Act***
>
> *84 (1) The Minister shall undertake and have completed an independent review of this Act during the sixth year after the date on which this Act comes into force.*
>
> *(2) The Minister shall table the review in the House of Assembly at the next sitting of the House.*

The Department of Health and Wellness has engaged the Honourable Justice Gérard V. La Forest, supported by the Dalhousie Health Law Institute, to provide advice and recommendations regarding the approach to be taken to the reviews and their conduct. In the discharge of Justice La Forest's mandate, the project has been divided into two stages:

- Stage 1 to develop a work plan for stage 2 (due February 15, 2011);
- Stage 2 to prepare one or more reports on the approach to be taken to the reviews and

their conduct; terms of reference and procedure for each review; and recommendations on actions to be taken by the Department of Health and Wellness and/or the mental health system of Nova Scotia to prepare for the conduct of the reviews (due January 30, 2012).

WORK PLAN

The following work has taken place during Stage 1 of the project:

- Canadian literature review of broad mental health issues
- Literature review regarding operation and critiques of IPTA
- Review of Hansard debates at time of IPTA introduction
- Meetings with DOH staff
- Meeting with DOH Liaison Group
- Preliminary discussion as to data and statistics that are currently available and those that need to be gathered
- Preliminary identification of high-level issues in mental health legislation
- Development of work plan for Stage 2

This work plan fulfills the requirements of Stage 1 of the mandate. It is divided into two sections. Section A sets out a high level description of the tasks to be completed and approaches to be taken for the purpose of developing recommendations during Stage 2.

Section B consists of a preliminary issues identification document which highlights broad issues or themes that will need to be considered in Stage 2. These issues or themes were identified based on a preliminary literature review. It draws primarily on Canadian literature but also international sources and occasionally those from other nations. Section B sets out broad issues at the beginning and then progresses to more specific, but still high-level, issues.

A series of quotations is provided in order to provide context to the various issues. This is not intended to be an exhaustive list of issues; nor do the quotations necessarily represent the entire spectrum of views; and nor do they canvass the details/sub-issues that are necessary for a full appreciation of each issue. Rather, the quotations selected are intended to provide a "sense" of the discussion relevant to high-level issues in mental health legislation. Sometimes this is done through a summary provided by a single author and sometimes multiple excerpts are provided. In addition, it must be recognized that these issues are at times inevitably interrelated such that categorization is difficult and perhaps artificial.

Section A. Work Plan Outline

Stage 2 of the mandate will involve the following for the purpose of developing recommendations regarding the conduct of the statutory IPTA reviews:

- Review Canadian mental health legislation and the Uniform Mental Health Act (Uniform Law Conference of Canada)
- Review legislative models from selected jurisdictions outside of Canada
- Review relevant national and international documents, including those dealing with human rights
- Review other Canadian mental health legislative reviews and other relevant reviews
- Review relevant case law
- Conduct further literature review, locally, nationally and internationally, regarding each of the issues identified in Section B of this document and other issues that emerge
- Review relationship between IPTA and other Nova Scotia legislation
- Review interaction between the operation of IPTA and the operation of other legislation, including criminal justice legislation
- Continue to identify data and sources of data relevant to the reviews, and recommend to DOH the collection of additional data as deemed appropriate
- Meet with the DOH Liaison Group as necessary
- Identify relevant mental health stakeholders
- Identify relevant experts
- Meet with mental health stakeholders as necessary
- Meet with experts as necessary
- Meet regularly with DOH staff
- Develop Terms of Reference for the reviews
- Develop a comprehensive plan for the conduct of the reviews, including recommendations as to how the reviews should be structured and conducted
- Make recommendations on further actions, if any, that should be taken by the DOH and/or the mental health system to ensure readiness and effectiveness of the reviews

Section B. High-level Preliminary Issues Identification

I. "BIG-PICTURE"

- **Focus of the statute**

NOTE: The debate about the appropriate focus of and philosophy behind mental health legislation permeates all aspects relating to mental health.

PETER CARVER

The principal characteristic of mental health law is that it is a law based on legal compulsion and coercion. ... While provincial mental health statutes deal with various other matters in the delivery of mental health services, their raison d'etre remains this framework of lawful coercion. [Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., Canadian Health Law and Policy, Third Edition (Markham: LexisNexis Canada Inc., 2007) at 399-436, at 403.]

CANADIAN PSYCHIATRIC ASSOCIATION

The need for mental health legislation is based on the fact that some citizens are prevented, by virtue of their mental condition, from making capable decisions, including the decision to autonomously seek treatment. ... The philosophy of legislation should be in keeping with the current legal and clinical notions of least restrictive, and least onerous interventions that are necessary to enable persons with mental illness to participate meaningfully in our free and democratic society. [Canadian Psychiatric Association, "The Role of Mental Health Legislation, Position Statement" approved April 10, 2005 http://publications.cpa-apc.org/media.php?mid=196 at 1.]

WORLD HEALTH ORGANIZATION

Mental health legislation can provide a legal framework for addressing critical issues such as the community integration of persons with mental disorders, the provision of care of high quality, the improvement of access to care, the protection of civil rights and the protection and promotion of rights in other critical areas such as housing, education and employment. Legislation can also play an important role in promoting mental health and preventing mental disorders. Mental health legislation is thus more than care and treatment legislation that is narrowly limited to the provision of treatment in institution-based health services. [World Health Organization, "Mental Health Legislation and Human Rights: Mental Health Policy and Service Guidance Package" 2003 http://www.who.int/mental_health/resources/en/Legislation.pdf at 2.]

ARCHIBALD KAISER

The new prominence of the need to destigmatize mental illness and to combat the harmful effects of prejudice would suggest a logically consistent shift away from laws based on the facilitation of intervention, towards legislation fostering social inclusion. ... Current law has largely made a volte-face, away from the ostensible promises of contemporary discourse. Mental health statutes make it easier to use the law to compel examinations, to detain patients and treat them forcibly in hospitals, and to extend controls over behaviour into the community. Positive entitlements to supports and services to the enjoyment of the full panoply of rights of Canadian citizenship are elusive or simply absent. [H. Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L.J. 139-194 at 233.]

- **Human rights**

JOHN GRAY

CMHL [Comprehensive Mental Health Legislation] could set out the rights and entitlements of people with a mental illness. The ordinary civil rights of people with mental disorders are governed by other laws. For example, the Canadian Charter of Rights and Freedoms (the "Charter") and human rights legislation now protect the equality rights of people with mental disabilities. However, people with mental disorders may require special rights, in addition to the rights enjoyed by others. Such rights could include the right of access to particular services and the right to participate in formulating care and treatment plans. CMHL could spell out special rights. As well, it could include or incorporate by reference to other legislation, provisions with respect to: treatment consent and substitute decision-making; guardianship; or the protection of privacy and the confidentiality of personal health information. CMHL could secure linkages to protective mechanisms in legislation that authorizes state intervention to protect adults at risk of abuse from other persons or that establishes a mental health advocate or ombudsman to handle complaints made by or on behalf of people with mental disorders. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 400-401.]

PETER CARVER

"Mental disability" in the human rights context is understood in a broad and non-medical fashion, not associated with particular dysfunctions, but with disadvantage caused by social response to actual or perceived variations from cognitive or emotional norms. [Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., Canadian Health Law and Policy, Third Edition (Markham: LexisNexis Canada Inc., 2007) at 399-436, at 402.]

WORLD HEALTH ORGANIZATION

In accordance with the objectives of the United Nations (UN) Charter and international agreements, a fundamental basis for mental health legislation is human rights. Key rights and principles include equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the rights to information and participation. Mental health legislation is a powerful tool for codifying and consolidating these fundamental values and principles. Equally, being unable to access care is an infringement of a person's right to health, and access can be included in legislation. [World Health Organization, "WHO Resource Book on Mental Health, Human Rights and Legislation" 2005 http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf at 3.]

ARCHIBALD KAISER

...broad guarantees of human rights are largely absent from Canadian mental health statutes. Earlier international declarations have established that "all human rights and fundamental freedoms are indivisible and interdependent," and that they "unreservedly include persons with disabilities." The content of such promises could demand that health care and social service providers consider the qualitative protections offered by their systems from rights-promoting perspectives, and could empower persons with mental health problems to require more of recalcitrant governments. The range of interests that could be articulated could include: summative references to the need to promote human rights; equal access to services compared to physical health care; invocation of health determinants extending beyond provision of treatment simpliciter; explicit references to the need to comply with the Charter; dedication to psychosocial, rehabilitative and community-based approaches; prevention of crises; health promotion; and general assurances of non-discrimination. [H. Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L.J. 139-194 at para 13.]

HYDE REPORT

Recommendation #73

The independent review of the Involuntary Psychiatric Treatment Act in 2013, required pursuant to section 84(1) of the Act, should include a thorough legal analysis of the legislation's conformity or lack thereof as the case may be to the Charter and the United Nations Convention of the Rights of Persons with Disabilities and recommend amendments as applicable.

Commentary:

Amongst a number of principles, the Convention on the Rights of Persons with Disabilities recognizes in its Preamble the "need to promote and protect the human

rights of all persons with disabilities, including those who require more intensive support" and "the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices." The purpose of the Convention is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." Under the Convention, "the existence of a disability shall in no case justify a deprivation of liberty." Even where not yet implemented by statute, the "values reflected in international human rights law may help inform the contextual approach to statutory interpretation and judicial review." It was Dr. Curry who proposed that this Inquiry and its recommendations could provide "some additional guidance to the Minister when the Ministerial Review [pursuant to section 84] takes place." [Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf at 374.]

- **Community supports**

HYDE REPORT

Recommendation #21

The Province should ensure that robust supports are in place for persons discharged from involuntary treatment or correctional facilities, such supports to include, at a minimum, adequate housing, regular access to appropriate mental health services, community outreach and support and intensive community support as needed. [Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf at 358.]

ARCHIBALD KAISER

... The CMHA, Ontario Division, argued, prior to the Ontario amendments creating CTOs, that several measures should be taken instead of creating more coercive legislation: using some existing legal provisions properly, which may require educational opportunities for providers; service agreements upon discharge between clients and service providers; diversion of people with personality and substance abuse problems away from the criminal justice system; special attention to homeless people; easier access to care; a comprehensive system of community support, with access to alternatives, such as crisis housing or outreach teams; consumer-based models of care provision, aimed at enlisting co-operation; and cessation of psychiatric bed closures. These steps are less politically attractive in the short run, but in the final analysis, such creative and anti-discriminatory options may well be more efficacious. [H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy,* Second Edition (Markham and Vancouver: Butterworths Canada Ltd., 2002) at 251-330 at 305-306.]

JOHN GRAY *et al.*

Most Canadian mental health legislation focuses on compulsory admission and treatment. However, it does not tell us what other legislation may assist people with mental disorders as part of a larger health or disability care system, or as part of a social support, education or employment system. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 396.]

- **Resource allocation**

WORLD HEALTH ORGANIZATION

In some legislative frameworks or countries it may be possible to include specific provisions for resources and funding of mental health services. Where this is possible, it is advisable to indicate where resources should be spent, thereby enabling adequate provision in areas such as community mental health care and prevention and promotion programmes. ... Examples of four ways in which legislation can direct funding are by stipulating the need for:

- *Equality with physical health ...*
- *Additional funding ...*
- *Redirecting funding ...*
- *Funding of statutory bodies...*

[World Health Organization, "WHO Resource Book on Mental Health, Human Rights and Legislation" 2005 http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf at 27-28.]

JOHN GRAY *et al.*

pp. 400-401 Many of the mental health services listed previously are offered under other administrative structures, for example, social services. Where this is so, CMHL [Comprehensive Mental Health Legislation] could establish a formal link between mental health care and these other resources, and require the people responsible for them to take the needs of people with mental disorders into account when planning for the use and delivery of their resources. ...CMHL could embody the obligation to fund and identify funding sources. Short of this, naming services in legislation would provide a strong indication that the services will be funded.

p. 442 Accountability is a watchword in health care, arising largely because of the high costs of hospitalization. Unnecessary hospital admissions and longer than average hospital stays, due to a person not taking treatment, not only cost money, but also deny other people timely treatment. The reduction in hospital costs attributable to assisted community treatment will probably become a stronger argument as population increases put even more pressure on health care resources. Similarly, the cost of treatment refusal ... is likely to be influential in debates on the right to refuse the treatment needed to be discharged from hospital. [John E. Gray, Margaret A.

Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 400-401 and 442.]

- **Geographical context**

WORLD HEALTH ORGANIZATION

Within countries, there are disparities in service provision. These disparities may be geographical (people in certain areas may have little access to mental health services) or segmental (certain populations, e.g. minority groups within society, may have reduced access to culturally appropriate mental health services). Legislation can help to reduce these disparities by laying down criteria for needs-based allocation of services. ... Laws can also simply state that mental health care must be provided equitably. [World Health Organization, "WHO Resource Book on Mental Health, Human Rights and Legislation" 2005 http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf at 29.]

REVIEW BOARD UNDER IPTA

The requirement for increased community supports such as appropriate housing, and outreach continues to be an urgent issue. Some areas of the province do not have the community mental health programs and staffing to fully utilize the tools available in the new legislation. The Review Board has been told that psychiatrists in some facilities are not authorized to use community treatment orders or leave certificates because there is not enough support in the community to ensure compliance. This is not an acceptable situation. If the Legislature has deemed it appropriate to include these options they should be available to involuntary patients throughout the province who satisfy the legislative criteria. The Review Board recommends that this be examined more fully and that funding be provided to allow treatment in the communities in which people live. [Annual Report, Review Board under the Involuntary Psychiatric Treatment Act, July 3, 2007 March 31, 2008, p.7.]

HYDE REPORT

Recommendation #16

The Province should examine how mental health services for persons in conflict with the law can be enhanced outside of the Halifax Regional Municipality.

...[Justice and Health workers working in the area of mental health] in rural parts of Nova Scotia face very real challenges and different challenges [than their counterparts in HRM.] [Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf at 355-356.]

- **Interaction between the Involuntary Psychiatric Treatment Act and the criminal justice system**

JOHN GRAY *et al.*

"Unfortunately, there is evidence that some inadequately treated psychiatric patients are starting to appear in the criminal justice system, which is already known for its lack of adequate psychiatric services. Ironically, the reason the very first mental health legislation was established in Ontario 148 years ago was that the legal/judicial/correctional system could not cope with the problems of the mentally ill. Have we come full circle?" [citing Deadman and Hoffman]

The answer to Deadman and Hoffman's question, posed in 1987, is "Yes". Canadian prisons now, as they were over 160 years ago, have increasingly become places of detention, but not treatment, for many people with treatable serious mental illnesses. ... Because of the increasing numbers of people with a mental illness being directed to jails rather than hospitals, efforts are being made in Canada to "divert" people to the mental health system from the criminal justice and correctional systems.

(p.412) ... The problems of the mentally ill inappropriately being in prison have been a social policy issue for a long time. The Law Reform Commission of Canada in 1976, for example, stated that "when dealing with a mentally disordered person, the criminal process should be invoked only when no other viable social alternative is available." [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 411-412.]

LAW REFORM COMMISSION OF CANADA

The mental problems of most people begin before they come into contact with the criminal process; they bring their mental disorder with them. It is important therefore, that the mentally disordered be identified as early as possible in the process to assure that they will be treated in legally and medically appropriate ways. One way of dealing with the mentally disordered before trial is to divert them from the criminal law altogether. [Law Reform Commission of Canada, Working Paper No. 14, "The criminal process and mental disorder", 1975 at 23.]

RIGHT HONOURABLE JUSTICE BEVERLEY McLACHLIN

"What", I asked the officer, "is the biggest challenge you face?"
...
"Our biggest problem," the officer answered, "is mental illness."

[He] went on to explain that a large proportion of the people arrested and brought into his police station were not true "criminals", but people who were mentally ill. They were people who had committed some offence, usually minor, sometimes more major, for no other reason than the confusion in their disordered minds. ...

...Whatever the reason, many such people, the officer told me, were taken into custody and brought to the police station every night. And once there, they posed further problems. The ordinary police processes did not fit well with their situation.... [Right Honourable Beverley McLachlin, P.C., Chief Justice of Canada, "Medicine and the Law: the Challenge of Mental Illness" 2005 http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp at 1-2.]

PETER CARVER

The Criminal Code provisions do not authorize psychiatric treatment of NCRMD persons. Therefore, the authority to treat, including any authority to treat where the individual is unable or unwilling to consent to psychiatric treatment, falls to be determined by the provincial mental health law in the province where the individual is detained. For this reason, forensic patients are often certified under mental health statutes as well as being detained pursuant to the Criminal Code. Forensic psychiatric facilities are provincially operated, either as free-standing hospitals or as forensic units in mental health hospitals. [Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., Canadian Health Law and Policy, Third Edition (Markham: LexisNexis Canada Inc., 2007) at 399-436 at 424.]

HYDE REPORT

What Mr. Hyde needed in a more comprehensive sense were better options from the mental health and criminal justice systems. After all I have listened to, and read, I am left to wonder, what could Mr. Hyde's story have been? There has to be another narrative, one that leads to hope and integration and speaks to alternatives to the courts and jail for persons with severe, persistent mental illness who come into conflict with the law. As the evidence before the Inquiry has vividly illustrated, grasping this nettle is not just the responsibility of the justice system; creativity and commitment to change are required of the health system and the community too. (p.386)

Recommendation #4

The Province should establish an inter-departmental (Justice and Health) Committee, to address mental health issues in the criminal justice system. The Committee should report to the Deputy Ministers for Health and Justice. (p.351) [Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf at 351 and 386.]

II. IMPACT ON PATIENT

- **Categories of admission (voluntary/capable; voluntary/incapable; involuntary)**

ARCHIBALD KAISER

Major policy issues must be faced even in the presumably less challenging sphere of voluntary admissions. In part this relates to the desirability of voluntary (or informal) patient status.... The difficulties surrounding this method of admission are inherent in the nature of any normal medical procedure. The consent to admission must be given by a competent person, who has been given enough information to make an informed decision and who is not subject to coercion, oppression, or any other pressure which would vitiate the voluntary character of the decision to seek admission to hospital. Many of these issues may be inadequately considered in the voluntary admission process. ... The danger for consumers is that, for perhaps laudable reasons, the requirements of competence, informed decision-making, and voluntariness may be undermined, blurring the distinction between statuses. Ironically, this could leave the voluntary patient with fewer explicit legal protections. [H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy,* Second Edition (Markham and Vancouver: Butterworths Canada Ltd., 2002) at 251-330 at 281-282.]

BOB SYMONDS

The threat to genuine voluntary status is further undermined by the continuing power of health care professionals to apply for compulsory admission for patients already in hospital informally and who want to exercise their right to leave. [Bob Symonds, "The philosophical and sociological context of mental health care legislation" (1998) 27 J of Advanced Nursing 946-954 at 947.]

JOHN GRAY *et al.*

p. 191 ... Children or incapable adults who are admitted on the authority of another person, unlike true voluntary patients, cannot discharge themselves unless the substitute decision-maker agrees. They are detained. ...

p. 194 ... One approach to this dilemma for a person who is willing to go along with admission and treatment but is not capable, is to lower the standard of capability using current standards of understanding and appreciating the consequences of the decision. Thus, if the person did not object to the admission, it would be sufficient. This might be considered as "assent" rather than "consent". The justification is that the alternative, involuntary admission is more restrictive. This option is not presently used in Canada. Another approach is to appoint a substitute decision-maker to admit the incapable person. This is permitted in Nova Scotia and Ontario ... The principle disadvantages of these approaches is that the person loses the protections of rights information, renewal certificates and review boards that are available to involuntary patients. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 191 and 194.]

LAW REFORM COMMISSION OF NOVA SCOTIA

It is possible that a person who does not have the capacity to provide or refuse consent to admission may seek to be admitted voluntarily to a facility. Although not resisting admission, some people may also not expressly consent to admission, but rather may simply acquiesce. In the interest of ensuring that people receive the care and treatment they require, the Commission takes the position that admission to facilities should be encouraged for those people who appear willing to seek care and treatment for mental illness. [Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf at 24.]

- **Criteria for examination, assessment and involuntary status**

JOHN GRAY *et al.*

Using the same criteria for police as for first certificate physicians would seem to be more consistent with a human needs approach, since the police opinion will be subject to independent confirmation by a physician. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 170.]

LAW REFORM COMMISSION OF NOVA SCOTIA

In the Discussion Paper, the Commission expressed the view that the test to admit persons for observation need not be as stringent as the test for involuntary admission as a patient. In the event of someone who shows signs of having a mental illness and being a danger to self or to others, more of an emphasis, it was suggested, should be placed on getting that person to the safety of a facility, where an assessment could be completed. With the passage of time after the original admission, more information would become available about the nature of a person's mental health. Given the availability of additional details, as well as the fact that admission as an involuntary patient would involve significant and perhaps lengthy infringement on personal freedom, the Commission took the position that the standard for involuntary admission should be higher. To accomplish these aims, the Commission suggested that the current wording of the Hospitals Act, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained. [Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf at 26.]

CANADIAN PSYCHIATRIC ASSOCIATION

The CPA believes that, when a patient has demonstrated a pattern of repeated nonadherence to treatment followed by decompensation to a level that requires involuntary inpatient admission, it may be clinically and ethically appropriate to take a preemptive approach to reduce the risk of serious harm to the patient and, although less common, to others. [Canadian Psychiatric Association, "Mandatory Outpatient Treatment, Position Paper" approved June 2, 2009 http://publications.cpa-apc.org/media.php?mid=912 at 2.]

Definition of mental disorder

JOHN GRAY *et al.*

p. 119 ... Broad definitions of mental disorder may be vulnerable to Charter challenges because they "appear unjustifiably vague and wide-ranging." A broad definition (any disease or disability of the mind) is in no way limited by diagnosis, severity or treatability, although the dangerousness criterion does address severity to a certain extent. ... To address the problems inherent in broad definitions of mental disorder [most provinces] now have similar, but not identical, specific definitions of mental disorder. ... There are three components to these specific definitions: the symptoms of the disorder, the consequences of these symptoms, and other exclusions or additions. ...

p. 124 ... Including the need for treatment in the definition of mental disorder performs the constitutionally virtuous function of further delineating and narrowing the scope of the potential deprivation of freedom. It also focuses on those whom many families, physicians and advocacy groups believe should be included, and those with disorders not treatable (e.g., mental

retardation and antisocial personality disorder) who should not. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 119-124.]

LAW REFORM COMMISSION OF NOVA SCOTIA

p. 33 ... The ULCC's Uniform Mental Health Act defines "mental disorder" as "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life." ...

... The Commission took the position that the ULCC definition of "mental disorder" is appropriate, being specific enough to provide guidance, but also general enough to allow flexibility in application.

p. 34 ... the Commission devoted considerable discussion to the question whether or not the definition of mental disorder (and therefore the criteria for involuntary admission) should include a requirement for the disorder's treatability. ...

p. 35 ... The lack of consensus among commentators illustrates the difficulty of attempting a definition of mental disorder that is acceptable to all. Given the lack of consensus, the Commission does not think it helpful to amend its proposed definition, either to include or exclude particular conditions. Rather, the Commission prefers a more general definition, which provides guidance by identifying the main possible symptoms of mental disorder, as well as the consequences of these symptoms, but which is adaptable to particular circumstances. [Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf at 33-35.]

ARCHIBALD KAISER

Although medical professionals need diagnostic tools to establish the existence and type of mental disorder, this necessity should not relegate the legislation to an entirely subsidiary role. There is an understandable tendency for review panels and judges to defer to professional expertise, but legislation must still state the policy requirements for the establishment of such a fundamental characteristic as a condition precedent to the invocation of state action. Considerable effort must be spent by lawyers and health professionals to ensure that any discussion of mental disorder fits within the statutory parameters, particularly where the concept of mental disorder is otherwise so expansive and comprehensive. Such vigilance may avoid the complete medicalization of what is still essentially a legal process.

The establishment of a statutory concept of mental disorder is but one fundamental building block. The degree of certainty on the basis of that concept must be considered simultaneously. The initial decision to invoke state authority to have a person transported for an examination must not be taken on the basis of a hunch or suspicion. Usually there must be reasonable and probable grounds to believe in the presence of disorder and dangerousness. ...

... For the later decision by a psychiatrist (or, for that matter, by a Review Board called upon to scrutinize a health professional's decision) to continue a person's detention beyond the initial period of observation, a higher level of certainty is often required, which is commensurate with the potentially longer nature of the patient's involuntary or formal status. ...

... Perhaps the best way of stating the level of care and amount of evidence required for such momentous decisions is to demand "... a preponderance of evidence of great cogency ..." establishing that this prerequisite of the statute [mental disorder] has been made out. [H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy,* Second Edition (Markham and Vancouver: Butterworths Canada Ltd., 2002) at 251-330 at 285.]

Dangerousness

JOHN GRAY *et al.*

It is recommended that the harm criteria include not just physical harm but also psychological, financial, emotional, vocational and other harms, resulting from untreated mental illness that significantly affect the person's life. From the human needs perspective, there is nothing special about physical harm as a committal criterion, either as a substantive or technical one (i.e., it is not inherently more accurate than broad harm criteria). Substantively, there is nothing inherently less concerning to individuals or society in non-physical harms than in physical harms. ... Technically, physical dangerousness criteria are probably less accurately assessed than broader harm criteria. Broad harm criteria, modified by treatability and other factors, can meet over breadth and vagueness criticisms. Finally, broad harm criteria can facilitate early treatment, essential to a good prognosis. People with a first psychotic episode can suffer greatly with severe non-bodily harm but never become physically dangerous. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 143.]

LAW REFORM COMMISSION OF NOVA SCOTIA

The majority of the Commission agrees with the appropriateness of the term "serious harm" as part of the involuntary admission criteria. "Serious harm" is a term which is easily understandable, flexible in its application, and acceptable under the Charter. The majority is also of the view that "serious harm" would take into account not only events about to happen immediately, but in addition, consequences which occur more gradually. As a result, use of the "serious harm" criterion would preclude the need for a deterioration or impairment standard. The medical profession and the courts would be entrusted to determine the contents of "serious harm." [Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf at 40.]

ARCHIBALD KAISER

p. 272 ... People with a mental disability can, on occasion be a danger to themselves or others. However, other people without such problems may present risks as well. The more critical issue is whether the often-assumed positive correlation between disorder and dangerousness should be so readily invoked or whether this association is yet another example of state action fuelled by mental disability prejudice. ...

p. 273 ... Given the inherent difficulties in conceptualizing and predicting dangerousness, one wonders what the proper role of the criterion is. The concern for dangerousness often speaks more of irrational fears than scientific criteria. ...

p. 289 ... The perennial argument between liberty and paternalism then arises. Those who would want the state to be most vigilant in its supervision of interventions would insist upon clear and convincing proof of the substantial certainty of imminent serious, perhaps life threatening, harm to the self or others. Those who prefer a mental health regime where confinement, examination, and treatment are made more readily available to help distressed individuals argue that society should more readily intervene. [H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy,* Second Edition (Markham and Vancouver: Butterworths Canada Ltd., 2002) at 251-330 at 272-273 and 289.]

Need for treatment

JOHN GRAY *et al.*

This criterion clearly establishes the purpose of involuntary hospitalization. It is, primarily, to facilitate treatment that addresses the health and safety needs of the person and society. It is not primarily for the protection of society or the individual through incarceration. A need for treatment criterion also links the admission into the treatment authorization provisions. If need for psychiatric treatment is a requirement for involuntary admission, it becomes harder to argue that treatment refusal should be allowed. The need for treatment criterion also makes committal criteria more "Charter-proof". It reduces possible over breadth and vagueness by determining, more precisely, who should and should not be involuntarily hospitalized. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 149-150.]

PETER CARVER

... Saskatchewan and Nova Scotia include treatment incompetence in the substantive criteria for involuntary hospitalization. This effectively avoids the consent to treatment dilemma. That is, any person who is treatment competent cannot be involuntarily hospitalized. The question of respecting or overriding a competent refusal does not arise. This model would seem to satisfy any Charter concerns. It does mean that competent persons with mental disorders who present a danger to others will not be committable. Only should they become incompetent, or commit an offence which brings them under the Criminal Code, will it be possible to detain them. A potential ambiguity in the approach adopted by Saskatchewan and Nova Scotia exists with respect to an individual committed to hospital on the basis of current incompetence, but who is then discovered to have given a competent refusal of treatment at an earlier, pre-committal time. [Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., Canadian Health Law and Policy, Third Edition (Markham: LexisNexis Canada Inc., 2007) at 399-436 at 419.]

Capacity

JOHN GRAY *et al.*

Another potential problem with the incapacity criterion is that, unless the standard for judging the capacity to make a valid treatment decision is set high, many people currently admitted will be refused admission on the grounds that they are capable of making a treatment decision. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 151.]

ARCHIBALD KAISER

Like the connection between mental disability and dangerousness, the link between disability and incompetence is also too readily made.

p. 277 ... The term "incompetent" can be used in the unusual situations where there has been proof of incapacity to a high level of certainty. Even then it should be applied only after great deliberation and with parsimony to specific decisions or functions, given the risk that the designation may be wrongfully permitted to describe a whole person. Intervention may be necessary at some point in order to safeguard vital individual or societal interests, but such intrusions must be crafted in a manner which assists the person to make as many of his or her own decisions as is possible, in order to help the individual achieve his or her highest potential. [H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy,* Second Edition (Markham and Vancouver: Butterworths Canada Ltd., 2002) at 251-330 at 275-277.]

CANADIAN PSYCHIATRIC ASSOCIATION

The CPA believes that it is inappropriate to compel a person who is capable of making treatment decisions to adhere to a plan of treatment in the community. However, the test for capacity in legislation must not be so low that patients with psychosis who are likely to exhibit harmful behaviour in the community are excluded. [Canadian Psychiatric Association, "Mandatory Outpatient Treatment, Position Paper" approved June 2, 2009 http://publications.cpa-apc.org/media.php?mid=912 at 4.]

- **Consent to treatment**

PETER CARVER

The question of whether competent involuntary patients should have the right in law to refuse psychiatric treatment is the most disputed issue in mental health law. ... Much of the debate over the consent issue is really a disagreement over whether there is ever such a thing as a competent refusal by an involuntary patient. Many people who oppose recognition of a right to refuse treatment believe that major mental illness makes it impossible for an individual to understand that he or she is ill and in need of treatment. In their view, only a naïve or shallow understanding of mental illness would suggest otherwise. Certainly, many persons who meet the criteria for involuntary admission to a psychiatric facility will lack treatment competence. Canadian law, however, rejects global assumptions about decision-making capacity. It views competence as a mutable quality that must be assessed with respect to the specific activity in question. A person may be incompetent for one purpose, such as making a will, but competent with respect to another, such as health care. As a consequence, and as a matter of principle, competence to consent to treatment must be assessed independently from the issue of whether the individual otherwise meets statutory criteria for involuntary status. A further complicating factor related to the consent issue is that a person may, during a period of competence, express a wish to refuse psychiatric treatment should he or she later become incompetent. ... In Canada, four distinct approaches to the question of consent to treatment can be identified. ... The approaches are:

(a) A right to refuse treatment (Ontario);
(b) No right to refuse treatment (British Columbia)
(c) A right to refuse, subject to a "best interest" override (Alberta, Manitoba)
(d) Excluding capable individuals from committal (Saskatchewan, Nova Scotia)

[Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., Canadian Health Law and Policy, Third Edition (Markham: LexisNexis Canada Inc., 2007) at 399-436 at 414-415.]

RIGHT HONOURABLE JUSTICE BEVERLEY McLACHLIN

Can we ever override a capable person's decision to refuse treatment? Who determines whether incapable persons should be medicated – physicians, a public official, a judge or perhaps a close relative? And how should that determination be made – do we try to make the decision that is in the person's "best interests" or should we seek to follow the wishes they expressed when capable?

Once again, the competing values of autonomy, treatment and protection are at play and the law in different provinces has adopted distinct approaches to deal with these issues. Forced treatment of a capable patient raises serious concerns with respect to liberty, physical integrity and equality. As the majority noted in Starson, *"The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy." Similarly, in* Fleming v. Reid, *Justice Robins of the Ontario Court of Appeal wrote that "Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs".*[39] *In the case of a mentally ill person who understands all relevant treatment information, as well as the benefits and risks of treatment, yet nevertheless refuses to consent, the interference with autonomy is great indeed.*

On the other hand stands the argument that not treating severely mentally ill persons on account of their refusal to consent represents a particularly impoverished understanding of their rights and civil liberties. It assumes that the "formal" autonomy rights of persons whose will and understanding are seriously impaired by illness should be preferred to their substantive freedom and to other fundamental rights and freedoms that continued mental illness denies them. Failure to treat may well result in permanent impairment of their right to be free from physical detention and their right to have a mind free from debilitating delusions, terrifying hallucinations and irrational thoughts. Although respecting a mentally ill person's decision to refuse treatment formally accords them equal treatment with non-mentally ill patients, abandoning such people to the torments of their illness, mental and physical deterioration, substance abuse and perhaps suicide surely does not respect their inherent dignity as human beings the argument concludes. [Right Honourable Beverley McLachlin, P.C., Chief Justice of Canada, "Medicine and the Law: the Challenge of Mental Illness" 2005 http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp at 11.]

CANADIAN MENTAL HEALTH ASSOCIATION

The consent dynamic is fundamental to the relationship between service provider and consumer. The right of the consumer to control treatment, often honoured more in the breach than the affirmation, exists as a fundamental precept of civil rights, self-respect and human dignity. [Canadian Mental Health Association, "Informed Consent to Treatment" December 1996 http://www.cmha.ca/bins/print_page.asp?cid=5-33-174&lang=1 at 1.]

WORLD HEALTH ORGANIZATION

Many individuals and organizations, especially user groups, object to combining involuntary admission and involuntary treatment and argue that a person's consent or refusal to admission and to treatment, are separate issues. Persons may require involuntary admission but not involuntary treatment, or, indeed, involuntary treatment without having to be placed outside their homes or communities. Moreover, it is argued that capacity is issue-specific, in that a person who is judged to be lacking capacity to make decisions regarding admission to a mental health facility may still retain the ability (capacity) to make decisions regarding treatment. It is argued that involuntary treatment violates fundamental human rights principles. For example, General Comment 14 to Article 12 of the ICESCR provides that the right to health includes the right to be free from non-consensual medical treatment ... [World Health Organization, "WHO Resource Book on Mental Health, Human Rights and Legislation" 2005 http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf at 48.]

SIMON DAVIS

The idea that patients committed to a psychiatric facility should have a (qualified) right to refuse treatment has been criticized, predominantly by clinicians. Several points have been raised. One is that, since the days of One Flew Over the Cuckoo's Nest, conditions in hospitals have improved, as have treatments, the latter with respect to both efficacy and side effects. A second argument is that the comparison with treatment refusal by nonpsychiatric patients is spurious since in the case of psychiatric patients the organ that is used to make decisions – the brain – is the very one impaired by illness. Another critic points to "the danger of advance directives being applied in a circumstance that a person could not foresee". Finally, perhaps the most compelling argument is that not offering treatment to a hospitalized patient may mean that the individual will have to be detained longer than would otherwise be the case and that further mental and physical deterioration, and greater risk to staff and other patients, will be the result. [Simon Davis, "The Legal and Ethical Context of Mental Health Practice" in Community Mental Health in Canada: Policy, Theory, and Practice (Vancouver: UBC Press, 2006) at 270-293 at 277.]

JACQUELYN SHAW

IPTA's s.39 empowers a substitute decision-maker to make treatment decisions for an involuntarily committed psychiatric patient using patients' prior capable informed expressed wishes, unless doing so endangers the patient's (or other's) "physical or mental health or safety", whereupon "best interests" are substituted. These words harbour radical negative effects: imposing treatment despite capable prior wishes displaces Canada's common law and legislation governing advance directives. Requiring only mentally but not physically ill persons to have medical decisions imposed upon them seems intuitively unacceptable and suggests blatant discrimination. ... This paper argues that IPTA s.39 violates the Canadian Charter of Rights and Freedoms s.15(1) equality guarantee. [Jacquelyn Shaw, "One Step Forward, Two

Steps Back: a Charter Analysis of s.39 of Nova Scotia's *Involuntary Psychiatric Treatment Act*" 2009 4(2) JEMH 1 at 1.]

HYDE REPORT

Recommendation #77

The legal requirements associated with obtaining consent to treatment should be rigorously adhered to by all health professionals. [Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf at 375.]

- **Confidentiality/access**

WORLD HEALTH ORGANIZATION

Persons with mental disorders have the right of confidentiality of information about themselves and their illness and treatment; such information should not be revealed to third parties without their consent.

... Persons with mental disorders should have a statutory right to free and full access to their clinical records maintained by mental health facilities and mental health professionals. This right is protected by general human rights norms...

p. 33 ... It is also important that health facilities have a staff member available to review and explain the information in the patient's file or record to the patient and/or legal representative. [World Health Organization, "WHO Resource Book on Mental Health, Human Rights and Legislation" 2005 http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf at 32-33.]

JOHN GRAY *et al.*

The purpose of a medical record is to facilitate treatment and the continuity of care. Its contents must be protected in the patient's best interests. However, in addition to an interest in releasing information only to those he or she wants, the patient has an interest in having safe, effective and timely treatment. Without information in the record being disclosed in a timely fashion, the treatment may be dangerous (e.g., allergies) or compromised. A number of advocacy organizations and coroners' juries have complained that rules of confidentiality, whether they be imposed by the Mental Health Act, other legislation or codes of professions, can work against the best interests of the person with the mental illness. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 384.]

LAW REFORM COMMISSION OF NOVA SCOTIA

For the reason expressed in the Discussion Paper, namely that a person should have access to all relevant information relating to his or her admission to a facility, the Commission recommends that copies of relevant police reports should be included in a patient's psychiatric file. [Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf at 47.]

HYDE REPORT

Recommendation #46

The Province should be addressing in the context of its proposed Personal Health Information Act (Bill 64) and the development of its electronic health record system – SHARe (Secure Health Access Record), the issues of confidentiality and privacy rights, consent, disclosure and stigma as they specifically relate to the health care records and needs of mental health service users and persons in custody, and consulting with the affected constituencies and mental health service providers. p. 366

Recommendation #47

District Health Authorities and the Mobile Mental Health Crisis Team should have available for clients information on advanced care/consent directives to assist persons with mental illness who are interested in putting either of these measures in place.

Commentary:

The Canadian Mental Health Association and the Schizophrenia Society of Nova Scotia proposed that advanced care and advanced consent directives could benefit persons with mental illness who anticipate the possibility of a crisis. The Consensus Project also advocates the use of "... advance planning [directives] relating to any future contacts with the criminal justice system. Individuals who have had previous contact with the law or individuals whose behaviours put them at significant risk should be offered the opportunity through the mental health system to indicate consent for sharing of certain information."

The Consensus Project suggests: "If possible, [mental health staff] should set up protocols that can enable an appropriate flow of information to law enforcement, detention, and other criminal justice personnel while preserving the confidentiality and privacy of individuals in the system." The caution is sounded that information about a prisoner's mental illness should "not be used to jeopardize a person's rights in criminal

proceedings." This suggests that independent legal advice may be needed in some cases before advanced consent directives concerning mental health information are signed. p. 367-368

Recommendation #72

Police agencies and health authorities should work together to establish a communication protocol that would alert police when an arrestee or an accused who was detained in hospital under the Involuntary Psychiatric Treatment Act is being released. If required, a Ministerial Authorization permitting health authorities to disclose this information to police should be prepared. Such an Authorization should limit the release of health information to permitting health authorities to inform the relevant police agency that the person is being discharged from hospital.

Commentary:

The Attorney General, the Nova Scotia Government and General Employees Union, Inquiry Counsel, and the Halifax Regional Police Service all proposed that information about discharge of an accused from involuntary committal should be made available to police. The evidence indicated that police have a concern about an arrestee not yet subject to any charges or release conditions being discharged from hospital, for example, in a case of domestic assault, and the police having no knowledge of this. p. 374 [Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf.]

- **Repetitive admissions**

NAWAF MADI *et al.*

In 2003-2004, 37.0% of patients with mental illness discharged from acute care hospitals were readmitted within a period of one year, compared with 27.3% of patients discharged with a non-mental illness. The findings also suggest that the probabilities of readmission were higher among older individuals and among individuals who had longer stays in hospital.

Although other settings (such as community and primary care) may be more regularly used in the treatment of mental illness, for those whose mental illness requires hospital care, multiple hospitalizations are not uncommon. Those whose primary diagnosis was a mental illness had a higher probability (15.0%) of being readmitted more than once within a year of an index discharge than those with a non-mental illness (9.9%). (p.30)

...

Unplanned readmissions for mental illness to hospital are generally considered undesirable events that often indicate relapse. Although not necessarily a reflection on the quality of the hospital care, they may reflect on the effectiveness of the system of mental healthcare as a whole.

For instance, hospital readmission rates for mental illness have been linked to the adequacy of discharge planning and transitional services, the availability and access to community and outpatient treatment services, the availability of social and family support systems, patient characteristics such as treatment-refractory illness, the adherence to prescribed medications and the co-occurrence of substance-related disorders. (p.31) [Nawaf Madi, Helen Zhao and Jerry Fang Li, "CIHI Survey: Hospital Readmissions for Patients with Mental Illness in Canada" Healthcare Quarterly Vol.10 No.2 2007 30-32 at 30-31.]

CANADIAN PSYCHIATRIC ASSOCIATION

Providing consistent care and treatment for so-called revolving-door patients has proved to be one of the major challenges of deinstitutionalization. Psychiatrists frequently encounter patients who respond to a course of treatment in hospital with remission of acute symptoms but who do not recover insight into the pathological nature of their illness. As a consequence, the patient repeatedly defaults from treatment when discharged from the structured environment of the hospital. Refusal of treatment in turn leads to a deterioration of the patient's clinical condition, which ultimately results in involuntary rehospitalization. [Canadian Psychiatric Association, "Mandatory Outpatient Treatment, Position Paper" approved June 2, 2009 http://publications.cpa-apc.org/media.php?mid=912 at 2.]

- **Community options (community treatment orders, leave certificates)**

SIMON DAVIS

The use of outpatient certification remains an issue that has produced strong divisions of opinion. Supporters argue, as noted above, that community treatment orders are effective in reducing rates of rehospitalization, a claim that seems to have some empirical support, and that they are, by definition, less restrictive than hospitalization since the person remains in the community. ...

On the other hand, critics have raised a number of concerns. One has to do with the implication, and stereotype, that the mentally ill are so dangerous that they need tight controls. ... Another criticism concerns resource availability, with some suggesting that the move to community treatment orders is a cynical way of trying to deal with the fact that there are insufficient treatment and rehabilitation services in place... Others have challenged the claim that outpatient certification is in fact "less restrictive," pointing to the indefinite length of the orders. There have also been concerns among mental health practitioners about the extra pressure on hospital beds if patients are "recalled," and about how community orders change the therapeutic relationship when the policing function of the worker's role necessarily becomes emphasized. [Simon Davis, "The Legal and Ethical Context of Mental Health Practice" in Community Mental Health in Canada: Policy, Theory, and Practice (Vancouver: UBC Press, 2006) at 270-293 at 279-280.]

PETER CARVER

... The idea [with CTOs] is to break the connection between involuntary hospitalization and non-consensual psychiatric treatment, and by addressing the problem of treatment non-compliance to keep persons healthy and in the community. It is worth asking, however, whether the extension of coercive mental health measures from the hospital into the community is either necessary, or consistent with the idea that the community represents a better alternative to institutional care, espoused by, among others, the Senate in Out of the Shadows at Last. ...

p. 421 ... Patients' groups have consistently criticized CTOs as an unnecessary and intrusive mechanism that stigmatizes persons with mental illness as needing to be subject to state control, even in the community. Apart from the argument over stigma, there are reasons for questioning whether the CTOs are capable of meeting the goals intended by proponents. The problem of non-compliance with psychiatric treatment by persons living in the community is a complex one, and it remains unclear whether the CTO can succeed in addressing it by compulsion. ...

p. 422-423 ... The leave of absence approach has advantages over the more complex CTO. The starting place is hospital and in-patient treatment, rather than an effort to enforce compliance on an individual living in the community who may not meet standard committal criteria.

A concern from a civil liberties perspective about leaves of absence is that they might too easily be used as a means of retaining control over individuals who, in fact, no longer meet the criteria for involuntary committal. To date, however, Canadian courts have not been receptive to this argument. [Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., Canadian Health Law and Policy, Third Edition (Markham: LexisNexis Canada Inc., 2007) at 399-436 at 420-423.]

III. ROLE OF SUBSTITUTE DECISION-MAKER

- **Voluntary/incapable**
- **Involuntary**

JOHN GRAY *et al.*

The advantage is that the director [of the psychiatric facility] is one step away from the treating physician, will usually have built up considerable expertise in making these decisions [authorizing treatment], and is concerned with getting the patient well and out of hospital, whereas this may not be the motive for a family who has spent considerable effort getting the person into hospital. If the director is a psychiatrist, he or she has more expertise than a lay decision-maker in detecting treatment plans that may be out of the ordinary...

... Some U.S. state courts have concluded that a relative consenting to or refusing treatment is not adequate protection because families are inherently biased, in the legal sense of that word.

... Some relatives have considerable experience with what is and what is not an appropriate psychiatric treatment plan because they have seen the person's symptoms and the treatment effects and side effects many times. They can, therefore, be very helpful in providing information to assist in making an optimal treatment plan authorization, or make a decision that protects from treatments that may not have worked in the past. However, no matter how experienced, relatives are not psychiatrists and there may be a bias in their decisions. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 379-381.]

PETER CARVER

... This approach [director of a psychiatric facility authorizing treatment] ensures that treatment can be provided to involuntary patients with a minimum of procedural delay. Given that it involves the clearest denial of a right to consent to treatment, it might seem the most vulnerable to Charter challenge on Fleming-like grounds... [Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., Canadian Health Law and Policy, Third Edition (Markham: LexisNexis Canada Inc., 2007) at 399-436 at 418-419.]

ARCHIBALD KAISER

A few jurisdictions provide a statutory scheme with far fewer limits on involuntary interventions. Various actors or institutions are empowered to make such vital decisions, with fewer protections of patient autonomy and emphasis being placed upon authorizing required treatment. [H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy,* Second Edition (Markham and Vancouver: Butterworths Canada Ltd., 2002) at 251-330 at 299-300.]

JOHN GRAY *et al.*

This section has shown that in some ways substitute decision legislation, especially guardianship legislation, can be more powerful than a Mental Health Act in the sense that it can be used to involuntarily admit a person to a psychiatric facility who could not be admitted under a Mental Health Act. Some people question the need to have a Mental Health Act. For example, Gordon's article, "Out to Pasture: A Case for the Retirement of Canadian Mental Health Legislation", argued that mental illness was just like any other illness that causes incapacity and, therefore, should be addressed under the same legislation. Others share that view.

... If, as Gordon stated, the function of Mental Health Acts can be replaced by this other legislation, why has it not happened? Bureaucratic lethargy, costs of guardianship, lack of knowledge and other factors may be the reason. Another plausible reason may be that these mechanisms are not seen as use-friendly to set up and apply by patients, families or providers. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 329.]

IV. ROLE OF HEALTH CARE PROVIDER

- Institution
- Psychiatrists
- Other health care providers

See also Role of Substitute Decision-Maker and Impact on Patients

LAW REFORM COMMISSION OF NOVA SCOTIA

The Commission remains of the view that health care professionals with sufficient education and experience should be able to make a determination about a person's capacity to consent to treatment. This proposal is not meant to replace the role of psychiatrists; rather, by expanding the range of health care professionals permitted to complete a capacity assessment, it can free psychiatrists to fulfill other responsibilities. [Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf at 56.]

HYDE REPORT

Recommendation #14

The Department of Health should explore alternate means of delivering mental health care and treatment in order to provide greater access to mental health services. Greater use could be made of nurse practitioners specializing in psychiatric issues, in community-based, mental health clinics. Individual psychiatrists could provide consultation services for family medicine practice groups. [Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf at 355.]

V. ROLE OF PATIENT ADVISOR

- **Advisor vs. advocate**
- **Funding**

JOHN GRAY *et al.*

It has been argued by some advocacy groups for people with schizophrenia that rights information provided by a paralegal system, unlike rights advice provided by hospital staff, is sometimes anti-therapeutic. It has been said that the paralegals or lawyers are not sufficiently trained to communicate with people in acute schizophrenic crises, so people are left with the impression that lawyers help get people out of hospitals rather than help patients cooperate with treatment. It is contended that some paralegals have an anti-psychiatry bias. They are said to encourage patients to resist treatment thus prolonging detention and worsening long-term prognoses. ...

p. 350-351 If rights advisors are not bound by the hospital ethic of healing but instead by the lawyers' obligation to assist their client to pursue their legal rights, it is not difficult to see that time might be spent fighting over the patient's treatment needs where they conflict with what the person wants. ... It is recommended that, as in Nova Scotia and Newfoundland and Labrador, rights advisors be required to "communicate in a neutral, non-judgmental manner". Otherwise the purpose of the Act could be vitiated. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 349-351.]

LAW REFORM COMMISSION OF NOVA SCOTIA

*... Most comments received expressed the view that rights advisers at each psychiatric facility are not required. Some commentators took the position that though that (*sic) *idea of rights advisers was appropriate generally, this position should not be restricted to psychiatric facilities. ... It was also suggested that rather than creating the position of rights adviser, appropriately trained nursing staff could fill this role. Other commentators, however, thought that rights advisers were necessary, not only to provide advice on rights, but to help patients to actually act upon the advice given, in order to attain what the patient wants to achieve.* [Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf at 103.]

REVIEW BOARD UNDER IPTA

Under section section (sic) 71(2) of IPTA where the patient is unable or unwilling to attend a hearing and has not appointed someone to act on the patient's behalf, the Review Board shall appoint a representative to attend the hearing and act on behalf of the patient. The question which has arisen for the Review Board is who should be appointed? The substitute decision

maker is a party to the hearing and is often not necessarily the person to best represent the patient. Lawyers will only represent clients if they are able to receive instructions and will not represent a patient if the patient does not wish to participate. This leaves the patient rights advisors who do not, at present, have the mandate to perform such duties.

The Review Board is of the view that in the absence of advocates who can represent involuntary patients that the patient rights advisors be alerted to this responsibility and trained to represent these patients. [Annual Report, Review Board under the Involuntary Psychiatric Treatment Act, July 3, 2007 – March 31, 2008, p.9]

VI. ROLE OF POLICE

- **Apprehension**
- **Criminalization of mental illness**

JOHN GRAY *et al.*

p. 163 ... The human needs perspective suggests that apprehension and transportation should not be limited to the police on humanitarian, stigma and economic grounds. Where it can be accomplished safely, having friends transport the patient is much less traumatizing and stigmatizing than involving the police. If this is not possible, the ambulance, the mode of transport for other medical conditions, would appear to be the next logical option. Only if these options cannot safely transport the patient should the police be involved. ...

p. 169 ... Nova Scotia is the only jurisdiction which allows apprehension by a police officer under mental health legislation if the person with an apparent mental disorder "is committing or about to commit an indictable offence" as an alternative to having to meet the physical harm or deterioration criteria. This provision... has the potential advantage of diverting people with a mental illness from the criminal justice system. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008).]

ARCHIBALD KAISER

Less commonly used as a way of ensuring a first diagnostic exposure is the ability of police officers to arrest without warrant a person who is presently a danger to the safety of himself or herself or others, and who is apparently mentally disordered, for the purpose of taking the citizen to a hospital for examination. This route is of real practical significance for police officers presented with situations involving a coalescence of some danger and apparent mental disorder. Although it would be unrealistic to expect that such decisions by police officers could always be informed by the judgement of an accompanying mental health professional, the recommendation of Gray et al. for legislative reform seems sound: "Where reasonably

practicable the police officer shall enlist the aid of a mental health professional in making the decision to apprehend."

For any formulation of a police intervention power to work effectively, police services must provide proper training for their members, and mental health professionals must have both well-structured working relationships with police and a knowledge of policing practices and procedures. [H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy,* Second Edition (Markham and Vancouver: Butterworths Canada Ltd., 2002) at 251-330 at 283.]

HYDE REPORT

p. 309 ... Supports and services in the community are essential to ensuring that people with mental illness can sustain themselves and their mental health outside of an institutional setting. Extra supports in the community have been lacking and "...the stop-gap has been that we criminalize people..."

p. 314 ... Access to services in the community such as safe, affordable and supportive housing has been shown to dramatically reduce involvement in the justice system, psychiatric hospitalization and emergency department visits.

The Inquiry also heard that reliance on coercion to gain treatment compliance from persons with mental illness is less likely to have a positive response from service users. Personal autonomy is infringed by a coercive system for securing compliance: where the forensic system is engaged, the available services are accessed through criminalization. [Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf.]

JUDE HALL

The high frequency of contact between police and persons with mental illness naturally leads to a questioning of what factors have contributed to this phenomenon. The predominant theory well advanced in the literature, both in Canada and the US, is generally known as the "criminalization of the mentally ill" phenomenon. The basic theory states that, with the deinstitutionalization of the mentally ill in the last fifty years, stricter civil commitment criterion in modern legislation, and a lack of community-based accessible mental health services, there are more persons with mental illness living in the community, many of whom find it difficult to integrate into society and for various reasons run afoul of the law. This analysis may be an over-simplified theory, given the complexity of mental health issues and the provision of societal resources dedicated to serving persons with mental illness. Despite the extent to which the theory has been discussed in the past, there appears to be no authoritative study, theory, or series of factors that can reliably explain why the incidences of police encounters with persons with mental illness, and their subsequent interaction with the criminal justice system, are so prevalent in a modern context. [Jude Hall, "Frontline Providers of Mental Healthcare: The Role

of Police Officers in Involuntary Psychiatric Assessments Under the Mental Health Care and Treatment Act." (2010) 19 Dalhousie J. Legal Stud. 107 at 114.]

LAW REFORM COMMISSION OF CANADA

It is not enough to say that the mentally ill should be diverted from the criminal process. Every departure implies an arrival and persons who leave the criminal process arrive somewhere else – possibly the community or another process. For the mentally disordered accused the other process is the mental health system and the vehicle of introduction can be involuntary civil commitment.

Diversion is intended to encourage community based solution of problems. This implies something more than simply shuffling individuals from one form of detention (criminal) to another (medical). It implies the use of community resources and community understanding to resolve problems within the community. The effect of diverting from the criminal process should not be to increase the use of civil commitment. [Law Reform Commission of Canada, Working Paper No. 14, "The criminal process and mental disorder", 1975 at 27.]

VII. ROLE OF REVIEW BOARD

- **Substantive**
- **Procedural**

LAW REFORM COMMISSION OF NOVA SCOTIA

The main function of a review board is to review the involuntary status of patients detained in psychiatric facilities. Since voluntary patients are not officially detained and are able to leave a facility if they choose, most provincial and territorial mental health statutes do not provide voluntary patients with a right of review. ...

p. 87 ... A review board is also able to provide recommendations respecting the treatment or care of a patient. These recommendations, however, are not binding on the parties. In other jurisdictions... the orders of review boards are binding on the parties.

... In general, it would not be appropriate for a review board, even one which included a psychiatrist, to substitute its opinion on treatment for that provided by a mental health care professional who was able to take sufficient time to assess a patient and monitor any changes in his or her condition. The Commission was also concerned that if a review board could provide an order about treatment, the review process would become unduly delayed by applications for review. As a result, the Commission suggested that in relation to treatment and care, review boards for the most part should continue to provide only non-binding recommendations. [Law

Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf at 86-87.]

JOHN GRAY *et al.*

From a human needs perspective, much can be said in favour of adopting an investigative approach. The investigative approach recognizes that it is the patient who has lost his or her liberty and who is entitled to be heard, and that the hospitalization may have an inhibiting effect on the patient's ability fully to prepare and make out his own case. The duty of the review board to inquire into all the facts operates for the protection of the patient and the benefit of society. Unnecessary and undesirable contention is avoided because the physician and hospital are not placed in the counter-therapeutic position of appearing as the patient's adversary. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 361.]

SIMON DAVIS

The most common method by which a patient may challenge certification is by an application to a review board or panel, which is available in all Canadian jurisdictions (except the Northwest Territories, where a court performs this function). The review board is supposed to function as an independent tribunal, which does not cost the patient anything and which is normally less formal than a court hearing. The composition of, and procedures used by, these boards vary somewhat from jurisdiction to jurisdiction. In some provinces periodic reviews of detention are mandatory.

A number of empirical studies of the review board process have been conducted in Canada. One survey of Ontario hospitals, for example, found that while only 9 percent of review board applications resulted in the certificate being rescinded, in 25 percent of cases the treating physician changed the patient status to voluntary after an application was made, suggesting – perhaps – an aversion to dealing with the "red tape" of tribunal proceedings. Data from British Columbia show that in 2004 patients successfully appealed their detention in 23 percent of cases when the appeal was heard; however, two-thirds of review applications never got to that stage, being suspended, rejected, or cancelled instead. [Simon Davis, "The Legal and Ethical Context of Mental Health Practice" in Community Mental Health in Canada: Policy, Theory, and Practice (Vancouver: UBC Press, 2006) at 270-293 at 280-281.]

JOHN GRAY *et al.*

The major issue concerning reviews by a review board or appeals to the court is whether treatment that has been authorized stops if a treatment-related review or appeal is launched. ... From a clinical and humanitarian point of view, and a Charter point of view, such an unnecessary deprivation of physical and psychological liberty (in the case of a deluded patient) and continuation of suffering is of great concern. This is especially true because a patient

deciding to apply for review or seek an appeal, unlike a person making a treatment decision, does not have to be capable of making a decision to exercise such a right. [John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008) at 258.]

LORA PATTON

The procedural rights established in the MHA [Mental Health Act, Ontario] allow a person to be fully informed of actions taken against him or her, how it will impact on his or her life, and provide a process to challenge the state's decision. These rights ensure that the MHA conforms to constitutional standards and also establishes an individual's value in society by confirming his or her very personhood and dignity. The intrinsic importance of the individual's rights under the MHA requires a committed effort to ensure they are upheld in every circumstance. Where rights fail, the values implicit in our constitution are devalued.

The weight that should be afforded to procedural rights under mental health law has been disputed. In part, those who downplay the role of rights point out that the purpose of the legislation is the "treatment of the mentally disordered who need protection and care." It is true that doctors as caregivers, are the primary actors for the state in civil commitment and medical care remains a significant issue to be addressed. Yet even those who would de-emphasize the importance of an individual's ability to fully participate in decisions made about them concede that legislation must balance care and protection against rights. Despite the almost universal acceptance of the need to protect individuals from improper state action, the practice of commitment in Ontario is significantly different from that which is carefully set out in the text of Ontario's Mental Health Act. [Lora Patton, "These Regulations Aren't Just Here to Annoy You: The Myth of Statutory Safeguards, Patient Rights and Charter Values in Ontario's Mental Health System (2008) 25 W.R.L.S.I. 9 at 13.]

VII. OTHER

- **Time frames**

LAW REFORM COMMISSION OF NOVA SCOTIA

p. 27 ... The Commission took note of the concern among a number of commentators, and in particular medical professionals, that the 24 hour period, suggested in the Discussion Paper for completion of an assessment, was not long enough. The Commission wishes to clarify that it had in mind in this context the time period for completion of an examination and not an assessment. In an ideal world, 24 hours would be a preferable standard, but this would not always be realistic. The Commission recommends instead that a period not to exceed 48 hours for completion of an examination by a psychiatrist would be a better standard, one which strikes a

balance between minimizing infringement on personal freedom and the need to conduct a complete examination based on sufficient information.

p. 50 ... If renewal periods are too short, it was suggested, then too many resources could be devoted to the review process. For instance, the Commission thought that as far as possible, psychiatrists should be involved in evaluating and treating patients, rather than being occupied with reviews. The Commission also cautioned, though, that if renewal periods are too long, in light of current psychiatric practice and available resources,
then some patients may spend more time in hospital than is warranted. [Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf.]

REFERENCES

Texts, chapters, articles

Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., Canadian Health Law and Policy, Third Edition (Markham: LexisNexis Canada Inc., 2007) at 399-436.

Simon Davis, "The Legal and Ethical Context of Mental Health Practice" in Community Mental Health in Canada: Policy, Theory, and Practice (Vancouver: UBC Press, 2006) at 270-293.

John E. Gray, Margaret A. Shone and Peter F. Liddle, Canadian Mental Health Law and Policy, Second Edition (Markham: LexisNexis Canada Inc., 2008).

Jude Hall, "Frontline Providers of Mental Healthcare: The Role of Police Officers in Involuntary Psychiatric Assessments Under the Mental Health Care and Treatment Act." (2010) 19 Dalhousie J. Legal Stud. 107.

H. Archibald Kaiser, "Mental Disability Law" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy,* Second Edition (Markham and Vancouver: Butterworths Canada Ltd., 2002) at 251-330.

H. Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L.J. 139-194.

Nawaf Madi, Helen Zhao and Jerry Fang Li, "CIHI Survey: Hospital Readmissions for Patients with Mental Illness in Canada" Healthcare Quarterly Vol.10 No.2 2007 30-32.

Right Honourable Beverley McLachlin, P.C., Chief Justice of Canada, "Medicine and the Law: the Challenge of Mental Illness" 2005 http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp.

Lora Patton, "These Regulations Aren't Just Here to Annoy You: The Myth of Statutory Safeguards, Patient Rights and Charter Values in Ontario's Mental Health System (2008) 25 W.R.L.S.I. 9.

Jacquelyn Shaw, "One Step Forward, Two Steps Back: a Charter Analysis of s.39 of Nova Scotia's *Involuntary Psychiatric Treatment Act*" 2009 4(2) JEMH 1.

Bob Symonds, "The philosophical and sociological context of mental health care legislation" (1998) 27 J of Advanced Nursing 946-954.

Position papers

Canadian Mental Health Association, "Informed Consent to Treatment" December 1996 http://www.cmha.ca/bins/print_page.asp?cid=5-33-174&lang=1.

Canadian Psychiatric Association, "The Role of Mental Health Legislation, Position Statement" approved April 10, 2005 http://publications.cpa-pc.org/media.php?mid=196.

Canadian Psychiatric Association, "Mandatory Outpatient Treatment, Position Paper" approved June 2, 2009 http://publications.cpa-apc.org/media.php?mid=912.

Reports

Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf.

Law Reform Commission of Canada, Working Paper No. 14, "The criminal process and mental disorder", 1975.

Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf.

Annual Report, Review Board under the Involuntary Psychiatric Treatment Act, July 3, 2007 – March 31, 2008.

International documents

World Health Organization, "Mental Health Legislation and Human Rights: Mental Health Policy and Service Guidance Package" 2003 http://www.who.int/mental_health/resources/en/Legislation.pdf.

World Health Organization, "WHO Resource Book on Mental Health, Human Rights and Legislation" 2005 http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf.

APPENDIX D

Gérard V. La Forest
320 University Avenue
Fredericton, NB
E3B 4J1

October 25, 2011

Kevin McNamara *Via mail and email* **Kevin.McNamara@gov.ns.ca**
Deputy Minister
Nova Scotia Department of Health and Wellness
Joseph Howe Building
1690 Hollis Street
Halifax, Nova Scotia B3J 2R8

Dear Mr. McNamara:

Re Data Issues Related to Planning for the
Review of the Involuntary Psychiatric Treatment Act (IPTA)

As you are aware, the Department of Health and Wellness has engaged me to provide advice and recommendations regarding the approach to be taken to the statutory reviews under IPTA which commence in July 2012. In the discharge of this mandate, it is contemplated that I make recommendations on actions to be taken by the Department of Health and Wellness and/or the mental health system of Nova Scotia to prepare for the conduct of the reviews.

Recommendations concerning data and informational needs will form part of my final report to the Department in January 2012. A task for the Review itself may be to further identify information that is important to gather or that should be tracked for the ongoing administration of the Act. This task may require expertise in epidemiology and statistics. At this pre-planning stage, I have identified key pieces of information that will be relevant to the IPTA review. Given the challenges that may be involved in gathering relevant information for the review, and the critical timeliness regarding the collection of data, I felt it important to draw these matters to your attention at this time.

As indicated in the work plan I submitted on February 11, 2011, I continue to work to identify data and sources of data relevant to the reviews. Through these efforts I have identified two main matters that may benefit from early consideration and action by the Department to ensure relevant data is available for the reviews: (1) collection of information within the health system relevant to the functioning of the Act; and (2) collection of information from outside of the health system. Below, I discuss each matter

briefly in turn and make recommendations for Departmental action to prepare for the reviews.

(1) Information within the health system relevant to the functioning of the Act

The review will need to evaluate how the Act functions on the ground. Analyzing information that is contained in the Forms prescribed in the IPTA Regulations ("IPTA Forms") will be one important aspect of this evaluation. I understand that the Department collects some of the information in the IPTA Forms for the purposes of supporting the work of the Review Board. The information in the IPTA Forms that the Department currently does not collect will be helpful when the review considers a variety of issues including those related to assessments; changes in patient admission status; the use of the new 'deterioration' criteria for involuntary admission; and patient rights protections.

Please refer to Appendix A which identifies the IPTA Forms, whether they are presently collected, and examples of relevance for the review.

Recommendation #1: ***I recommend that the Department collect the information in all of the IPTA Forms.***

In addition, there is information that is not collected in the ITPA Forms that would be of use.

IPTA allows for an incapable patient to be admitted as a voluntary patient with the consent of a substitute decision-maker. The review will need to identify how often this situation occurs and consider whether there are implications for patient rights in that the patient may remain in hospital for an extended period of time without the benefit of the rights ascribed to involuntary patients.

Recommendation #2: ***I recommend that the Department collect core information about patients admitted to a psychiatric facility as voluntary patients and whether they are capable or incapable to make admission and treatment decisions.***

All involuntary patients and incapable voluntary patients require a substitute decision-maker under IPTA. It will be helpful to understand the relationship between the patient and the substitute decision-maker as well as how the substitute decision-maker was chosen (i.e., were they chosen from the statutory hierarchy or were they appointed in a personal directive?).

Recommendation #3: ***I recommend that the Department collect information about the relationship of the substitute decision-maker to the patient and how the substitute decision-maker was chosen.***

For review of the Act, it would be highly beneficial to have the information identified in the above three recommendations for the five-year period during which IPTA has been in operation. If retroactive collection of information is viewed as too difficult or costly, the Department at minimum should begin collecting the information as soon as possible, and certainly before the review commences its work. For review of community treatment orders, section 59(2) of IPTA mandates that the review utilize data collected for the entire five-year period.

(2) Information from outside of the health system

The health system is not the only system engaged in the operation of IPTA. Of particular significance is the role of the police under IPTA. I understand that some police forces may collect information about their officers' exercise of authority under the Act. It does not appear that this information is presently reported to the Department.

Specifically, the police are authorized under section 14 of IPTA to take a person into custody for the purposes of having the person undergo a medical examination. It will be important to know how often the police exercise this authority and upon which of the three section 14 criteria they base their decision. This information, when combined with information about assessment and admission, will help the review address the question of whether police are appropriately applying the criteria and the frequency with which they bring individuals to hospital for assessments. In addition to the value of this information to the review, I understand some police forces may be interested in this information to help them evaluate the effectiveness of their training.

It will also be valuable to know how often the police exercise other authority under the Act, including taking a person into custody for breach of a certificate of leave or breach of a community treatment order. This information will help address the question of how often the police are being engaged and provide a basis for considering the implications of the role of the police in enforcing orders under IPTA.

I understand that gathering the policing information may require negotiation with police forces. People experiencing a mental disorder often come in contact with the police, either as a first step into the IPTA regime or as a consequence of an action taken pursuant to IPTA. As such, it is important for the review to examine the role of the police and their interactions with patients.

Recommendation #4: *I recommend that the Department talk with police forces across the province to determine what information they collect and how it might be made available for the review.*

Closing Remarks

I continue to work towards the development of my recommendations to you on the approach to be taken to the reviews mandated by IPTA. I anticipate other recommendations concerning informational needs may form part of my final report to the Department in January 2012. As indicated earlier in this letter, I felt it important to draw these two matters to your attention at this time so that the Department could consider taking action at an early stage. I would be pleased to discuss the recommendations in this letter should you wish.

Yours sincerely,

Gérard V. La Forest

Appendix A – Relevance of IPTA Forms for the Review

Form Number and Title	Presently Collected by the Department?	Examples of Relevance for the Review
Form 1 – Detainment of Voluntary Patient	No	There is concern that the status of patients is switched between involuntary and voluntary too frequently and in questionable circumstances. The information in this form may help address the question of whether patient status is being appropriately determined and whether there are patterns of improper status changes. This issue has potential implications for the Charter rights of psychiatric patients whose rights under IPTA are determined by their admission status. The information in Form 1 should be considered in combination with the data identified above about voluntary admissions and whether the patient is capable or incapable.
Form 2 – Medical Certificate for Involuntary Psychiatric Assessment – Part 1	No	It will be useful to track how many assessments result in involuntary admissions. It will also be important to track whether the criteria of 'deterioration,' which is new to IPTA, is being used as a trigger for an assessment.
Form 3 - Medical Certificate for Involuntary Psychiatric Assessment – Part 2	No	It will be important to track how often assessments are triggered without the involvement of a second physician.

Form Number and Title	Presently Collected by the Department?	Examples of Relevance for the Review
Form 4 – Declaration of Involuntary Admission	Yes for patients that are admitted for 60+ days or who have requested a hearing with the Review Board.	Collecting the information in this form for all patients will help address a number of issues that the review must consider. It will help track how many patients are admitted and their lengths of stay. It will help the review understand when and how the new 'deterioration' criteria is being used. It will also help address whether there are patterns of patients switching between voluntary and involuntary status, which, as indicated earlier, may have implications for patient rights, including the right to a hearing. The information in the form may also identify the patient's primary diagnosis, although I understand this information may be accessed through other databases such as the Discharge Abstract Database.
Form 5 – Declaration of Renewal of Involuntary Admission	Yes for patients that are admitted for 60+ days or who have requested a hearing with the Review Board.	Collecting the information in this form for all patients will help address the question of how many patients are admitted between 30-59 days and thus do not have an automatic right to a hearing. The information on the form will also be important for tracking the use of the 'deterioration' criteria.
Form 6 – Declaration of Change of Status	Yes for patients that are admitted for 60+ days.	The information in this form works in concert with the information in Form 4 to help address the concern of whether patients are being switched between voluntary and involuntary status in questionable circumstances.
Form 7 - Certificate of Leave	Yes	The review will need to consider how often the Certificate of Leave is used and in what circumstances. The information in this form will assist in addressing these issues.

Form Number and Title	Presently Collected by the Department?	Examples of Relevance for the Review
Form 8 - Certificate of Cancellation of Leave	Yes	The information in this form identifies the reason for cancelling the Certificate of Leave which may help the review understand why Certificates of Leave are being cancelled but also why they may or may not be used in the first place.
Form 9 - Community Treatment Order	Yes	Section 59(1)(a) of IPTA requires that the Minister undertake a review of whether community treatment orders were or were not used during the review period. The information in this form will address that statutory requirement.
Form 10 - Renewal of Community Treatment Order	Yes	Section 59(1)(b) of IPTA requires that the Minister undertake a review of the effectiveness of community treatment orders during the review period. The information in this form may provide some insight into that issue.
A- Form 11 A,B,C – Revocation of Community Treatment Order no longer meets criteria B- patient breach of order C- services not available in community	Yes	Section 59(1)(b) of IPTA requires that the Minister undertake a review of the effectiveness of community treatment orders during the review period. Understanding the reasons why community treatment orders are revoked may be one aspect of evaluating the effectiveness of community treatment orders.

Form Number and Title	Presently Collected by the Department?	Examples of Relevance for the Review
Form 12 - Request for Review	Yes	The information in this form will help the review understand why a hearing is requested and who is making the request. This information can be considered in combination with how many requests result in a hearing and what are the outcome of those hearings to gain a fuller appreciation of the Review Board process.
Form 13 – Notice of Hearing	Yes	The information in this form will help the review consider whether timelines specified in the Act are being adhered to. This information can be considered in combination with the information in Form 12 and data regarding procedural aspects of hearings to gain a fuller appreciation of the operation of the Review Board.

SELECTED REFERENCES

Legislation (including related regulations)

Nova Scotia

Adult Protection Act, R.S.N.S. 1989, c.2.

Children and Family Services Act, S.N.S. 1990, c.5.

Health Authorities Act, S.N.S. 2000, c.6.

Hospitals Act, R.S.N.S. 1989, c.208.

Human Rights Act, R.S.N.S. 1989, c.214.

Incompetent Persons Act, R.S.N.S. 1989, c.218.

Inebriates' Guardianship Act, R.S.N.S. 1989, c.227.

Involuntary Psychiatric Treatment Act, S.N.S. 2005, c.42.

Narcotic Drug Addicts Act, R.S.N.S., c.307.

Personal Directives Act, S.N.S. 2008, c.8.

Personal Health Information Act, S.N.S. 2010, c.41 (not in force).

Protection for Persons in Care Act, S.N.S. 2004, c.33.

Other Canadian jurisdictions

Mental Health Act, R.S.A., 2000, c.M-13.

Mental Health Act, R.S.B.C. 1996, c.288.

Mental Health Act, C.C.S.M., c.M110.

Mental Health Act, S.N.B. 1973, c.M-10.

Mental Health Services Act, R.S.N.B. 2011, c.190.

Mental Health Act, R.S.N.W.T. (Nu) 1988, c.M-10.

Mental Health Act, R.S.O. 1990, c.M.7.

Mental Health Care and Treatment Act, S.N.L. 2006, c.M-9.1.

Mental Health Act, R.S.N.W.T. 1988, c.M-10.

Mental Health Act, R.S.P.E.I. 1994, M-6.1.

An Act respecting the protection of persons whose mental state presents a danger to themselves or to others, R.S.Q. c.P-38.001.

Civil Code of Quebec, S.Q. 1991.

Mental Health Services Act, S.S. 1984-85-86, c.M-13.1.

Mental Health Act, R.S.Y. 2022, c.150.

International

United Kingdom: *Mental Health Act* 1983 c.20 (including 2007 amendments) (http://www.legislation.gov.uk/ukpga/1983/20/contents).

Norway: *Mental Health Care Act* (Act No. 62/1999) (s 1-1a) (translated from Norwegian) (http://www.ub.uio.no/ujur/ulovdata/lov-19990702-062-eng.pdf).

New Zealand: *Mental Health (Compulsory Assessment and Treatment) Act* 1992 No 46 as of July 1 1999, Public Act s 2(1) (http://www.legislation.govt.nz/act/public/1992/0046/latest/DLM262176.html?search=ts_act_mental+health_resel&p=1&sr=1).

United States, Ohio: *Ohio Revised Code*, Chapter 5119 (http://codes.ohio.gov/orc/5119).

United States, Massachusetts: *Massachusetts Laws*, Chapters 19 and 123 (http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123 and http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter19/).

Case law

Centre for Addiction and Mental Health v. Al-Sherewadi, [2011] O.J. No. 1755 (OSCJ).

R. v. K.A.S, [2007] N.S.J. No. 504 (NSCA).

R. v. S.(R.D.), [1997] 3 S.C.R. 484.

Re Crewe, [2007] N.S.J. No. 450 (NSSC(Fam Div).

Starson v. *Swayze*, [2003] 1 S.C.R. 722.

Conventions

United Nations, "Convention on the Rights of Persons with Disabilities and Optional Protocol" http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf.

Reports

Mark Asbridge, Chris Pauley, Donald Langille, *et al.*, "Mental Health and Addictions Epidemiological & Demographic Analysis" prepared for the Nova Scotia Mental Health and Addictions Strategy Project, September 2011.

Roger Bland and Brian Dufton, *Mental Health: A Time for Action*, submitted to the Deputy Minister of Health, Province of Nova Scotia – Dr. T. Ward, May 31, 2000.

Canada Parliament, Senate Standing Committee on Social Affairs, Science and Technology, "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada" 2006 http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/rep02may06-e.htm#FOREWORD .

Canadian Human Rights Act Review Panel, "Canadian Human Rights Act Review Panel Report, Promoting Equality: A New Vision" 2000 http://publications.gc.ca/collections/Collection/J2-168-2000E.pdf.

Nicole Chammartin, Christine Ogaranko, Beverly Froese, "Equality, Dignity and Inclusion: Legislation that Enhances Human Rights for People Living with Mental Illness: Final Report" submitted to Evaluation Project Committee, Mental Health and the Law Advisory Committee, Mental Health Commission of Canada, November 30, 2011. Also Christine Ogaranko, Beverly Froese, Nicole Chammartin, "Equality, Dignity and Inclusion: Legislation that Enhances Human Rights for People Living with Mental Illness: Mental Health and Human Rights Evaluation Instrument" November 30, 2011.

Commission on the Future of Health Care in Canada, "Building on Values: The Future of Health Care in Canada – Final Report" 2002 http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf.

Commission on the Review of Federal Labour Standards, "Fairness at Work: Federal Labour Standards for the 21st Century: Review of the Canada Labour Code Part III" 2006 http://www.hrsdc.gc.ca/eng/labour/employment_standards/fls/pdf/final_report.pdf.

Anne S. Derrick, Provincial Court Judge, "Report of the Fatality Inquiry into the Death of Howard Hyde" (November 30, 2010) http://www.courts.ns.ca/hyde_inquiry/hyde_inquiry_report.pdf.

Dreezer & Dreezer Inc. "Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act, For the Ontario Ministry of Health and Long-Term Care" December 2005, http://www.health.gov.on.ca/english/public/pub/ministry_reports/dreezer/dreezer.pdf.

Government of Nova Scotia, Building Bridges: Improving Care in Custody for People Living with Mental Illness May 2011 http://gov.ns.ca/just/global_docs/Building_Bridges_Hyde_Report.pdf.

International Financial Consulting, "The Legislative Review of Export Development Canada" 2008 http://www.international.gc.ca/commerce/assets/pdfs/edc-eng.pdf.

Law Commission of Ontario, "The Law as it Affects Persons with Disabilities: Consultation Paper" September 2011 http://www.lco-cdo.org/en/disabilities-consultation-paper.

Law Reform Commission of Canada, Working Paper No. 14, "The criminal process and mental disorder", 1975.

Law Reform Commission of Nova Scotia, Discussion Paper, *Mental Health Provisions of the Hospitals Act*, September 2000 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_DIS.pdf.

Law Reform Commission of Nova Scotia, Final Report, *Mental Health Provisions of the Hospitals Act*, February 2002 http://www.lawreform.ns.ca/Downloads/Hospitals_Act_FIN.pdf.

Mary Pat MacKinnon, Sonia Pitre and Judy Watling, "Matching Methods with Policy Purpose: Two Case Examples of Public Engagement" 2007 http://cprn.org/documents/47131_en.pdf.

Nova Scotia Department of the Environment, "Nova Scotia's Environment Act, legislative review process 2000 : committee report" (Halifax: Nova Scotia, Dept. of the Environment, 2000).

Nova Scotia Environment, "Proposed changes to the Nova Scotia Environment Act A discussion paper" 2011 http://www.gov.ns.ca/nse/dept/docs/env.act.review.2011.pdf.

Nova Scotia Department of Health, "Better Care Sooner: the plan to improve emergency care" (December 2010).

Nova Scotia Mental Health Strategy Advisory Committee, Nova Scotia Health Research Foundation, "Mental Health Strategy Background Document: A summary of the current state of mental health and addictions services in Nova Scotia" June 24, 2011. http://www.nshrf.ca/sites/default/files/mental_health_and_addictions_summary_document_09.14.11.pdf.

Review Board under the *Hospitals Act* and the *Involuntary Psychiatric Treatment Act*, Annual Reports 1979-2009.

Dr. John Ross, "The Patient Journey Through Emergency Care in Nova Scotia: A Prescription for New Medicine" October 2010 http://www.gov.ns.ca/health/emergencycarereport/docs/Dr-Ross-The-Patient-Journey-Through-Emergency-Care-in-Nova-Scotia.pdf.

Uniform Mental Health Act, Uniform Law Conference of Canada, adopted 1987.

World Health Organization, "Mental Health Information Systems" 2005 http://www.who.int/mental_health/policy/mnh_info_sys.pdf.

World Health Organization, "Mental Health Legislation and Human Rights: Mental Health Policy and Service Guidance Package" 2003 http://www.who.int/mental_health/resources/en/Legislation.pdf.

World Health Organization, "WHO Resource Book on Mental Health, Human Rights and Legislation" 2005 http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf.

Position papers

Canadian Psychiatric Association, "Mandatory Outpatient Treatment, Position Paper" approved June 2, 2009 http://publications.cpa-apc.org/media.php?mid=912.

Canadian Psychiatric Association, "Principles Underlying Mental Health Legislation" Position Paper, approved June 2010, (2010) 55 (10) Can J. Psychiatry 1-5.

Texts, chapters, articles

J. Brink, J. Livingston, S. Desmarais, *et al.,* (2011). A study of how people with mental illness perceive and interact with the police. Calgary, Alberta: Mental Health Commission of Canada. http://www.mentalhealthcommission.ca.

Peter J. Carver, "Mental Health Law in Canada", in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds., *Canadian Health Law and Policy*, Fourth Edition (Markham: LexisNexis Canada Inc., 2011) at 341-383.

Simon Davis, "The Legal and Ethical Context of Mental Health Practice" in *Community Mental Health in Canada: Policy, Theory, and Practice* (Vancouver: UBC Press, 2006) at 270-293.

John E. Gray, Margaret A. Shone and Peter F. Liddle, *Canadian Mental Health Law and Policy*, Second Edition (Markham: LexisNexis Canada Inc., 2008).

Jude Hall, "Frontline Providers of Mental Healthcare: The Role of Police Officers in Involuntary Psychiatric Assessments Under the Mental Health Care and Treatment Act." (2010) 19 Dalhousie J. Legal Stud. 107.

H. Archibald Kaiser, "Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State" (2009) 17 Health L.J. 139-194.

H. Archibald Kaiser, "Law and Psychiatry in the Age of the Convention on the Rights of Persons with Disabilities" in Hy Bloom and Richard Schneider, eds., *Law and Mental Disorder: A comprehensive and practical approach to mental disorder and the law* (Toronto: Irwin Law and Centre for Addiction and Mental Health, forthcoming).

Stephen Kisely, Leslie Anne Campbell, Sarah Peddle, Susan Hare, Mary Pyche, Don Spicer, Bill Moore, "A Controlled Before-and-After Evaluation of a Mobile Crisis Partnership Between Mental Health and Police Services in Nova Scotia" Can J. Psychiatry, 2010; 55: 662.

Right Honourable Beverley McLachlin, P.C., Chief Justice of Canada, "Medicine and the Law: the Challenge of Mental Illness" 2005 http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp.

Richard O'Reilly, Gary Chaimowitz, Aileen Brunet, Karl Looper, Philip Beck, "Principles Underlying Mental health Legislation" Position Paper , Canadian Psychiatric Association approved June 2010, (2010) 55 (10) Can J. Psychiatry 1-5.

Lora Patton, "These Regulations Aren't Just Here to Annoy You: The Myth of Statutory Safeguards, Patient Rights and Charter Values in Ontario's Mental Health System (2008) 25 W.R.L.S.I. 9.

Ed Ratushny, *Conduct of Public Inquiries: Law, Policy and Practice* (Toronto: Irwin Law, 2009).

Gerald Robertson, *Mental Disability and the Law in Canada*, Second Edition (Scarborough, Ontario: Thomson Canada Limited, 1994).

Becky Rynor, "Value of community treatment orders remains at issue" (2010) 182(8) CMAJ 337.

Karen Schwartz, Ann-Marie O'Brien, Vanessa Moral *et al.*, "Community Treatment Orders: The Service User Speaks. Exploring the Lived Experience of Community Treatment Orders" (2010) 15(1) International Journal of Psychosocial Rehabilitation 39-50.

Jacquelyn Shaw, "One Step Forward, Two Steps Back: a Charter Analysis of s.39 of Nova Scotia's *Involuntary Psychiatric Treatment Act*" 2009 4(2) JEMH 1.

Alexander Simpson, "Mental Health Law in Ontario: Challenges for Reform" (2011) 31(3) Health Law in Canada 65-80.

Shelley Trueman, "Community Treatment Orders and Nova Scotia – The Least Restrictive Alternative?" (2003) 11 Health L.J. 1-34.

Anita G. Wandzura, "Community Treatment Orders in Saskatchewan: What Went Wrong?" (2008), 71 Sask. L. Rev. 269-306.

Sheila Wildeman, "Access to Treatment of Serious Mental Illness: Enabling Choice or Enabling Treatment?" in C. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006).

Sheila Wildeman, "Insight revisited: a relational approach to the status of capacity to make treatment decisions in involuntary psychiatric hospital settings" in J. Downie & J. Llewellyn, eds., *Being relational: reflections on relational theory and health law* (Vancouver : UBC Press, 2011).

Michael Woody, "Community Crisis Intervention Team" undated. Copy provided at Police Mental Health Liaison Conference, Halifax, June 13, 2011.

Other

Health Information Standards Committee for Alberta, "Mental Health Reporting Requirements: Inpatient Interval Reporting Data Set" version 2 February 11, 2010 http://www.health.alberta.ca/documents/HISCA-Mental-Health-IIR.pdf.

Canadian Institute for Health Information website www.cihi.ca.

Canadian Institute for Health Information, "Ontario Mental Health Reporting System Resource Manual, 2011-2012," (Module 1 – Clinical Coding and Module 2 - Technical Specifications and Data Submission).

Canadian Mental Health Association website www.cmha.ca.

Mental Health Commission of Canada website http://www.mentalhealthcommission.ca/english/pages/default.aspx.

Nova Scotia Legislature, Hansard, Second Reading Debates for the *Involuntary Psychiatric Treatment Act*, May 2005 and October 2005.

Nova Scotia Health Research Foundation website regarding Mental Health Strategy Project, http://www.nshrf.ca/initiatives/initiatives/mental-health-strategy/mental-health-strategy-background-document.

National Institute of Mental Health. Series FN No.10, "Data Standards for Mental Health Decision Support Systems." Washington DC: Supt. Of Docs, U.S. Govt. Print. Off. 1989. DHHS Publications No. (ADM) 89-1589.1989.

Police Mental Health Liaison Conference, Halifax, June 13, 2011.

Population Health Research Unit, Dalhousie University, data fields in Research Data Repository, http://metadata.phru.dal.ca/.

United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, "Decision Support 2000+, Draft Requirements Analysis of Decision Support 2000+, Background Statement" undated www.mhsip.org/ds2000/backgroundstatment1.pdf.

World Health Organization website regarding Mental Health
http://www.who.int/topics/mental_health/en/.

MEETINGS

Meetings between stakeholders and Justice La Forest

Stephen Ayer, Executive Director, Schizophrenia Society of Nova Scotia

Dr. John Campbell, Director Mental Health Services, Annapolis Valley Health

Sharon Davis-Murdoch, Health Association of African Canadians

Joe Denny, Executive Director, Native Alcohol and Drug Abuse Counseling Association of Nova Scotia

Dr. David Elliott, Nova Scotia Department of Health and Wellness

Gail Gardiner, Executive Director, Canadian Mental Health Association, Nova Scotia

Jean Hughes, Associate Professor, Dalhousie School of Nursing

Involuntary Psychiatric Treatment Act Liaison Group established by the Nova Scotia Department of Health and Wellness as a resource for Justice La Forest's work. Members include: Dr. John Campbell, Dr. Ruth Carter, Susan Hare, Avai Kochanoff, Dr. Herb Orlik, Dr. Michael Teehan, Dr. Scott Theriault.

Anne Jackman, Chair, *Involuntary Psychiatric Treatment Act* Review Board

Malcolm Jeffcock, Nova Scotia Legal Aid

Arlene Johnson, Acting Executive Director, Mi'kmaw Family & Children's Services of Nova Scotia

Archibald Kaiser, Professor, Schulich School of Law

Lana MacLean, Health Association of African Canadians

Lesley McKee, Program Manager for Child Protection Services, Mi'kmaw Family & Children's Services of Nova Scotia

Judith McPhee, Executive Director, Policy and Information Management, Nova Scotia Department of Justice

Mental Health Directors, Chiefs of Psychiatry and Vice-Presidents Community Mental Health for the District Health Authorities

Superintendent William (Bill) Moore, Halifax Regional Police

Patricia Murray, Nova Scotia Department of Health and Wellness

Don Roper, Empowerment Connections

Ken Scott, Nova Scotia Department of Health and Wellness

Donna Smith, Co-Chair, Health Association of African Canadians

Terry Taylor, Nova Scotia Mental Health and Addictions Strategy

Dr. Scott Theriault, Clinical Director, Adult Specialty Services and Forensic Services, Capital District Health Authority

Ida Vincent, Executive Director, Tawaak Housing

Sheila Wildeman, Assistant Professor, Schulich School of Law

Ken Winch, Executive Director, Court Services, Department of Justice

Other Communications

Eileen Allen, Health Information Services, Capital District Health Authority

Mark Asbridge, Community Health & Epidemiology, Dalhousie University

Lynn Cheek, Nova Scotia Department of Health and Wellness

Tina Hall, Nova Scotia Department of Health and Wellness

Michelle MacDonald, Nova Scotia Department of Health and Wellness

Lorna MacPherson, Nova Scotia Department of Community Services

Peter Nestman, Community Health & Epidemiology, Dalhousie University

Denice Nicholson, Nova Scotia Department of Health and Wellness

Connie Paris, Program Lead, Mental Health & Addictions, Canadian Institute for Health Information

Mary Pyche, Acting Program Leader, Crisis/Emergency Services, Capital Health Mental Health Program

Carrie Ricker, Legal Counsel, Capital District Health Authority

Charlotte Smith, Colchester East Hants Health Authority

Jennifer Thorne, Nova Scotia Department of Health and Wellness

Appendix C

IPTA Review Technical Reference Group Membership

IPTA Review Technical Reference Group

Kimberley Brennan
IPTA Coordinator
Capital District Health Authority

Dr. John Campbell
Director, Mental Health and Addiction Services
Annapolis Valley District Health Authority

Dr. Ruth Carter
Director, Mental Health and Addictions
IWK

Dr. Linda Courey
Director, Mental Health and Addiction Services
Cape Breton District Health Authority

Dr. Gerald (Jerry) Gray
Assistant Professor, Dalhousie University
Department of Psychiatry
Staff Psychiatrist, IWK Health Centre

Todd Leader
Director, Health Services - Community
South Shore District Health Authority

Dr. Kathleen Pajer
Chief of Psychiatry, IWK Health Centre
Senior Physician, Mental Health and Addiction Program
Professor and Head, Division of Child and Adolescent Psychiatry
Dalhousie University Faculty of Medicine

Mary Pyche
Program Leader MH Program
Acute Care and Crisis Supports
Capital District Health Authority

Dr. Scott Theriault
Clinical Director, Adult Specialty Services and Forensic Services
Capital District Health Authority

Appendix D

Independent Review of the *Involuntary Psychiatric Treatment Act*, Discussion Paper

Independent Review of the *Involuntary Psychiatric Treatment Act*

Discussion Paper

(This discussion paper may be found online at http://www.nshrf.ca/initiatives/initiatives/independent-review-ipta)

Contents

Introduction 2

Discussion and Questions 5

- Optional self-identification 5
- Purpose of the *Involuntary Psychiatric Treatment Act* 5
- Definition of Mental Disorder 6
- Categories of Admissions - Voluntary and Involuntary Patients 7
- Court 9
- Substitute decision-makers 9
- Certificates of Leave 10
- Community Treatment Orders 10
- Patient Advisor Service 11
- Review Board 12
- Confidentiality 13
- Police 13
- Other Issues 14
- Other Comments 15

Introduction

This document is meant to help you share your thoughts about the *Involuntary Psychiatric Treatment Act.*

The *Involuntary Psychiatric Treatment Act* is the legislation that governs the provision of psychiatric treatment on an involuntary basis to those who are determined to be incapable of making admission and treatment decisions for themselves due to mental illness. It also authorizes the admission of patients into psychiatric facilities on a voluntary basis. The legislation has been in force since July 2007.

Reviewing the Act

The legislation requires that two reviews of the Act must take place in 2012-2013. The first review requires the Minister of Health and Wellness to look at **community treatment orders**.[1] In particular, this review looks at:

1) whether community treatment orders were or were not used between July 2007 and July 2012;
2) the effectiveness of community treatment orders during that time frame; and

3) the methods used to evaluate the outcome of any treatment used under community treatment orders.

The second review requires the Minister to have the **entire Act independently reviewed**.

The Department of Health and Wellness appointed us, Justice Gérard La Forest and Professor William Lahey, to carry out these reviews.

Our mandate requires us to consider whether:

- the objectives of the Act are the right objectives, or whether they should be changed, clarified or strengthened;
- the Act is effectively meeting its current objectives;
- the Act is otherwise working properly;
- the way the Act works could be improved; and
- amendments should be made to the Act or associated legislation or changes should be made in the administration of the Act or of associated legislation.

[1] A community treatment order allows for involuntary psychiatric treatment while the person is living in the community as opposed to in a psychiatric facility.

In considering whether to recommend legislative amendments or changes in administration ofthe Act, we are to consider whether the amendments or the administrative changes would improve or strengthen the functioning of the Act relative to:

- its proper objectives;
- patient well-being;
- applicable human rights principles;
- the importance of mental health and the mental health system; and
- Nova Scotia's mental health policy objectives, including those articulated in Nova Scotia's mental health strategy.

Consultation purpose

The purpose of this consultation is to ensure that our review of the Act is informed by the perspective of all interested stakeholders. In this document, we identify issues or questions on which stakeholders may want to comment or provide input, following in a general way the existing layout and language of the Act as much as possible. Please feel free however to tell us what you think about any part of the Act and how it is working from your perspective.

This consultation document can be used any way you like. You can answer all, none or some of the questions. Detailed answers can be provided for all questions, as well as short answers. Answers can also be submitted on behalf of a group. All information is welcome and will be considered. See below for more ways that you can submit your comments to the review team.

Submitting your comments

If you want to read the Act and regulations in their entirety, they can be found at http://nslegislature.ca/legc/statutes/invpsych.htm and http://www.gov.ns.ca/just/regulations/regs/IPTtreatmentregs.htm respectively.

We hope you will help us by sharing your thoughts on, experiences with, or opinions of the Act. There are many ways you can do this:

- You may respond to some or all of the issues or questions set out in this document. You may complete the document online [link] or fill in the Microsoft Word document [link] and send it to us at the email or regular mailing address below.
- You may send us your thoughts in a note by email to IPTAReview@gov.ns.ca or regular mail at:
  Independent Review of the *Involuntary Psychiatric Treatment Act*
  Barrington Tower, 6th Floor
  1894 Barrington Street
  P.O. Box 488 Halifax, Nova Scotia B3J 2R8
- You may leave your comments on a voicemail at 1- 855-424-0521; or

- You may attend a public meeting. The schedule for public meetings is on our website http://www.nshrf.ca/initiatives/initiatives/independent-review-ipta

We encourage anyone interested in how the *Involuntary Psychiatric Treatment Act* operates to share their thoughts with us by May 1, 2013. We will file our final report with government in early July of 2013.

Your responses will be kept confidential. We will report responses in group form only so that your specific comments cannot be linked to you.

Discussion and Questions

Optional self-identification

Although you are not required to identify yourself in any way, knowing a little bit about you may help us better understand the information you provide and the perspective you have about the Act. Therefore, if you so desire, we invite you to provide us with any information you think is relevant for understanding your perspective and the comments you make. For example, if you are a person living with a mental health issue; a friend or family member of a person living with a mental health issue; a health or social service worker; a caregiver; or an advocate, you are welcome to describe your unique situation, interest and involvement in the space below. This information will be kept strictly confidential and will only be reported in ways that will not identify you on an individual level. If you prefer not to complete this section, please move on to the next question.

Is there anything you would like to tell us about yourself or your experience with the Involuntary Psychiatric Treatment Act?

Purpose of the *Involuntary Psychiatric Treatment Act*

The stated purpose of the Act is to ensure that issues dealing with mental health are dealt with in accordance with the following guiding principles:

- People with mental disorders are entitled to be treated with dignity and respect;
- Everyone has the right to make treatment decisions to the extent they are able;
- People should be offered treatment and services in the least-restrictive manner and environment with the goal of having them continue to live in the community or return to their homes as soon as possible;
- Patients should be admitted as voluntary patients wherever possible;
- Treatment and services, where possible, should promote the person's self-determination and self-reliance;
- Everyone has the right to a treatment plan that maximizes their potential and is based on the principles of evidence-based best practice;
- Persons with mental disorders should have access to mental health services as close to their homes as practicable;
- All declarations of involuntary admission or declaration of incapacity are made on the basis of evidence.

Questions about objectives, purpose and principles of the Act:

1. *Do you have any comments about the purpose of the Act as it is currently stated?*

2. *Do you have any comments about whether or not the Act is effectively meeting its objectives?*

3. *Do you have any comments on whether the Act should state other objectives in addition to that of ensuring that issues dealing with mental health are dealt with in accordance with the guiding principles?*

4. *Do you have any comments about whether the guiding principles are the right ones? Should the guiding principles be different or should others be added?*

5. *Do you have any comments about the extent to which the guiding principles are being upheld appropriately? Can you give examples of how the principles are upheld or not upheld in your experience?*

6. *Do you have any comments on whether improvements are needed in upholding the guiding principles of the Act?*

Definition of Mental Disorder

The *Involuntary Psychiatric Treatment Act* provides for involuntary **assessment** of those who are suspected of having a mental disorder and for involuntary **treatment** of those who are determined to have a mental disorder. For this reason, the definition of 'mental disorder' in the Act is very important. The definition reads:

"mental disorder" means a substantial disorder of behaviour, thought, mood, perception, orientation or memory that severely impairs judgement, behaviour, capacity to recognize reality or the ability to meet the ordinary demands of life, in respect of which psychiatric treatment is advisable"

Question about definition of mental disorder

1. *Do you have any comments about the definition of 'mental disorder' under the Act?*

Categories of Admissions - Voluntary and Involuntary Patients

Under the *Involuntary Psychiatric Treatment Act,* individuals may be admitted to a psychiatric facility as:

- a voluntary patient who is capable of making treatment decisions
- a voluntary patient who is incapable of making treatment decisions, or
- an involuntary patient.

Voluntary Patients

A person may be admitted to a psychiatric facility as a voluntary patient if a psychiatrist believes the person would benefit from being admitted. A person meets the criteria to be admitted as a voluntary patient under the Act if the person:

- either is capable of consenting to treatment OR has a substitute decision-maker who can consent to treatment on his or her behalf, and
- does not meet the criteria for being admitted as an involuntary patient

If a voluntary patient requests to be discharged from the psychiatric facility, the patient may be examined before leaving to determine whether he or she should become an involuntary patient and kept in the facility.

Questions about voluntary patients

1. *Do you have any comments about the voluntary patient status under the Act?*

2. *Do you have any comments about the criteria for being admitted as a voluntary patient?*

3. *Do you have any comments about the process of being admitted as a voluntary patient?*

4. *Do you have any comments about the process of being discharged as a voluntary patient?*

Involuntary Patients

The *Involuntary Psychiatric Treatment Act* allows for a physician to examine a person and determine whether the person should have an involuntary psychiatric assessment done. The physician will order the assessment where:

- the physician believes the person appears to have a mental disorder ;

- as a result of the mental disorder, the person is threatening to or has caused serious harm to someone (including himself or herself) or the person will likely suffer serious physical impairment or serious mental deterioration; and
- the person cannot be admitted as a voluntary patient.

The purpose of the involuntary psychiatric assessment is to determine whether the person should be admitted to a psychiatric facility as an involuntary patient. The person may be held for the assessment for a maximum of 72 hours. If after that time the person has not been admitted, then he or she must be released.

After an involuntary psychiatric assessment is completed, the person will be admitted as an involuntary patient if a psychiatrist determines:

- the person has a mental disorder;
- the person needs psychiatric treatment in a psychiatric facility;
- as a result of the mental disorder, the person is threatening to or has caused serious harm to someone (including himself or herself) or the person will likely suffer serious physical impairment or serious mental deterioration;
- the person is not suitable to be admitted as a voluntary patient; and
- as a result of the mental disorder, the person does not have the capacity to make admission and treatment decisions

An involuntary patient's status must be considered regularly by a psychiatrist to determine if he or she continues to meet the criteria for involuntary admission. The length of time between renewals of the patient's status varies between 1 and 3 months depending upon how long the patient has been admitted as an involuntary patient.

Questions about involuntary patients

1. *Do you have any comments about the involuntary patient status under the Act?*

2. *Do you have any comments about the criteria for being admitted as an involuntary patient?*

3. *Do you have any comments about the process of being admitted as an involuntary patient?*

4. *Do you have any comments about the process of being released as an involuntary patient?*

Court

Anyone may ask a judge to order a medical examination of another person by a physician. The judge may order the police or someone else to take the person for the medical examination where the judge believes the person:

- has a mental disorder
- will not consent to the medical examination; and
- as a result of the mental disorder, is threatening to or has caused serious harm to someone (including himself or herself) or the person will likely suffer serious physical impairment or serious mental deterioration.

The court's order is valid for seven days.

Questions about the Courts

1. *Do you have any comments about the role of the Courts under the Act?*

Substitute decision-makers

Under the Act, all involuntary hospital patients and patients on community treatment orders have a substitute decision-maker to make decisions on care or treatment on their behalf. The substitute decision-maker is a person chosen by the patient when the person had capacity to make that choice or a person identified in accordance with a hierarchy of potential substitute decision-makers laid out in the Act.

The substitute decision-maker must make decisions in accordance with the informed wishes the patient expressed when he or she was capable unless following those wishes would endanger the health or safety of the patient or someone else. If following the wishes of the patient would endanger the health or safety of the patient or someone else or if the substitute decision-maker does not know of the patient's wishes, then he or she makes the decision that he or she believes is in the patient's best interests.

Questions about substitute decision makers

1. *Do you have any comments about the role of substitute decision-makers under the Act?*

Certificates of Leave

A certificate of leave allows an involuntary patient to live outside of the psychiatric facility after a period of involuntary admission. A certificate can be issued for a period of leave of up to 6 months. The purpose of the certificate of leave is to help an involuntary patient transition from living in the facility to living in the community. The involuntary patient's substitute decision-maker must agree to the certificate and the patient must comply with the treatment plan.

The psychiatrist may cancel the certificate of leave if the patient breaches a condition of the certificate or if the psychiatrist believes:

- the patient's condition may be a danger to the patient or others; or
- the patient has failed to report as required by the certificate of leave.

Questions about certificates of leave

1. *Do you have any comments about certificates of leave in general?*

2. *Do you have any comments about when and how or if certificates of leave should be used?*

3. *Do you have any comments about the effectiveness of certificates of leave?*

Community Treatment Orders

The *Involuntary Psychiatric Treatment Act* allows a person to receive involuntary psychiatric treatment outside of a psychiatric facility through a community treatment order. A community treatment order may be put in place where a psychiatrist determines:

- the person needs treatment for a mental disorder and the treatment can be provided in the community;
- as a result of the mental disorder, the person is threatening to or has caused serious harm to someone (including himself or herself) or the person will likely suffer serious physical impairment or serious mental deterioration;
- the person does not have the capacity to make treatment decisions
- in the last 2 years, the person
    - has been an involuntary patient in a psychiatric facility for 60+ days;
    - has been an involuntary patient in a psychiatric facility two or more times; or
    - has already been subject to a community treatment order; and
- the services that the person needs are available and will be provided to the person in the community.

Each community treatment order requires a treatment plan which deals with such matters as where the patient will live, how often he or she must attend appointments, the responsibilities of the patient and substitute decision-maker, the psychiatrist's responsibilities, and responsibilities of other caregivers and agencies involved in the patient's care.

A community treatment order is valid for 6 months. It may be renewed where it is shown to be effective.

The psychiatrist may cancel a community treatment order and return the patient to a psychiatric facility for assessment where the patient has seriously failed to comply with the order or the services required for the community treatment order are no longer available. The psychiatrist may also cancel the order where he or she determines that the person is able to continue to live in the community without being subject to the order.

Questions about community treatment orders

1. *Do you have any general comments about community treatment orders?*

2. *Do you have any comments about the criteria for receiving a community treatment order?*

3. *Do you have any comments about the process for issuing community treatment orders?*

4. *Do you have any comments about the effectiveness of community treatment orders?*

Patient Advisor Service

When a person is admitted as an involuntary patient, a patient advisor is assigned to the person. Patient advisors work for the independent Patient Advisor Service. Their role is to help involuntary patients and substitute decision-makers understand their rights under the Act and help them make applications to the Review Board and obtain legal counsel.

Question about patient advisors

1. *Do you have any comments about the role of patient advisors?*

Review Board

The Review Board established under the *Involuntary Psychiatric Treatment Act* is made up of lawyers, psychiatrists, and members of the public who have an interest in mental health issues. The main purpose of the Review Board is to review the status of patients admitted as involuntary patients into a psychiatric facility and of patients living in the community on a community treatment order. The Review Board has no authority with respect to voluntary patients.

There are certain times that the Board must review an involuntary patient's status, including:

- when a patient is admitted as an involuntary patient or the patient's involuntary admission is extended and the patient or the substitute decision-maker applies for the review;
- 60 days after the patient is involuntarily admitted;
- every 6 months after the patient is involuntarily admitted for the first 2 years of involuntary admission;
- every year after a patient has been involuntarily admitted for more than 2 years;
- when a community treatment order is renewed and on every 2nd renewal;
- when an application[2] is made to review of an involuntary admission or its renewal;
- when an application[3] is made to review of a community treatment order or renewal of a community treatment order;
- when an application[4] is made to review a certificate of leave or its cancellation.

Where the Board is requested to review the status of a patient, the Board must hold a hearing within 21 days after it receives an application. The patient, the substitute decision-maker and the patient's psychiatrists are all entitled to participate at the hearing. Other people may be allowed to participate where the Review Board thinks it is appropriate. Within 10 days of the hearing, the Board must provide a written decision.

Questions about the Review Board

1. *Do you have any comments about the role of the Review Board in general?*

2. *Do you have any comments about the role of the Review Board regarding involuntary patients?*

---

[2] An application for review can be made by the following persons: the patient; a substitute decision-maker; a guardian appointed by law; a person who has been authorized to give consent under the Medical Consent Act' a person authorized by the patient to act on the patient's behalf; the chief executive officer; the Minister; or the Review Board where it believes it is in the patient's interest to have a review.

[3] An application for review can be made by the individuals listed in footnote 2 above.

[4] An application for review can be made by the individuals listed in footnote 2 above.

3. *Do you have any comments about the role of the Review Board regarding patients on a community treatment order?*

4. *Do you have any comments about the Review Board's processes?*

Confidentiality

The rules around the confidentiality of health care information also apply to mental health information. The *Involuntary Psychiatric Treatment Act* does not address the rules around the confidentiality of patient information, except to say that the rules around confidentiality set out in the *Hospitals Act* apply to the records of a patient in a psychiatric facility. As of June 1, 2013, the rules set out in the *Personal Health Information Act* will apply.

Questions about confidentiality

1. *Do you have any comments about the sharing of patient information for individuals under the Involuntary Psychiatric Treatment Act?*

2. *Do you have any comments about patient confidentiality under the Involuntary Psychiatric Treatment Act?*

Police

The police are often the first contact a person may have with the *Involuntary Psychiatric Treatment Act*. They are authorized to take a person for a medical examination where they believe:

- the person apparently has a mental disorder;
- the person will not consent to go for a medical examination;
- it is not feasible to ask a judge to order the medical examination; and
- the person
    - as a result of the mental disorder, is threatening to or has caused serious harm to someone (including himself or herself) or the person will likely suffer serious physical impairment or serious mental deterioration; or
    - is committing or about to commit a criminal offence.

They are also authorized to take a person for a medical examination where the court orders that the person be taken for the medical examination. The police must stay with the person while the medical examination is completed. If the person is not recommended for an involuntary psychiatric assessment, the police must take the person back to where the person was taken into custody or some other appropriate place.

The police are also authorized to take a person to a psychiatric facility in a number of circumstance such as the following: where a certificate(s) for involuntary psychiatric assessment has/have been issued; where the person has left a psychiatric facility without permission; where the person is thought to have breached the conditions for the person's absence from a psychiatric facility; and where the certificate authorizing the person's absence from a psychiatric facility has been cancelled.

The police are also authorized to bring a person to a psychiatrist who issued or renewed a community treatment order for a medical examination where the psychiatrist believes the person has seriously breached the conditions of the community treatment order.

Questions about police involvement

1. *Do you have any comments about the role of the police under the Act?*

2. *Do you have any comments about the criteria for police intervention?*

3. *Do you have any comments about the process for police involvement?*

Other Issues

There are a number of factors that have been identified as potentially affecting the *Involuntary Psychiatric Treatment Act* that are not written in the Act. These factors include (but are not limited to) the following:

- How the availability of support services for individuals living with a mental disorder may affect the need or likelihood to engage the Act.
- How diversity may affect an individual's experience with the Act. In particular, groups that are known to be not served well by the mental health system include First Nations and Aboriginal citizens, African Nova Scotians, Acadian and Francophone Nova Scotians, new immigrants to Nova Scotia, and the Lesbian, Gay, Bi-sexual, Transgender and Intersex (LGBTI) community.
- How the Act may relate to the criminalization of people living with mental disorders.
- How the Act works with other legislation, such as the *Adult Protection Act*, the *Incompetent Persons Act*, the *Personal Directives Act*.

Questions about other issues

1. *Do you have any comments about any of these factors?*

2. *Are there other factors not listed above that should be considered?*

Other Comments

1. *Is there anything else you would like to tell us about the Involuntary Psychiatric Treatment Act***?**

2. *Are there matters relating to mental health that are not addressed in the Involuntary Psychiatric Treatment Act or in associated legislation that you think should be addressed in legislation in Nova Scotia?*

3. *Are there matters relating to mental health that are currently addressed in the Involuntary Psychiatric Treatment Act or in associated legislation that you think should not be addressed in legislation in Nova Scotia?*

Appendix E

Participants, Individuals and Organizations, in Stakeholder and Discussion Group Meetings

Participants

This Appendix was changed by the Reviewers after the Final Report was submitted. The original appendix included the names of individuals who provided input during the Review process. We are confident that most of the people with whom we spoke or who provided input in other ways would be comfortable with their names being listed in the participant list. However, we cannot say with confidence that all people who provided input to the Review would want their names listed when the Final Report is released to the public. For this reason, we have revised Appendix E to remove the names of individuals.

Organizations

Annapolis Valley District Health Authority

Amherst Police Department

Bourque Security

Bridgewater Police Service

Canadian Mental Health Association, Nova Scotia Division and branches

Cape Breton District Health Authority

Cape Breton Regional Police Service

Capital District Health Authority

Capital District Health Authority Family Groups

Colchester East Hants Health Authority

Cumberland Health Authority

Dalhousie Department of Psychiatry

Dalhousie Health Law Institute

Emergency Health Services

Emergency Medical Services Inc.

Empowerment Connection (Patient Advisor Service)

Guysborough Antigonish-Strait Health Authority

Halifax Regional Police

Harbour House

Health Association of African Canadians

Hillside Pines

IWK Health Centre

Kentville Police Service

La Have Manor

Lunenburg County Home Support

Mental Health Directors (District Health Authorities)

Nova Scotia Health Directors and Nova Scotia Mi'kmaq Maliseet Atlantic Health Board Chiefs

Mental Health and Addictions Strategy Advisory Committee

Mental Health and Justice Liaison Committee

Mobile Mental Health Crisis Team (Capital District)

Nova Scotia Department of Community Services

Nova Scotia Department of Health and Wellness

Nova Scotia Department of Justice

Nova Scotia Legal Aid

Pictou County Health Authority

Pictou County Community Health Board

Réseau Santé

Review Board (Involuntary Psychiatric Treatment Act)

Royal Canadian Mounted Police

Schizophrenia Society of Nova Scotia

South Shore District Health Authority

South West Nova District Health Authority

Springhill Police Service

Truro Police Service

Appendix F

Stakeholder Discussion Outline

Stakeholder Discussion Outline

- Are the objectives of the Act the right objectives?
    - Should they be revised, clarified or strengthened?
- Is the Act effectively meeting its current objectives?
    - Is it functioning effectively and appropriately?
    - Is the functioning of the Act in need of improvement in specific areas or more generally?
- Should
    - amendments be made to the Act or to associated legislation; or
    - changes be made in the administration of the Act or of associated legislation to improve or strengthen the functioning of the Act relative to its proper objectives, patient well-being, applicable human rights principles, the importance of mental health and the mental health system, and Nova Scotia's mental health policy objectives, including as articulated in Nova Scotia's mental health strategy?
- What changes would you recommend?
- What would you recommend remain the same?

Appendix G

Stakeholder Focus Group Participants

Geoff Alcock

Sean Auld

Erin Austen

Karen Briand

David Fairfax

Jim Flemming

Anne Jackman

Yvonne Libbus

Elizabeth Lock

Constance MacIsaac

Cecilia McRae

Patti Melanson

Mary Pyche

Carrie Ricker

Janet Sears

Ian Slayter

Michael Teehan

Theresa Vienneau

Appendix H

Report of the Nova Scotia Health Research Foundation

Involuntary Psychiatric Treatment Act (IPTA) Review

Interview Analysis

June 2013

Nova Scotia Health Research Foundation

Table of Contents

Executive Summary: Involuntary Psychiatric Treatment Act Review 3
Introduction 5
Method 5
Limitations 5
Results 6
Overall findings 6
1. Categories of admission 7
1.1 Involuntary admission 7
1.2 Voluntary admission 9
2. Admission process 9
3. Patient support and treatment 10
3.1 Substitute decision makers 10
3.2 Patient advisors 11
3.3 Human rights 12
3.4 Diversity and cultural issues 14
4. Community Treatment Orders (CTOs) 15
5. Role of the police 17
6. Role of other legislation 19
7. Review Board 20
8. Role of healthcare professionals 21
9. Access to information 21
9.1 Confidentiality issues 21
9.2 Public access to data 22
10. General administrative concerns 23
10.1 Timeframes 23
10.2 Forms 24
11. IPTA: What is missing 24
Conclusion 25
Appendix A: Interview guide 26

Executive Summary: Involuntary Psychiatric Treatment Act Review

At the direction of the Involuntary Psychiatric Treatment Act (IPTA; the Act) Review Committee (the Committee), the Nova Scotia Health Research Foundation (NSHRF) was asked to organize and analyze data collected on the IPTA legislation. Interview notes and transcripts from consultations with stakeholders across the province regarding the IPTA were provided from March 17th 2011 to May 15th 2013Data was analyzed using a qualitative analysis software program (Atlas.ti), which allowed the data to be coded and synthesized into ten distinct emergent themes.

Findings from the analysis indicated that many parties were satisfied with the Act and found that it better dealt with mental health issues than the old Hospitals Act. A variety of constructive criticism was provided with hopes of improving the Act.

A number of issues with admission criteria were identified. Many took issue with the use and subjectivity of the capacity and deterioration criteria. Specifically, there were concerns that the police were not in a position to properly assess capacity and deterioration and instead were forced to wait for individuals to become a risk of serious harm to themselves or others. Others did not understand how the 'voluntary but incapable' status could exist; respondents suggested that if a patient is voluntary, then they should be permitted to leave the hospital if they want but this is not the case under the Act. There were many logistical procedures in the admission process that were perceived as unclear, specifically who has the authority to admit a patient under the Act. Representatives of the DHA that does not have a designated psychiatric treatment facility felt that mentally ill patients who were assessed at their facility were at a clear disadvantage.

Another theme that emerged concerned the roles and responsibilities of substitute decision makers and patient rights advisors. These concerns mainly focused on communication between these individuals and either the hospital, the patient or the Review Board. Other issues raised by participants pertained to the definition of roles and responsibilities for various players. For example, there were concerns about the role of patient rights advisors and whether these individuals should or should not engage in advocacy as part of their role. Although, there was praise for IPTA in its success in attempting to balance the human rights perspective and the human needs perspective, the treatment of patients was of great concern for respondents. The importance of treating the patients with respect and dignity was highlighted; this was seen as particularly important for patients of specific demographic groups such as youth, Aboriginals, African Nova Scotians and the Francophone community.

Community Treatment Orders (CTOs) generated a great deal of discussion. While CTOs were generally met with a positive response, this was accompanied by concerns regarding issues associated with implementation in rural areas, availability of community resources, and clarity of authority and eligibility criteria. Some viewed certificates of leave as a trial for CTOs that could help patients transition back into the community.

The process as laid out in IPTA was deemed to be challenging for police who are called to a scene involving an individual with a mental illness. Respondents indicated that such challenges could be addressed with increased training about mental health and about assessing mental stability to help the police determine whether the criteria set out in the Act are met. Another concern expressed was around the logistical issues regarding the duty of the police officer to remain with the patient until he/she is medically assessed. The implementation of the Mobile Mental Health Crisis Team (MMHCT) in the Halifax Regional Municipality was deemed to provide some solutions to the issues the police face, but the Mobile Team is only available in urban settings and the model may not directly translate to rural regions.

There was some criticism concerning the Review Board, as many individuals found that there were issues with the organization of the Board and its protocols. The Act dictates many different time frames pertaining to different processes. Representatives from nearly all groups consulted- patients, family member, healthcare professionals, the Department of Health and Wellness and even the Review Board- found that the Board struggled to meet timeframes laid out by the Act.

Concern was also raised as to whether or not healthcare professionals who deal with mentally ill patients have received the proper training and education as some believe that individuals who operate under the authority of IPTA, such as nurses, police officers and psychiatrists, were not given sufficient education on the Act.

Many healthcare professionals found that confidentiality precautions were perhaps too extreme and made the process of admission and treatment much more difficult. The public was concerned that adequate data and statistical records concerning the Act were not collected. They also felt that the data available to them was extremely limited.

Issues were also raised concerning the scope of the Act specifically with regard to the situations where the Act does not apply; this includes after the patient is released from the hospital, before they are admitted as well as issues with those who were not deemed to be eligible under the Act. Respondents were concerned that many individuals do not get the help that they need because there is not enough available healthcare. Others report an insufficient amount of supports available for the patient after discharge may contribute to the high re-admittance rate. Finally, many of those consulted wondered if something could be done to help individuals before they deteriorate to a state in which they must be admitted under IPTA.

Introduction

At the direction of Involuntary Psychiatric Treatment Act (IPTA) Review Committee, the Nova Scotia Health Research Foundation was asked to organize and analyze data collected on the Involuntary Psychiatric Treatment Act (IPTA) through an independent consultation process. Data was collected from a variety of sources including open public consultations, targeted stakeholder consultation groups, one-on-one informant interviews, online surveys, written submissions and toll free phone messages. This report presents the findings of an analysis of the consultation data.

Methods

The IPTA Review Committee conducted consultations across the province and provided data collected in a written format. Consultations were semi-structured and covered a range of topics related to the IPTA, including objectives and definitions, criteria of admissions, community treatment orders, the Review Board, patient advisor services, police and confidentiality (see Appendix A for the complete discussion guide). Interview notes and transcripts were recorded in written format and analyzed using Atlas.ti software. Data was coded based on key elements of the interview guide as well as emergent issues and main ideas. Codes were synthesized into several broad themes, which were subsequently analyzed in greater depth resulting in multiple sub-themes emerging from the data.

Limitations

There are several limitations that should be noted. Some stakeholder groups were better able to respond to certain areas of discussion than others, thus some topics of discussion may be over representative of a particular stakeholder group(s). Furthermore, individuals with mental illnesses or those who had been directly affected by IPTA may not have been adequately represented in the report. Family members and other healthcare professionals expressed concern that these individuals might have avoided stakeholder or public meetings concerning the review of the IPTA due to fear or stigma associated with having a mental disorder. Given these concerns with including this stakeholder group, alternative methods of submission were provided to attempt to minimize any barriers to participation. As such, submissions were also gathered using an anonymous online consultation, phone consultation, and through mail (both electronic and traditional). The Review Committee also engaged advocacy organizations and patient support systems to organize meetings with constituents and encourage them to contact the Review Board Committee.

It was deemed important for data analysis to be conducted by a third party to minimize bias and ensure a systematic approach. Such an approach is generally accompanied by a loss of context. Transcripts of interviews provided the most accurate representation of the data collected in an interview, however the context in which individuals shared information as well as any non-verbal cues are lost to the third party analyst who is not present for the consultation. Members of the review committee reviewed and

provided feedback on the analysis as a means of addressing this limitation, however, the disconnect between those collecting and those analyzing data should be considered in the interpretation of findings.

Results

Overall Findings

When asked in general to comment on how they felt about the Act, most stakeholder groups expressed relief at the implementation of the Act, and found it to be a considerable improvement in comparison to the Hospitals Act. They felt it addressed many of their ongoing concerns and that it afforded a level of protection for individuals requiring treatment under the Act. However, this did not prevent respondents from freely and openly providing feedback on how the Act could be improved.

Most people consulted felt that the Act generally does well in accomplishing the objectives it dictates, although this can often be complicated by interpretation of the Act, which is often overshadowed by gray areas where the process and interpretation are vague. It was suggested that this is perhaps due to a lack of resources and training that is needed to support the Act's objectives. Interpretation of the Act was a main concern for respondents. It was noted that there are disparities in what the Act means depending on the context and location; it remains a constant struggle to find a balance between necessary flexibility and consistency in interpretation. Many believe they would benefit from a resource that clarified the application of the Act in practice. When the Act was initially implemented, support was initiated to provide guidance regarding implementation of the Act; there are requests for this role to be established to assist with interpretation.

Almost all persons felt that individuals were treated with dignity and respect under the Act; however, some concerns were raised about this in relation to section 2(c), which states that treatment is to be offered in the least restrictive environment with the view of getting the patient back into the community. However, some reported that the Act has actually resulted in patients remaining in the treatment process for a longer period. Under the Hospitals Act, patients could be kept seven days for assessment and they often got better before they needed to be made involuntary. Under IPTA, it was changed to three days (seventy two hours). Respondents suggested that most people take longer than three days to recover and that once admitted under the Act, the relative inertia of the process can result in longer stays. Respondents suggested that the least restrictive treatment with the goal of having the person continue to live in the community as stated in Section 2(c) can be fulfilled by CTOs. Many have interpreted this guiding principle by presupposing that all effort should be focused towards implementing CTOs; yet do not think this is the case. Section 4 of this report deals with these issues.

The key findings that emerged from the data analysis are summarized and organized into 10 broad themes, which are each elaborated on throughout the remainder of the report. This report is not a

comprehensive assessment of all details of the data collected, but rather reports the following 10 emergent themes.

1. Categories of admission
2. Admission process
3. Patient support and treatment
4. Community Treatment Orders (CTOs)
5. Role of the police
6. Role of other legislation
7. Review Board
8. Role of healthcare professionals
9. Access to information
10. General administrative concerns
11. IPTA: What is missing?

1. Categories of Admission:

1.1 Involuntary admission

Individuals raised concerns related to inconsistencies in the application of the involuntary admission criteria with regards to capacity, deterioration and dangerousness. Respondents reported that the admission criteria did not take prior history into consideration and that the snapshot assessment based on capacity, deterioration or dangerousness may not be accurate.

Capacity:

There is concern that the capacity criterion is too subjective. S.18 identifies criteria for determining the capacity of the patient; some respondents indicate that vague language is used and there is no process for a standardized assessment. Consulted participants were concerned with how doctors interpret and apply the standard of treatment capacity. It was reported that some clinicians may feel forced to make a premature assessment about capacity and as a result, may end up holding the individual as an involuntary patient longer in order to make this determination. On the other hand, some participants believe that the mandate should be 'incapable until proven otherwise' in order to minimize the number of patients that slip through the cracks. One patient expressed complete agreeableness with the capacity criteria, saying that if a person lacks insight, they should be involuntarily admitted no matter what.

The degree of confusion was high amongst respondents regarding the admission criteria and the requirement that the patient be incapable regarding treatment. Although insight and capacity are used interchangeably when talking about capacity under the Act, some stakeholders appear to have misinterpreted capacity and deterioration. People suggest that both criteria must be better defined individually as well as in relation to one another. One individual believed that giving a patient involuntary status should not require the assessment that the patient is incapable of making treatment

decisions. They suggested that a patient may have done something (e.g. - attempted suicide) related to their mental disorder, but it does not necessarily relate to their capacity to make treatment decisions.

Deterioration

Respondents reported that since the implementation of the deterioration criteria outlined in the Act, there have been fewer calls from families concerned about a lack of hospital response to treatment. The feedback surrounding the deterioration criteria has been positive – those consulted report that it allows the patient to be admitted before the situation reaches a crisis stage. This preventative method was not in place before IPTA was implemented, and the community sees the positive implications of this criterion and expresses appreciation for it. The main concern is that deterioration is a grey area and is open to interpretation amongst various stakeholders.

Front line police expressed that they are not comfortable with the deterioration criteria, particularly where they have no prior knowledge of the individual and thus have an inability to properly assess a deteriorating situation. The policing representatives consulted conveyed that they are generally most comfortable bringing in an individual who is suicidal or a threat to another, but when it comes to assessing deterioration, there is a certain lack of comfort as it is a more subjective decision. Family members are apprehensive that doctors and staff do not adequately use the deterioration criteria due to a lack of sufficient education of the criteria. It is also frustrating for the families who report that the use of deterioration criteria is extremely subjective depending on who does the assessment. Many have called for a more precise and standardized definition of deterioration that they believe would help to ensure that it is used consistently in the criteria analysis. A suggestion was that a working group be created to collectively determine how the deterioration criteria can be adequately defined.

Dangerousness

Contributors believe that the dangerousness criteria laid out in S.17(c) is much more objective than the deterioration criteria and much easier to use when assessing a patient. Family members worry that police cannot bring mentally ill individuals to the hospital until the individual progresses to a state in which they are at risk of causing serious harm to themselves or others. They have been requesting that the deterioration criteria be used before the individual gets to this state of dangerousness and that dangerousness should be used as a last resort only. Calm individuals with mental illnesses often feel they are refused admittance because they are not a physical danger to themselves or others; they suspect that because they are not considered violent, the police refuse to intervene despite them meeting the deterioration criteria.

Confounding medical issues

Additional non-psychiatric medical issues are thought to confound the psychiatric assessment. Psychiatrists insist that current medical conditions must be dealt with before the capacity of the patient is assessed especially if the physical health of the patient is at risk. Many physicians are reluctant to put a medically unstable individual under the Act; however they are unsure of what to do during the period where the medical condition is being assessed. Psychiatrists report that they often encounter uncertainty in how patients with both dementia and mental illness should be treated differently. They

are adamant that a patient with both dementia and a mental illness must be treated differently than other patients under the Act, but there are no guidelines on doing so. Psychiatrists also experience issues with mentally ill individuals who have addiction problems. They recognize that they cannot diagnose an individual who is under the influence of a substance, but are unsure how and where to allow the patient to detox before assessment. A final comment concerning this issue was that people with mental illness have higher risk factors for chronic illnesses. Many family members feel that the chronically ill patient requires many resources to address their needs and are often discriminated against in obtaining access due to their mental illness. There are requests for special consideration and care to be given to these patients.

1.2 Voluntary Admission

Section 3(aa) defines a voluntary person as one who remains in a psychiatric facility with that person's consent or the consent of a substitute decision-maker. Respondents noted uncertainty as to how someone can be a voluntary patient if someone else is in charge of giving consent on his or her behalf. Multiple respondents flagged the issue of 'voluntary but incapable' status and were unsure when it was appropriate to use that status. Many believe this status should not exist, as it is contradictory to itself and questioned how someone can be voluntary, yet have another person decide to admit them and discharge them from the hospital. Respondents report that many patients are confused that they have voluntary status yet are told by hospital staff they cannot leave which contradicts section 24(3) which states a voluntary patient has the right to leave the psychiatric facility.

Respondents also expressed concern regarding the process for changing a patient's status from 'involuntary' to 'voluntary but incapable.' Patients, family and healthcare professionals in particular were concerned that changes in status were made based on compliance with unwritten rules or conditions such as the patient agreeing to stay for a designated amount of time, taking specific medications or being generally agreeable and compliant. These respondents believed this to be contradictory to their voluntary status as they are unable to exercise control over their treatment. Others reported that a change in status may be made to allow patients to attend court sessions or other scheduled appointments and that this may be done without a proper assessment by a psychiatrist. Some perceived that the change in status may be prompted by an upcoming Review Board hearing that the psychiatrist may not want to attend. Some individuals have begun to suggest that clinical justification no longer solely dictates status changes and would like more attention to be paid to this matter.

2. Admission Process

There are varying opinions surrounding the admission process under the Involuntary Psychiatric Treatment Act. Patients, nurses, police officers, general practitioners and psychiatrists have expressed that there is a lack of clarity when it comes to how individuals interpret the Act with respect to the process with both medical examination and involuntary psychiatric assessment.

There are divergent views with regards to the medical examination, which can be done by a MD, and the involuntary psychiatric assessment, which must be done by a psychiatrist. Medical doctors were not always aware that the medical examination and completion of Form 2 was their responsibility and not the responsibility of the psychiatrist; this is noted to be a particularly prominent issue when there is no psychiatrist on shift and a situation arises. There are reports that general physicians are admitting patients without a psychiatry exam. Some physicians claim this is under the supervision of a psychiatrist but others insist that there are practices outside of the HRM that are not operating under the supervision of a psychiatrist. Many physicians have responded that there are no other accessible options when there is no psychiatrist available. Wait times are also a concern due to the restricted hours of some of the smaller units which forces the emergency room to hold patients until a psychiatrist is available and can admit them.

Section 10 of the Act states, among other matters, that the two certificates for involuntary assessment are sufficient authority for the person to be detained, restrained and observed in a psychiatric facility for not more than 72 hours. A few individuals took issue with the fact that some hospitals are not considered to be psychiatric facilities under the Act, and felt that patients waiting for an involuntary psychiatric assessment had to be transferred to the Emergency Room of a psychiatric facility. These individuals explained that many of these patients no longer meet the involuntary criteria when they reach the receiving facility and will be required to return to the original hospital. They believe that this process creates undue hardship for patients and drains on resources Several DHAs felt an inpatient psychiatric unit was not necessary to providing a range of mental health and psychiatric care. Some suggested that all DHAs should have a facility designated under the Act as a psychiatric facility, or that the Act should state that the involuntary psychiatric assessment does not need to be conducted in a psychiatric facility.

3. Patient Support and Treatment

3.1 Substitute decision makers (SDMs)

Respondents reported operational issues regarding the amount of time it takes to find a substitute decision maker (SDM) and subsequently deal with the information that must be exchanged according to the Act. One of these issues is cases in which an involuntary patient is willing to accept treatment, but the hospital cannot locate the SDM; hospital staff does not understand why they cannot treat in these circumstances, particularly when they view it as an emergency. Many individuals feel that the psychiatrist, who is normally responsible for locating the SDM, rarely has the time to coordinate a meeting with potential SDMs in order to obtain consent. Patients, families and health care workers wonder if alternate healthcare professionals such as general practitioners or nurses can take on the role of locating the SDM.

There is concern about the appropriateness of selection of the SDM. Section 38(1) lays out who can give consent on behalf of an involuntary patient; however participants report that choosing an SDM is not as simple as following a hierarchical list. One individual requested more direction on what happens when

there are two individuals who are at the same hierarchical level- e.g. two parents or two adult children. Participants reported situations where the substitute decision-maker has not been in contact with the patient within the last year, as required under section 48(4)(a). In such situations, many individuals were apprehensive that if the SDM has not had recent contact with the individual, they may not fully understand the situation and therefore would not be in a position to make decisions in the patient's best interest. Furthermore, there is concern that a patient may have prior issues with the chosen SDM or family member, who may not act in their best interest. Many respondents recommended that there should be more direction in choosing an SDM to ensure that they are truly acting in the best interest of the patient. Healthcare workers encourage individuals to do an advance directive, in which they choose an SDM when they are healthy and capable. Another suggestion was a form where patients can object to the current SDM and apply for a different SDM; changes to the role of the Review Board were identified as relevant to this suggestion.

Many took issue that the SDM's decisions could not be challenged, as they believe the SDM may not always make the correct judgment about what constitutes the best treatment for the patient. Although section 42(1) states that the Review Board may review the capacity of the SDM, a few individuals worry that this does not always occur. In determining the best interest of a patient under section 40, regard is given to whether the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the other requirements of section 40. It was reported that often there was no stated plan of action for doing so. There was a general consensus that substitute decision-makers are often not fully aware of their roles or obligations and their rights and thus the role of the SDM must be more adequately defined. Some feel that their only role is as a contact person while others feel they must only be aware of treatment options in order to inform the patient. A few individuals expressed the desire for more information surrounding their roles and rights as SDM, perhaps a pamphlet or information session. Concerns were also raised about long term resentment from the patient resulting from the SDM making a decision they did not agree with; it was suggested that having individuals prepare their own advance directives may be a better alternative.

Substitute decision makers commented that access to information is often a challenge. SDMs report that they are often not involved in discharge planning nor are they notified that the patient is being discharged. This can result in SDMs missing important appointments. There is uncertainty about whether psychiatrists or patient rights advisors should be tasked with notifying the SDM.

There were a few administrative suggestions regarding making procedures easier for SDMs. Section 38(4)(d) requires that a statement in writing certifying the person's relationship to the patient as well as other matters required under the Act. Respondents reported that this could be an issue as SDMs are sometimes initially contacted by phone during an emergency and it can be difficult to obtain the certification in writing in time. Healthcare administrators wondered if this statement could be done over the phone with a witness present until a physical statement can be received. As a final point, the front line staff mentioned that they are not always clear on the role of the SDM and as a result, may delegate SDM authority to social workers, other family members, or patient rights advisors.

3.2 Patient rights advisors

There was a high level of positive response to the patient advisor service from the hospital staff, patient and family members. Participants explain that it allows the patient an avenue to feel connected and have some degree of control even though their freedom is taken away. Criticisms of the patient advisor service were similar to those of the SDM. Most individuals consulted reported that the past experience of the patient advisor was appropriate for the role. The review board examines the capacity of the SDM, some wonder if this same type of review can be incorporated with the rights advisors. Respondents also highlighted that it is also important for the patient rights advisors to reflect cultural diversity, specifically in cases where the patient needs a patient advisor that they can relate to. Some stakeholders expressed concern that hospital staff are still learning about the role of the patient advisor and that access to qualified patient advisors was inconsistent amongst different geographic areas.

Respondents noted that in situations where the SDM is making the decisions on behalf of the patient, it is critical that the SDM meets with the patient advisor to learn the patient's rights. When patient advisors are notified of the patient admission, only the last name, first initial and hospital identification number are provided. Patient advisors have experienced difficulty with use of resources and delays in locating the patient because staff usually addresses patients by their first name.

Concerns were expressed about the hospital's ability to communicate sufficient information in a timely manner; the concerns related to non-reporting of admission, changes of status, renewal and community transfer orders (CTOs). Patient advisors described that they are not always advised of the outcome of the Review Board hearing and thus are unable to answer questions from the patients concerning hearing results. Patient advisors also described how they are not notified of CTOs until after they occur, forcing them to search for the person in the community. Due to privacy concerns, they report they do not always receive contact information for the patient in the community and suggest that if they are notified when a CTO is under consideration, it would allow them to provide proper advice before the patient leaves hospital.

Opinions regarding the role of the patient advisor service versus an advocacy service were expressed. Many, including patient advisors and healthcare professionals, saw an advantage to being an advisory role only and were concerned that they would be compromising the requirement that they maintain an arm's length status if they were to take on an advocacy role. A small number of patient rights advisor expressed the belief that a patient advocate could ideally encompass both the role of the patient advisor as well as provide a much-needed advocate for the patient and family.

3.3 Human rights

Most people consulted felt that IPTA balances the human rights perspective with the human needs perspective fairly well, yet there was room for improvement. A few individuals commented that some healthcare professionals tended to focus more on the Act and treatment and have forgotten the patient is a human being with rights and emotions. Many strongly believe that a coercive approach is not helpful in the psychiatric context; providing supports rather than providing involuntary admission is preferable. A few individuals encouraged the government to go beyond the medical model and shift towards a social model to better respect the rights of the patient. It was suggested that Canada's ratification of

the U.N. Convention on the Rights of Persons with Disability signaled a potential shift towards this social model, allowing the integration of social and economic rights in addition to civil rights. Furthermore, these individuals felt that some of the language from the U.N Convention should be incorporated into the purpose of the Act.

Some healthcare professionals are worried that when a person is brought in against their will and treated poorly, that person will not seek help the next time they have a mental health problem. They feel that treatment adherence drops when people feel coerced and there is a strong connection between providing enhanced supports in the community and lowering the risks of forced treatment that must be exploited. Creating, enhancing and broadening community support was viewed as essential by many family members in this review. Families are also concerned that often health care workers are preparing for discharge from the start and are solely focused on symptoms that they sometimes forget they are dealing with a human being. Parents in particular felt that giving a patient hope and joy and allowing social interaction can make an enormous difference in their situation.

Some stakeholders described how the structural issues of some of the older hospitals impacted the humane treatment of a person. For example, they mentioned how there are no washroom facilities in the therapeutic quiet rooms in the Abbey Lane Hospital. The patient may request a bathroom visit but staff requires the accompaniment of a security guard, which often results in a longer wait and can lead to degrading situations. The stakeholders report that there are washroom facilities in the therapeutic quiet rooms in the new forensic hospital and so the issue does not arise. They suggest that renovations to add washroom facilities to older buildings can easily solve this problem.

It was suggested that from a cultural perspective, parts of IPTA do not work in the best interests of the patient. One example that was given cites section 31, which allows for a patient to be transferred to a bed outside their home area. It was explained that this does not consider either the culture or the location of the patient's personal support network and that moving the person may mean the family cannot access the person to provide support.

Family members have also emphasized how treatment under the Act is very limited. Treatment is typically limited to medication, but many believe this is not always the best for patients, as they have no control over the outcome. It was suggested that talk therapy or cognitive behavioral therapy could be considered as possible treatments.

Many individuals consulted mentioned that the Act should not cover both youth and adults. By covering youth in the Act, many believe that the healthcare system is giving them full adult rights and freedoms that they are not developmentally ready for. Many rights advocates feel that youth are not provided with developmentally appropriate containment or proper treatment of their mental health condition as they attempt to grow up. Consequently, it was reported that many youth see the Act as 'paternalistic' and feel trapped. It is possible and necessary to address this gap. Many are optimistic about this situation as they feel that human rights safeguards can be built in by creating an appropriate legislative framework to address the higher level of vulnerability in youth as compared to an older population.

There were also suggestions that family members should be educated about the rights of the patient

who may not have enough insight to understand them. Families feel forced to find information to educate themselves within a short period; often they are not educated on mental illness until they are suddenly faced with it. Many expressed interest in a pamphlet with details of IPTA in an easy to read format. Families simply just don't know where to go or how to access IPTA and have expressed an essential need for support, education and ease of access from a health professional.

3.4 Diversity and cultural issues

Respondents requested better protection for demographic groups, including Aboriginals, African Nova Scotians, immigrants and Francophones, by means of clear articulation throughout the Act and regulations of Charter values in relation to equality rights. The consultations that occurred when IPTA was prepared in 2005 did not, to their knowledge, include methods that sought to engage diverse groups. Minority groups have expressed a desire for the Act and regulations to specifically mention cultural diversity.

Respondents believe that Aboriginals may be falsely viewed as any other minority community. They identify as a minority that has been dispossessed of their language, land and culture and described that many individuals in their community experience feelings of hopelessness and powerlessness. Consequently, they feel that the support for individuals in their community who are experiencing mental health issues should be culturally appropriate to deal with these issues. Some of the other issues that were identified include: the underfunding of agencies that specifically service the Aboriginal peoples and the short timeframe of mental health counseling sessions that are unable to address the deep historical issues underlying some of the mental health issues. It was reported that other legislation commonly have a section where certain aspects are specific to minority groups including Aboriginals; respondents suggested that IPTA also investigate this as an option.

Respondents also felt that IPTA does not meet the cultural needs of African Nova Scotians and immigrants. They believe that symptoms often present differently for their culture compared to Caucasians and majority populations and as a result, the person may not be seen to fit the IPTA criteria. They insist that the system and the Act need to take this into account and that education is necessary for all professionals dealing with people of African descent. People consulted expressed the view that African Nova Scotians do not want to be treated the same as everyone else- they wish to be treated specific to their culture where the outcome is the same but the approach is different.

Finally, respondents reported that the Francophone community often expressed frustration that they are not fairly treated under the Act. They reported that there are very few healthcare services available to them in their first language; they are often forced to use English, which affects their degree of comfort and causes unnecessary miscommunication. These individuals wonder if stipulations can be incorporated in the Act to ensure that consultations are carried out in the patient's mother tongue. These issues allude to situations in which they must receive services from Anglophone patient advisors, healthcare professionals and psychiatrists.

4. Community Treatment Orders (CTOs)

Many families speak highly of the Community Transfer Orders (CTOs) and their results. There is extremely positive feedback from many healthcare professionals who see the direct benefit for their clients; they view CTOs as valuable in that they allow mental health workers to increase their efforts at engaging patients who are somewhat challenging to stimulate. Healthcare professionals report that this option is much easier and less invasive for patients who normally struggle with having their freedom taken away. Very few were strongly against the use of CTOs in principle. They did not agree that the patient must be an involuntary patient to obtain a CTO and also felt that they were not always used in the way they were originally intended.

Although most District Health Authority (DHA) representatives report that the CTOs were not initially used, they note that there has slowly been an increase in their implementation over the past few years. This hindrance to the uptake of CTOs was thought to be related to education. One hospital unit reported that many of their clinicians in the psychiatric unit did not know the undertakings of a CTO. The education efforts of Ontario's CTO coordinator were perceived as making a major difference in the uptake of CTOs in that province; many stakeholders ask if something like this exists in Nova Scotia and believe it would be ideal to have a provincial senior consultant on CTOs who could act as a resource to people who are responsible for administering the Act. The DHA representatives are confident that this would solve many problems that exist merely because there is no source to obtain additional information.

The primary issue, concerning CTOs, of those consulted is the lack of resources, specifically in rural areas. Stakeholders clearly expressed that CTOs cannot function unless community resources are available, citing the struggle of rural regions to implement CTOs as an example. . Nearly everybody consulted agreed that people on CTOs need more transportation, housing and financial resources. They observe that individuals are released into the community on a CTO, but are often deterred by a lack of resources to assist them such as inadequate housing, lack of transportation to/from hospital, poor funding for medication, food and other necessities. Many worry that IPTA assumes that families and communities have resources, but this is often not the case. They elaborate that without a family member or caregiver to help provide these necessities, the CTO will fail. Social supports are challenging and families often feel burdened financially and legally. There are strong feelings that CTOs should not exist unless the government or district health authority can provide these resources.

Many consider CTOs to be advantageous over hospitalization and feel that some of the additional criteria for CTOs challenged the health care system unnecessarily. There is uncertainty as to why incapacity is a prerequisite for a CTO; often there are cases where patients are improving, but are not yet ready for release. One of the burdens families experience once the patient is discharged, is that there is nothing to hold the patient to their treatment and ensure they did not regress. Families find that patients are often discharged without adequate support; the use of CTOs as an alternative was thought to be a preferred process to help the patient transition back into the community. One patient who had capacity wished to continue on the CTO because they recognized the risk of relapse and felt that its value was worth the limit on their freedom.

There was concern about the requirements for qualifying on a CTO (e.g. 60+ days in the previous two years). Respondents noted that the earlier a patient receives treatment the better the outcome; thus, patients who, for example, must wait 60 days to go on a CTO often miss out on opportunities where they could have benefited from the CTO. Many judged it to be preferable for a person to stay in the community rather than be in and out of hospital. In essence, many believe CTOs are preferable to admission, yet find that the criteria are more stringent than admission.

Many DHAs report that the Act is unclear regarding authority for the CTO. Healthcare professionals believe that the police are unsure of their responsibilities in relation to the CTO and that there is confusion about their role in administering medications. There have also been misunderstandings as to which psychiatrist is in charge of the CTO at different stages. Individuals have questioned which psychiatrist fills out the CTO: the inpatient psychiatrist or the outpatient psychiatrist. Many believe that the inpatient psychiatrist is initially responsible, but once the patient goes out in the community, the outpatient psychiatrist should take over responsibility. Because of the difficulty with communication between inpatient and outpatient teams for CTOs, it has been suggested that both teams should be required to sign the CTO form

The mechanisms to address a violation of the CTO under the Act were deemed vague and unclear. Healthcare professionals remarked that guidelines to determine if a breach was significant enough to warrant bringing the patient back to hospital do not exist. Initially there was concern about patients who violated the CTO by leaving a pre-defined geographic region, as there was uncertainty about the mechanism for bringing back the person. CDHA reported that they resolved this issue by having the MMHCT deal with all CTOs in any situation like this. However, in regions that don't have a MMHCT, many have requested clarity in terms of who is responsible for bringing the person back in situations of breach. Healthcare professionals mentioned that when there is a breach of the order, the only avenue is to bring the person to emergency services, which reverts back to deciding whether the patient falls under involuntary admission. They feel that it is not feasible to restart the process because the CTO is terminated and insist that there needs to be more flexibility to decide if it makes sense to continue.

There has been a great deal of confusion surrounding the three forms used for cancelling CTOs. Individuals who fill out the forms find that the three forms around CTO cancel are specific and there are often cases that don't fit the process. They maintain that these forms must be reexamined and amended. Furthermore, the use of three separate forms is confusing for those who believe that one Form 11 is sufficient.

Most of the feedback surrounding certificates of leave has been positive. Many individuals who were consulted perceive certificates of leave as a quasi- trial CTO or something that can be used for patients who do not meet the criteria for a CTO. Many acknowledged that there have not been high rates of use reported for certificates of leave and believe the higher control with the certificate of leave compared to the CTO does not make up for the lack of possibility of renewal. Some of the concerns mentioned above for CTOs such as lack of resources and community support were reported as an issue here as well. As the criteria for a certificate of leave is less stringent, parties noted that the challenge is determining when a patient is stable enough for this decision; unaccompanied passes where the patient is involuntary is

reported to often lead to difficulties when preparing someone to transition to the community. Nurses and psychiatrists believe that attendance at Review hearings becomes a problem for patients on leave certificates because it means they have to return to the hospital.

5. Role of the police

Many patients and family members did not believe that the police had adequate training to deal with mental health issues and felt that they were not always equipped with the proper skills to identify and then appropriately deal with these individuals. They were unsure as to whether or not police officers were mandated to take training about their roles and responsibilities when dealing with an individual with a mental illness.

Some of the main concerns surround the ability of the police to assess the patient; specifically many believed that the police struggle to address the lack of capacity. It was unclear how well police are able to make that determination. Family members report that the police are very reluctant to respond unless there is a risk of harm to self or harm to others. They also sense that front line police experienced a great deal of confusion around deterioration when they have no history with which to determine if the individual is in fact deteriorating. The police officers who were consulted agree that the deterioration criterion is difficult to determine because they do not have any prior information; instead they must often default to the dangerousness criteria. Family members report that they provide information to the police that demonstrate that the individual is deteriorating, but become frustrated when the police do not accept the information to inform their decision. Police expressed that they do listen to families but ultimately have to make their own determination.

Police officers believe they may be jumping too quickly to take individuals to hospital (e.g. in situations where person has expressed thoughts of suicide) because they are not seeing an increase in hospital committal rates. They have expressed frustration in bringing someone to the hospital only to have them discharged. Some health administration stakeholders believe that the police appear to be more reluctant to bring an individual in to the hospital since the publication of the Hyde report. Advocates of mental health believe that much can be accomplished by speaking to the police about their role and explaining to them that it is not a waste of time to bring someone in and then have them discharged. It was felt that this was an indication that the system works.

There were divergent views concerning the interpretation of the medical examination and the duty of the police officer to remain with the patient. Staying with the patient is a source of frustration for some police officers, who can spend up to 24 hours in the emergency room waiting for the medical examination. Under Section 16(2), either the police involved or an 'authorized individual' must stay with the person until the medical examination is complete. The police have requested that there be clarification on who the 'authorized person' is so that a mechanism can be put in place in which a non-violent person can be left with someone reliable at the hospital. It was reported that there were instances in which the police officer leaves before the medical examination is complete. One practical issue was that the police become reticent to invoke the Act because they sometimes end up spending 14-15 hours waiting to have the person examined. Patients have also reported that they are not

comfortable waiting in the emergency room with individuals with medical emergency issues while accompanied by the police and wonder if there is a separate place or room where they can wait.

There was some initial concern about section 16(3), which states that the person is to be returned to the place where they were taken into custody or "some other appropriate place" because the police officer might be required to travel an unrealistic distance. One police force described their internal policy that they will only return the person to a place within their jurisdiction and suggest that this can be adopted into the legislation of the Act. Some police have argued that they do not have a mandate to take a person to another place, but need only to drop them off where they picked them up. An agreement between the Department of Justice and the Department of Health and Wellness was described, which establishes that individuals who surpass the physical environment in a psychiatric facility or who are violent will be transferred to the East Coast Forensic Hospital. It was suggested to add this to IPTA to avoid any future miscommunications.

The Mobile Mental Health Crisis Team (MMHCT), which consists of police officers in Halifax, mental health professionals in Capital Health, the IWK Health Centre, and is supported by the Department of Health, was described. The feedback surrounding the MMHCT has been extremely positive especially in regards to their ability to ensure that persons of all ages with mental disorders are treated with dignity and respect. Some family members expressed concern about the MMHCT's ability to make a proper assessment of capacity and deterioration during their visit with the patient. Some rural areas described a team that has a similar role to the MMHCT. These teams have been met with positive results, which has led to suggestions that other rural municipalities adopt a similar service.

Criminalization

Police officers are, at times, unsure if an individual should be admitted under the health system or the criminal system. They are unsure who makes the final determination as to whether or not the person is mentally ill or guilty of a crime. Many of the police officers are very sensitive to those with mental health issues; the last thing that they say they want to do is put a mentally ill individual into a jail cell. Nevertheless, individuals expressed concern that the police have apprehended people who are in need of mental health help yet because the person is violent, they take the person back to cells and monitor until the person settles even though the jail environment is not the best setting for the person.

There were reports of instances in which the individual meets the criteria for involuntary psychiatric treatment, but the charge is so serious that the police do not release the patient to the hospital. Some people commented that there is a risk that people in more rural areas are charged with crimes because that area does not have a place to admit the patient involuntarily. Participants also noted that some psychiatric units outside of Halifax decline to admit patients if they are too violent and raised the question of whether that unit is truly a psychiatric unit for involuntary patients. Many wonder if a mechanism can be put in place to ensure that IPTA is implemented before criminal charges.

Police expressed concern about the lack of a feedback mechanism for people who commit an offence but who are not admitted under IPTA. They observed that the police are not always notified when they are discharged or if they are not admitted after the psychiatric assessment so the police cannot always

address the criminal charges. Police stress that it is particularly important to know when the person is released where there are safety concerns for the victim and would like to see something in IPTA to allow for this sort of disclosure.

Challenges were raised concerning the knowledge of the courts to be able to address mental health issues when the person charged with a crime has been found not criminally responsible or fit to stand trial. Individuals state that there is no mechanism for the legal system to deal with mental illness unless the individual is formally arrested and thus in the system. Preferably, respondents wanted to see early diversion that better allows IPTA and the criminal court to both function together.

6. Role of other legislation

Many individuals consulted struggled to see the connection between the various legislative laws and mental health issues. With many new Acts coming into place, people wanted to see an amalgamation of the Acts that reflect how they all work. There was a recommendation to examine all the statutes in Nova Scotia that affect mental disability law and the mental health system; these include the Personal Health Information Act (PHIA), the Personal Directives Act, the Adult Protection Act and the Incompetent Persons Act.

Multiple different individuals identified what they believed to be many notable differences between IPTA and the old provisions under the Hospitals Act. Consultants felt that under IPTA, patients are being brought in earlier (before a crisis) to get treatment; this is seen as an improvement over the Hospitals Act. Others perceive IPTA as more interventionist than the original Hospitals Act, although there is still concern regarding the change from the old Hospitals Act that specified that someone who is made involuntary must be incapable to make their own decisions; previously the person may have been able to make his or her own treatment decisions, but this is reported to no longer be the case. Respondents gave examples of patients who live in the hospital and were reviewed annually by the Review Board under the Hospitals Act; under IPTA these patients' status changed to voluntary and there is no review. Another difference conveyed was that, under the Hospitals Act there was a reporting mechanism to the Department of Justice in relation to the police to say when the Act was invoked.

Some individuals stated that although the Mental Health Strategy doesn't have much direct application to the Act itself, they believe it is very relevant to the services that support people. When a decision is made to put the person on a CTO, many expect that the MH strategy should facilitate the community supports that the person needs to succeed in the community. Many stakeholders are persuaded that the MH strategy provides the grounding principles that can help IPTA be implemented and that the application of these principles has the potential to decrease the overall need for IPTA. Some expressed skepticism that the MH strategy would be implemented.

7. Review Board

The administration of the Review Board was criticized. Primary concerns were scheduling issues and difficulty in meeting required time frames. The Act requires the Review Board shall review a patient's

status no later than 21 days after the request; families, patients and healthcare workers all found that this timeframe was often not met and as a result, patients were discharged and then readmitted. They also reported times that the Review Board sets a hearing date to meet the 21 day timeline, yet know that it will be adjourned regardless. Both of these situations were reported to be highly stressful for the family and the patient.

Family members, nurses and psychiatrists have requested that there be more leniencies in the timelines for the Review Board hearing if the regular psychiatrist is away; currently when the attending psychiatrist is away, the substitute psychiatrist must attend the hearing. There is concern that this psychiatrist would not be as familiar with the case as the attending and thus the patient's situation would not be represented adequately. Despite these challenges, many do not want the timeframe to be extended but rather request that the Review Board find other means to meet these deadlines. Both psychiatrists and assisting healthcare workers have expressed that psychiatrists are often overworked and have difficulty clearing their schedule in order to attend the hearing. Another complication that was reported is that neither the Review Board nor the patients have the ability to waive a hearing. Individuals explained that at the 60-day mark a patient may still be acutely ill but the Review Board is still required to hold a hearing. Some felt that the inability to waive a hearing can be burdensome for some patients and their families.

Psychiatrists and others feel the Review Board is sometimes disorganized and feel uncomfortable with the administrative aspects of the Board including procedural issues, gathering of proper information, and timeliness. Some suspect that some psychiatrists attempt to avoid hearings by making the patient voluntary. Many reported concern about changes of patient status from involuntary to voluntary just before a scheduled hearing. They are concerned that this counters the purpose of the Act and ask that this issue be addressed.

There have been a few other administrative concerns with the Review Board that are believed to affect the credibility of the Act and its process. Section 70(2) states that the Review Board must give all parties involved 3 days notice before a hearing; some perceive that SDMs are often not notified. There were reports of situations where panel members or psychiatrist did not show up because they hadn't received notice and thus the hearing cannot take place. Once again, the patient and family members find this emotionally taxing and stressful. There have also been issues with finding an appropriate setting for the hearing where there is adequate space and privacy. Finally, there were complaints about the cultural diversity on the Review Board, which is thought by some to disadvantage minority patients.

The role of the Department of Health and Wellness (DHW) is to support the Review Board in administration by coordinating with the Board and legal aid lawyers among others but many believe there is a gap and lack of communication between the two organizations. When a psychiatrist raises an issue about the Review Board, there is concern that there is no formal place for him or her to take the issue within the DHW.

8. Role of healthcare professionals

The role of the healthcare professionals is considered by many to be extremely important in ensuring that the purpose and objectives of the Act are adequately met. One commonly cited concern for respondents was the education and general knowledge of the healthcare professionals, specifically it was expressed that the training around the Act is not sufficient and as a result there is a lack of proper understanding. These issues were thought to begin with front-end healthcare professionals who appear to lack training and knowledge about admissions and thus did not use the deterioration and capacity criteria properly. Families believe that the onus of knowing the Act should be on healthcare professionals. Some individuals claimed that the staff in the DHW does not know the Act, nor do they understand the importance of timelines within the Act and thus have difficulty ensuring all the regulations are followed. It was reported that psychiatrists new to the province or country particularly need training about the legislation; it was suggested that there be a training process designed to cover the workings of the Act and that this be delivered on a regular basis. Concerns related to health human resources were raised, in particular with regards to psychiatrists. It was acknowledged that efforts are currently being made to tackle this resource issue.

9. Access to Information

9.1 Confidentiality Issues

Confidentiality precautions are often implemented to protect the rights of the patient. Findings suggest that concerns arise not because of a lack of adequate protections but rather because of a perceived overemphasis on confidentiality. Many feel the law protecting health information of patients is too restrictive, potentially even paternalistic; some believe that the legislation should explicitly allow the sharing of whatever information is necessary between the appropriate parties involved.

One specific confidentiality issue concerns the police. Health professionals are unsure of the extent of information that can be disclosed to the police and believe guidelines around disclosure would be helpful. In situations where doctors must call the police to help with breaches of CTO, there is disagreement as to what information should be shared.

Hospital staff finds it particularly challenging to know what information should be released to the police, particularly when a patient leaves the hospital. As a result, police officers sometimes feel that hospital staff is not cooperative when it comes to information sharing. Police officers believe that they consistently provide information pertaining to their observations in the field, but do not receive information in return. The police find this to be particularly problematic when an individual, who has committed a crime, is released back into the community; the police worry that both the victim of the crime and the patient may need protection and that this lack of knowledge that the patient is back in the community will limit their ability to respond. Some representatives of district health authorities who have acknowledged this issue have expressed an interest in a memorandum of understanding between the police and the District Health Authority. Nevertheless, both parties feel that complete disclosure is not necessary; the police do not need to know full medical details and the hospital does not need to

know all legal details. One individual suggested the 'dome of service' framework in which certain clusters of services are considered under the dome of a "service" and so information may be shared within that dome. This was hypothesized to minimize many of the problems mentioned above.

Only a few individuals disagreed with the over-confidentiality issues stated above. One individual felt there was a shift in health services in which information sharing is proposed and sometimes used to benefit the patient; however they see it as a complete breach of confidentiality. The following issue of inadequate confidentiality was also relayed; currently hearings conducted before the Review Board are closed in recognition of the private nature of much of the subject matter and in consideration of the health of the person subject to the review. One individual believed that there was a discrepancy between IPTA and section 58 of the Hospitals Act which states: 58 (2) "A declaration of capacity for a patient in a hospital or a psychiatric facility or a declaration of competency for a patient in a hospital or a voluntary patient may be reviewed by the Supreme Court of Nova Scotia (Family Division) or by the Family Court where there is no Supreme Court (Family Division)." It was reported that in this setting, there is no closed court room and the press will often attempt to gain access by arguing that the public has a right to know what goes on in the provincial court. It was suggested that this confidentiality threat could be avoided if the Review Board determined the declaration of capacity.

8.2 Public access to data

There were multiple concerns regarding the availability of data to the public as well as a lack of pertinent data collected. Individuals commented that there was limited public access to IPTA Review Board decisions; this was compared to a similar review board in Ontario, which provides public access and anonymizes information. Many feel that there is a great deal of information that would be helpful to people affected by the Act that is not being collected. There is a strong overarching view from stakeholders that the government needs to start collecting information that would lead to well-informed reviews of legislation. Furthermore, there is a concern that that the lack of data collection may mean that health administrators are unable to assess their population base. Some of the information that people would like to see collected includes: differences in the tendency to detain against a person's will under IPTA as compared to the Hospitals Act, statistics of CTOs and involuntary admittance, timelines of status changes, whether or not IPTA allows psychiatrists to intervene at an earlier stage in the illness and demographic information on the patients.

10. General administrative concerns

10.1 Timeframes

As previously mentioned in section 6 of this document, many believe the timelines indicated in the Act are not being met. Some individuals reported that the board is not meeting within twenty-one days nor do they give the parties involved three days notice. There is a worry that because of administrative difficulties with regards to timelines, the Act is often violated and therefore these timelines must be re-examined. It was suggested that if the timelines are unrealistic and there is difficulty in adhering to them, they should perhaps not be stipulated in the Act.

Many concerns arose regarding the appropriateness of the seventy-two hour timeline. There is concern that this time period was chosen arbitrarily and individuals have requested that this timeframe be reviewed. There are divergent views concerning whether or not a patient can be assessed within the seventy-two hour period. Specifically individuals from smaller communities with fewer mental health professionals believe there may not be adequate resources available to assess the individual by the deadline. Some people commented that meeting the deadline becomes even more complicated when the seventy-two hour period includes holidays and weekends. Others have expressed the opposing view that seventy-two hours is too long for the patient to wait to be admitted or released. One of the major issues expressed with the seventy-two hour timeline is that staff does not feel they need to be proactive; if they are given a seventy-two hour maximum, they will use the full seventy-two hours. A final consideration that was mentioned has to do with when patients are transferred out of the district because there is no available bed in the hospital. It was reported that the DHA must accept the person but the assessment must be done by the home psychiatrist, so when the patient arrives at the unit, a day has been lost in the process. People questioned whether or not this should change the timelines set out in the Act.

The time period set for the review board to arrange a hearing is twenty-one days. Some consider this to be a long time; one individual described the practical implication that many people will get better within that timeframe and will be discharged. Individuals consulted noted that many patients seemed to understand that they can ask for a hearing but know that they'll be released before the twenty-one days; there is uncertainty if this is a good or bad thing.

There were a few other timeframe concerns, one being the discrepancy between the use of the word "month" in the Act, but "30 days" in the Forms." A few individuals were concerned with frequent discharges where there is an automatic hearing after sixty days but if the patient, for example, is discharged for two days, time restarts. These frequent discharges are reported to be quite common and often delay the patient's right to a hearing. There is confusion between section 7(2) in which a voluntary patient requesting to be discharged can be detained for up to three hours so that a physician can examine them and section 15 in which an individual brought in by the police may be detained for up to twenty four hours. Some healthcare professionals report using the three hour time limit for both situations and have had extreme difficulty in meeting this deadline; there are requests to clarify this in the Act to ensure there are no misinterpretations.

10.2 Forms

The forms generally require that a staff psychiatrist sign them; this is reported to be quite difficult at times as a staff psychiatrist is not always readily available. Further practicality concerns were identified with the requirement for two separate Form 2s to be filled out as well; it was reported that physicians do not fully understand the circumstances under which Form 3 can be invoked. When a patient is admitted for involuntary psychiatric assessment, the Act dictates that the patient is detained until a psychiatrist can do a psychiatric assessment to assess capacity and other criteria. Individuals are uncertain what happens if they must be treated in the emergency room in crisis citing a primary issue of a lack of consent forms for this under IPTA. Doctors described how they are forced to use the Hospitals

Act consent form if anyone must be treated before or during the assessment. They explain that having the patient or SDM sign the consent form under the Hospitals Act ensures coverage from a legal perspective. A final issue that arose in regards to forms was that there was no form that allows the doctor to provide written confirmation that they have assessed a patient as voluntary. For this reason, there is a period of time during which the staff is unsure if the patient is voluntary or involuntary.

11. IPTA – What is missing

Many individuals expressed concern about what happens in cases where the Act does not apply including after release, before being admitted and issues with those who were not admitted under the Act.

There was a perceived high re-admittance rate that caused much concern from family members about the process upon release. They feel that there is very little done in the discharge planning and there are minimal supports available for the individual. The family also expressed fear about their loved one going off their medication. They believe that the capacity that was regained during treatment quickly goes away once the medication is discontinued causing many individuals to regress back to satisfy the criteria for involuntary assessment. They insist that measures must be put in place to ensure that this cycle does not continue.

Many have expressed a desire for timely intervention; they feel if problems are caught early, they can be handled more appropriately. There were many reported situations where the individual may be high functioning yet the family knows they are not well. Many of these situations are those where the individual enters, what some respondents called, a 'just before' stage and remains there until something dangerous happens. Many inquired as to whether or not something can be done before things deteriorate. There was a request for health promotion such as implementation of programs that promote and educate on mental health issues. Individuals have asked if there is any other program that can help support individuals if they are not deemed to fall under the authority of IPTA.

Many families believe their mentally ill family member is not admitted under IPTA because they have learned how to act 'normal' to avoid being admitted. Families understand that the information they provide to authorities may not be sufficient to admit the person, but expressed a desire for a better way to ensure that mentally ill patients do not "fool" the police or psychiatrist. Family members explained that when mentally ill people are confronted with an authority figure, they are often able to present themselves fairly well.

There appeared to be more individuals who were upset because they were not admitted than those who were upset because there were admitted. There were reports of overwhelming large amount of individuals who do not get the help that they need because there is not enough available healthcare. Multiple individuals shared stories in which people who were turned away from the hospital ended up committing suicide. People of all backgrounds feel that individuals are often refused assessment when they shouldn't be; they ask how the Act can be improved to ensure that fewer individuals slip through the cracks. A major concern was the number of people who were brought to the hospital for assessment

but were not admitted; there is concern that these individuals are susceptible for further deterioration and perhaps should be tracked.

Conclusion

This report provides an analysis of the information gathered across a wide range of individuals and organizations involved with the workings of the IPTA as well as consultations with stakeholders across the province. It also includes findings related to admission under the Act, patient and community support, legal guidance and general administrative concerns. The general consensus based on the results of the review is that the Act was viewed as extremely positive. Many individuals, families and organizations expressed relief that an Act exists to ensure the mentally ill individual is given treatment that assists them medically while ensuring a process that is modeled with dignity and respect. The need for further refinement of the Act was expressed and there were many suggestions to be considered when moving forward.

Appendix I

Department of Health and Wellness Data, including data requested and Department of Health and Wellness Response

Total Separations and Length of Stay for Mental Health Patients and Mental Health Patients with Project 304 or Formal Status

Formal Patients are included in the Mental Health Totals
****Fiscal 2007 is only until July 3 2007***

Institution DHA	2001 Total seps	2001 Seps w Proj 304	2001 %Seps w Project 304 of Total MH Seps	2002 Total seps	2002 Seps w Proj 304	2002 %Seps w Project 304 of Total MH Seps	2003 Total seps	2003 Seps w Proj 304	2003 %Seps w Project 304 of Total MH Seps	2004 Total seps	2004 Seps w Proj 304	2004 %Seps w Project 304 of Total MH Seps	2005 Total seps	2005 Seps w Proj 304	2005 %Seps w Project 304 of Total MH Seps	2006 Total seps	2006 Seps w Proj 304	2006 %Seps w Project 304 of Total MH Seps	2007 Total seps*	2007 Seps w Proj 304*	2007 %Seps w Project 304 of Total MH Seps*
DHA 1	128	16	12.5	137	25	18.2	102	23	22.5	119	24	20.2	150	21	14.0	151	25	16.6	139	6	<5
DHA 2	299	27	9.0	236	23	9.7	278	18	6.5	314	14	<5	256	13	5.1	222	15	6.8	223	<5	<5
DHA 3	197	<5	<5	225	8	<5	225	<5	<5	192	8	<5	181	<5	<5	201	0	0.0	150	<5	<5
DHA 4	217	38	17.5	247	15	6.1	270	36	13.3	236	21	8.9	191	15	7.9	164	11	6.7	187	<5	<5
DHA 6	247	0	0.0	294	0	0.0	237	0	0.0	284	0	0.0	348	0	0.0	313	0	0.0	211	0	0.0
DHA 7	177	19	10.7	155	16	10.3	185	9	<5	152	17	11.2	202	14	6.9	185	14	7.6	192	10	5.2
DHA 8	898	59	6.6	913	62	6.8	934	63	6.7	933	88	9.4	776	81	10.4	753	108	14.3	642	36	5.6
DHA 9	1470	207	14.1	1233	182	14.8	1147	185	16.1	1154	198	17.2	1170	181	15.5	1189	183	15.4	1273	83	6.5
IWK	200	15	7.5	221	22	10.0	206	18	8.7	146	12	8.2	155	14	9.0	219	17	7.8	214	10	<5
Total	**3833**	**385**	**10.0**	**3661**	**353**	**9.6**	**3584**	**356**	**9.9**	**3530**	**382**	**10.8**	**3429**	**342**	**10.0**	**3397**	**373**	**11.0**	**3231**	**151**	**<5**

Source: CIHI Discharge Abstract Database

For privacy reasons values less than 5 have been suppressed

Total Separations and Length of Stay for Mental Health Patients and Mental Health Patients with Project 304 or Formal Status

Formal Patients are included in the Mental Health Totals
****Fiscal 2007 is only until July 3 2007***

Institution DHA	2001 Total Stay	2001 Total days Proj 304	2001 % Formal Days of Total Days	2002 Total Stay	2002 Total days Proj 304	2002 % Formal Days of Total Days	2003 Total Stay	2003 Total days Proj 304	2003 % Formal Days of Total Days	2004 Total Stay	2004 Total days Proj 304	2004 % Formal Days of Total Days	2005 Total Stay	2005 Total days Proj 304	2005 % Formal Days of Total Days	2006 Total Stay	2006 Total days Proj 304	2006 % Formal Days of Total Days	2007 Total Stay	2007 Total days Proj 304	2007 % Formal Days of Total Days
DHA 1	2572	394	15.3	2109	455	21.6	2602	538	20.7	2632	573	21.8	3101	411	13.3	2836	577	20.3	2312	162	7.0
DHA 2	4365	777	17.8	3447	448	13.0	2892	194	6.7	2715	271	10.0	3079	285	9.3	3140	526	16.8	2632	7	<5
DHA 3	1981	71	<5	2156	101	<5	2236	20	<5	1217	72	5.9	1012	27	<5	1120		0.0	1009	6	<5
DHA 4	3462	668	19.3	4137	347	8.4	3984	786	19.7	3010	286	9.5	2650	249	9.4	3756	417	11.1	3018	123	<5
DHA 6	2550		0.0	2770		0.0	2511		0.0	2813		0.0	2852		0.0	2250		0.0	2457		0.0
DHA 7	2864	447	15.6	2001	269	13.4	1963	124	6.3	2312	328	14.2	2829	324	11.5	2626	178	6.8	2590	178	6.9
DHA 8	11755	894	7.6	9864	879	8.9	13896	1741	12.5	15184	1745	11.5	11494	1236	10.8	11555	2056	17.8	12329	1265	10.3
DHA 9	54303	6907	12.7	51840	7244	14.0	46573	6493	13.9	65178	7927	12.2	41202	6110	14.8	69875	8987	12.9	61666	3868	6.3
IWK	4194	498	11.9	3919	689	17.6	4425	460	10.4	4399	561	12.8	4182	311	7.4	3581	259	7.2	4324	341	7.9
Total	**88046**	**10656**	**12.1**	**82243**	**10432**	**12.7**	**81082**	**10356**	**12.8**	**99460**	**11763**	**11.8**	**72401**	**8953**	**12.4**	**100739**	**13000**	**12.9**	**92337**	**5950**	**6.4**

Source: CIHI Discharge Abstract Database

For privacy reasons values less than 5 have been suppressed

Median and Average Length of Stay for Mental Health Patients with a Formal Status or Project 340 and the calculations for the Formal stay

***Values relate to separations with a formal status coded and then the formal status**

DHA	Values*	2001	2002	2003	2004	2005	2006	2007
DHA 1	Median total stay	34	20	42	32	28	29.5	20
	Average total stay (ALOS)	41.5	24.7	50.7	39.1	31.6	42.7	33.7
	Median Formal Stay	20	13	30	19	17.5	11.5	14.5
	Average formal Stay	24.6	18.5	24.5	24.6	20	23.8	27
DHA 2	Median total stay	31	24	17.5	24.5	33	44	9
	Average total stay (ALOS)	44.5	32.7	20.4	38.1	40	53	9
	Median Formal Stay	25	13	8	14	22	28	7
	Average formal Stay	28.8	19.5	10.8	19.4	21.9	35.1	7
DHA 3	Median total stay	45	17.5	11.5	12	6	14	
	Average total stay (ALOS)	38.3	20.1	9.8	15.3	12.7	14.0	
	Median Formal Stay	14	10	<5	7.5	5	6	
	Average formal Stay	17.8	12.6	5.0	9.0	9.0	6.0	
DHA 4	Median total stay	23	22	24	15	15	34	48
	Average total stay (ALOS)	29.7	75.3	35.2	28.5	32.5	49.6	43.0
	Median Formal Stay	12	12	16	7	8	27	31
	Average formal Stay	19.0	24.6	22.9	14.7	17.6	37.9	30.8
DHA 7	Median total stay	20.5	20.5	27	31	35.5	24	17
	Average total stay (ALOS)	30.9	24.4	31.1	30.2	33.7	21.4	50.5
	Median Formal Stay	15	12.5	12	18	25.5	18.5	10.5
	Average formal Stay	24.7	16.8	13.8	18.4	23.1	14.6	21.8
DHA 8	Median total stay	15.5	19	24	20	25.5	21.5	27.5
	Average total stay (ALOS)	26.1	32.7	64.2	20.4	37.9	40.6	70.2
	Median Formal Stay	9	10.5	9	12	10	13	17.5
	Average formal Stay	15.4	15.3	30.0	20.4	16.1	20.8	36.5
DHA 9	Median total stay	47.5	52	43	47	41	56	59
	Average total stay (ALOS)	84.7	125.4	78.2	160.1	75.0	220.1	135.9
	Median Formal Stay	28	30	29.5	28	26.5	30	30
	Average formal Stay	37.0	41.0	36.1	41.2	34.8	50.7	47.5
iwk	Median total stay	54	35.5	29	78	26.5	24	25

Source: CIHI Discharge Abstract Database

For privacy reasons values less than 5 have been suppressed

Median and Average Length of Stay for Mental Health Patients with a Formal Status or Project 340 and the calculations for the Formal stay

***Values relate to separations with a formal status coded and then the formal status**

DHA	Values*	2001	2002	2003	2004	2005	2006	2007
	Average total stay (ALOS)	57.7	50.7	53.2	82.6	36.1	27.4	47.4
	Average total	28	27.5	21	30.5	18.5	14	19.5
	Median Formal Stay	33.2	32.9	25.6	46.8	22.2	15.6	34.1

Source: CIHI Discharge Abstract Database

For privacy reasons values less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Total Seperations, Unique Patients and Involuntary Admissions from 2007-2011

DHA	TYPE	2007*	2008	2009	2010	2011	DHA Total
DHA 1	SEPS	107	113	147	121	116	**604**
	CASES	83	93	121	106	101	**504**
	INV ADM	**40**	**35**	**40**	**50**	**56**	**221**
DHA 2	SEPS	159	203	226	256	220	**1064**
	CASES	113	151	172	201	165	**802**
	INV ADM	**33**	**45**	**39**	**42**	**61**	**220**
DHA 3	SEPS	112	182	189	205	240	**928**
	CASES	93	135	130	147	168	**673**
	INV ADM	**34**	**56**	**59**	**51**	**74**	**274**
DHA 4	SEPS	130	160	151	195	174	**810**
	CASES	101	144	135	174	156	**710**
	INV ADM	**45**	**64**	**57**	**76**	**79**	**321**
DHA 5	SEPS						
	CASES						
	INV ADM						
DHA 6	SEPS	143	221	254	242	283	**1143**
	CASES	97	160	183	190	211	**841**
	INV ADM	**5**	**<5**	**<5**	**<5**	**9**	**21**
DHA 7	SEPS	155	192	213	178	195	**933**
	CASES	118	146	172	142	159	**737**
	INV ADM	**30**	**43**	**42**	**40**	**39**	**194**
DHA 8	SEPS	488	639	618	615	684	**3044**
	CASES	323	476	464	472	525	**2260**
	INV ADM	**159**	**209**	**198**	**173**	**202**	**941**
DHA 9	SEPS	1081	1269	1190	1111	1181	**5832**
	CASES	787	1025	994	929	976	**4711**
	INV ADM	**427**	**562**	**600**	**552**	**592**	**2733**
IWK	SEPS	163	223	207	240	388	**1221**
	CASES	111	158	160	188	258	**875**
	INV ADM	**43**	**60**	**51**	**74**	**112**	**340**
Total SEPS For Year		**2538**	**3202**	**3195**	**3163**	**3481**	**15579**
Total CASES For Year		**1826**	**2488**	**2531**	**2549**	**2719**	**12113**
Total INV ADM For Year		**816**	**1076**	**1088**	**1061**	**1224**	**5265**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

-Count of cases is based on unique HCN's. On an average about 1% of cases have wrong or missing HCN's

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness

IPTA REVIEW REPORT

Total Seperations, Unique Patients and Percentage Involuntary Admissions from 2007-2011

DHA	TYPE	2007 *	2008	2009	2010	2011	DHA Total
DHA 1	SEPS	107	113	147	121	116	604
	CASES	83	93	121	106	101	504
	INV ADM	**37.4%**	**31.0%**	**27.2%**	**41.3%**	**48.3%**	**36.6%**
DHA 2	SEPS	159	203	226	256	220	1064
	CASES	113	151	172	201	165	802
	INV ADM	**20.8%**	**22.2%**	**17.3%**	**16.4%**	**27.7%**	**20.7%**
DHA 3	SEPS	112	182	189	205	240	928
	CASES	93	135	130	147	168	673
	INV ADM	**30.4%**	**30.8%**	**31.2%**	**24.9%**	**30.8%**	**29.5%**
DHA 4	SEPS	130	160	151	195	174	810
	CASES	101	144	135	174	156	710
	INV ADM	**34.6%**	**40.0%**	**37.7%**	**39.0%**	**45.4%**	**39.6%**
DHA 5	SEPS						
	CASES						
	INV ADM						
DHA 6	SEPS	143	221	254	242	283	1143
	CASES	97	160	183	190	211	841
	INV ADM	**3.5%**	**0.9%**	**0.8%**	**1.2%**	**3.2%**	**1.8%**
DHA 7	SEPS	155	192	213	178	195	933
	CASES	118	146	172	142	159	737
	INV ADM	**19.4%**	**22.4%**	**19.7%**	**22.5%**	**20.0%**	**20.8%**
DHA 8	SEPS	488	639	618	615	684	3044
	CASES	323	476	464	472	525	2260
	INV ADM	**32.6%**	**32.7%**	**32.0%**	**28.1%**	**29.5%**	**30.9%**
DHA 9	SEPS	1081	1269	1190	1111	1181	5832
	CASES	787	1025	994	929	976	4711
	INV ADM	**39.5%**	**44.3%**	**50.4%**	**49.7%**	**50.1%**	**46.9%**
IWK	SEPS	163	223	207	240	388	1221
	CASES	111	158	160	188	258	875
	INV ADM	**26.4%**	**26.9%**	**24.6%**	**30.8%**	**28.9%**	**27.8%**
Total SEPS For Year		**2538**	**3202**	**3195**	**3163**	**3481**	**15579**
Total CASES For Year		**1826**	**2488**	**2531**	**2549**	**2719**	**12113**
Total INV ADM For Year		**32.2%**	**33.6%**	**34.1%**	**33.5%**	**35.2%**	**33.8%**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

-Count of cases is based on unique HCN's. On an average about 1% of cases have wrong or missing HCN's

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Unique Cases ,Involuntary Admissions and Seperations by Gender from 2007 to 2011

FISCAL YEAR	DHA	UNIQUE CASES			INVOLUNTARY ADMISSIONS			SEPERATIONS		
		F	M	Total	F	M	Total	F	M	Total
2007 *	DHA 1	40	43	**83**	18	22	**40**	54	53	**107**
	DHA 2	55	58	**113**	11	22	**33**	82	77	**159**
	DHA 3	52	41	**93**	17	17	**34**	63	49	**112**
	DHA 4	49	52	**101**	22	23	**45**	65	65	**130**
	DHA 6	57	40	**97**	<5	<5	**5**	85	58	**143**
	DHA 7	56	62	**118**	13	17	**30**	74	81	**155**
	DHA 8	131	192	**323**	67	92	**159**	209	279	**488**
	DHA 9	386	401	**787**	198	229	**427**	551	530	**1081**
	IWK	65	46	**111**	23	20	**43**	95	68	**163**
	Nova Scotia 2007	**891**	**935**	**1826**	**371**	**445**	**816**	**1278**	**1260**	**2538**
2008	DHA 1	47	46	**93**	17	18	**35**	60	53	**113**
	DHA 2	85	66	**151**	25	20	**45**	112	91	**203**
	DHA 3	62	73	**135**	31	25	**56**	78	104	**182**
	DHA 4	83	61	**144**	38	26	**64**	91	69	**160**
	DHA 6	84	76	**160**	<5	<5	**<5**	125	96	**221**
	DHA 7	68	78	**146**	18	25	**43**	95	97	**192**
	DHA 8	233	243	**476**	92	117	**209**	319	320	**639**
	DHA 9	538	487	**1025**	283	279	**562**	683	586	**1269**
	IWK	90	68	**158**	22	38	**60**	118	105	**223**
	Nova Scotia 2008	**1290**	**1198**	**2488**	**527**	**549**	**1076**	**1681**	**1521**	**3202**
2009	DHA 1	50	71	**121**	17	23	**40**	63	84	**147**
	DHA 2	84	88	**172**	17	22	**39**	112	114	**226**
	DHA 3	66	64	**130**	34	25	**59**	107	82	**189**
	DHA 4	68	67	**135**	27	30	**57**	77	74	**151**
	DHA 6	86	97	**183**	<5		**<5**	134	120	**254**
	DHA 7	78	94	**172**	16	26	**42**	97	116	**213**
	DHA 8	212	252	**464**	82	116	**198**	285	333	**618**
	DHA 9	521	473	**994**	304	296	**600**	635	555	**1190**
	IWK	88	72	**160**	18	33	**51**	113	94	**207**
	Nova Scotia 2009	**1253**	**1278**	**2531**	**517**	**571**	**1088**	**1623**	**1572**	**3195**
2010	DHA 1	52	54	**106**	26	24	**50**	63	58	**121**
	DHA 2	106	95	**201**	21	21	**42**	132	124	**256**
	DHA 3	70	77	**147**	22	29	**51**	117	88	**205**
	DHA 4	80	94	**174**	32	44	**76**	89	106	**195**
	DHA 6	97	93	**190**	<5	<5	**<5**	123	119	**242**
	DHA 7	65	77	**142**	18	22	**40**	79	99	**178**
	DHA 8	223	249	**472**	60	113	**173**	296	319	**615**
	DHA 9	449	480	**929**	258	294	**552**	549	562	**1111**
	IWK	89	99	**188**	33	41	**74**	111	129	**240**
	Nova Scotia 2010	**1231**	**1318**	**2549**	**472**	**589**	**1061**	**1559**	**1604**	**3163**
2011	DHA 1	48	53	**101**	26	30	**56**	56	60	**116**
	DHA 2	87	78	**165**	32	29	**61**	122	98	**220**
	DHA 3	85	83	**168**	45	29	**74**	139	101	**240**
	DHA 4	74	82	**156**	42	37	**79**	88	86	**174**
	DHA 6	97	114	**211**	<5	5		144	139	**283**
	DHA 7	74	85	**159**	20	19	**39**	97	98	**195**
	DHA 8	259	266	**525**	85	117	**202**	331	353	**684**
	DHA 9	495	481	**976**	297	295	**592**	622	559	**1181**
	IWK	161	97	**258**	54	58	**112**	253	135	**388**
	Nova Scotia 2011	**1380**	**1339**	**2719**	**605**	**619**	**1224**	**1852**	**1629**	**3481**
	Nova Scotia Total	**6045**	**6068**	**12113**	**2492**	**2773**	**5265**	**7993**	**7586**	**15579**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

-Count of cases is based on unique HCN's. On an average about 1% of cases have wrong or missing HCN's

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Unique Cases , Involuntary Admissions and Seperations by Gender (Percentages) from 2007 to 2011

FISCAL YEAR	DHA	UNIQUE CASES			INVOLUNTARY ADMISSIONS			SEPERATIONS		
		F	M	Total	F	M	Total	F	M	Total
2007 *	DHA 1	48.2%	51.8%	83	45.0%	55.0%	40	50.5%	49.5%	107
	DHA 2	48.7%	51.3%	113	33.3%	66.7%	33	51.6%	48.4%	159
	DHA 3	55.9%	44.1%	93	50.0%	50.0%	34	56.3%	43.8%	112
	DHA 4	48.5%	51.5%	101	48.9%	51.1%	45	50.0%	50.0%	130
	DHA 6	58.8%	41.2%	97	40.0%	60.0%	5	59.4%	40.6%	143
	DHA 7	47.5%	52.5%	118	43.3%	56.7%	30	47.7%	52.3%	155
	DHA 8	40.6%	59.4%	323	42.1%	57.9%	159	42.8%	57.2%	488
	DHA 9	49.0%	51.0%	787	46.4%	53.6%	427	51.0%	49.0%	1081
	IWK	58.6%	41.4%	111	53.5%	46.5%	43	58.3%	41.7%	163
	Nova Scotia 2007	48.8%	51.2%	1826	45.5%	54.5%	816	50.4%	49.6%	2538
2008	DHA 1	50.5%	49.5%	93	48.6%	51.4%	35	53.1%	46.9%	113
	DHA 2	56.3%	43.7%	151	55.6%	44.4%	45	55.2%	44.8%	203
	DHA 3	45.9%	54.1%	135	55.4%	44.6%	56	42.9%	57.1%	182
	DHA 4	57.6%	42.4%	144	59.4%	40.6%	64	56.9%	43.1%	160
	DHA 6	52.5%	47.5%	160			<5	56.6%	43.4%	221
	DHA 7	46.6%	53.4%	146	41.9%	58.1%	43	49.5%	50.5%	192
	DHA 8	48.9%	51.1%	476	44.0%	56.0%	209	49.9%	50.1%	639
	DHA 9	52.5%	47.5%	1025	50.4%	49.6%	562	53.8%	46.2%	1269
	IWK	57.0%	43.0%	158	36.7%	63.3%	60	52.9%	47.1%	223
	Nova Scotia 2008	51.8%	48.2%	2488	49.0%	51.0%	1076	52.5%	47.5%	3202
2009	DHA 1	41.3%	58.7%	121	42.5%	57.5%	40	42.9%	57.1%	147
	DHA 2	48.8%	51.2%	172	43.6%	56.4%	39	49.6%	50.4%	226
	DHA 3	50.8%	49.2%	130	57.6%	42.4%	59	56.6%	43.4%	189
	DHA 4	50.4%	49.6%	135	47.4%	52.6%	57	51.0%	49.0%	151
	DHA 6	47.0%	53.0%	183			<5	52.8%	47.2%	254
	DHA 7	45.3%	54.7%	172	38.1%	61.9%	42	45.5%	54.5%	213
	DHA 8	45.7%	54.3%	464	41.4%	58.6%	198	46.1%	53.9%	618
	DHA 9	52.4%	47.6%	994	50.7%	49.3%	600	53.4%	46.6%	1190
	IWK	55.0%	45.0%	160	35.3%	64.7%	51	54.6%	45.4%	207
	Nova Scotia 2009	49.5%	50.5%	2531	47.5%	52.5%	1088	50.8%	49.2%	3195
2010	DHA 1	49.1%	50.9%	106	52.0%	48.0%	50	52.1%	47.9%	121
	DHA 2	52.7%	47.3%	201	50.0%	50.0%	42	51.6%	48.4%	256
	DHA 3	47.6%	52.4%	147	43.1%	56.9%	51	57.1%	42.9%	205
	DHA 4	46.0%	54.0%	174	42.1%	57.9%	76	45.6%	54.4%	195
	DHA 6	51.1%	48.9%	190	66.7%	33.3%	<5	50.8%	49.2%	242
	DHA 7	45.8%	54.2%	142	45.0%	55.0%	40	44.4%	55.6%	178
	DHA 8	47.2%	52.8%	472	34.7%	65.3%	173	48.1%	51.9%	615
	DHA 9	48.3%	51.7%	929	46.7%	53.3%	552	49.4%	50.6%	1111
	IWK	47.3%	52.7%	188	44.6%	55.4%	74	46.3%	53.8%	240
	Nova Scotia 2010	48.3%	51.7%	2549	44.5%	55.5%	1061	49.3%	50.7%	3163
2011	DHA 1	47.5%	52.5%	101	46.4%	53.6%	56	48.3%	51.7%	116
	DHA 2	52.7%	47.3%	165	52.5%	47.5%	61	55.5%	44.5%	220
	DHA 3	50.6%	49.4%	168	60.8%	39.2%	74	57.9%	42.1%	240
	DHA 4	47.4%	52.6%	156	53.2%	46.8%	79	50.6%	49.4%	174
	DHA 6	46.0%	54.0%	211			9	50.9%	49.1%	283
	DHA 7	46.5%	53.5%	159	51.3%	48.7%	39	49.7%	50.3%	195
	DHA 8	49.3%	50.7%	525	42.1%	57.9%	202	48.4%	51.6%	684
	DHA 9	50.7%	49.3%	976	50.2%	49.8%	592	52.7%	47.3%	1181
	IWK	62.4%	37.6%	258	48.2%	51.8%	112	65.2%	34.8%	388
	Nova Scotia 2011	50.8%	49.2%	2719	49.4%	50.6%	1224	53.2%	46.8%	3481
	Nova Scotia Total	49.9%	50.1%	12113	47.3%	52.7%	5265	51.3%	48.7%	15579

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

-Count of cases is based on unique HCN's. On an average about 1% of cases have wrong or missing HCN's

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Highest Reported Education Level by Unique Cases and Involuntary Admissions For 2011

	EDUCATION LEVEL	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
UNIQUE CASES	Elementary	6	6	<5	5	5	<5	69	46	85	**225**
	Some high school	15	8	26	39	18	21	76	103	133	**439**
	High school diploma	10	9	20	44	6	14	70	103	<5	**279**
	Non university or university training	11	5	11	21	<5	24	37	90	<5	**205**
	Non-university completed	8	<5	15	12	<5	<5	53	62		**159**
	University	6	<5	10	8	<5	6	34	79		**146**
	Unknown	45	131	84	27	176	89	186	491	33	**1262**
	None					<5			<5	<5	**<5**
INVOLUNTARY ADMISSIONS	Elementary	<5	<5					22	25	25	**76**
	Some high school	10	<5	8	20		5	34	57	41	**178**
	High school diploma	<5	<5	8	19		<5	21	53	<5	**110**
	Non university or university training	5	<5	5	11		6	14	52	<5	**96**
	Non-university completed	<5	<5	7	<5		<5	9	34		**60**
	University			5	<5		<5	10	46		**64**
	Unknown	23	34	34	13	7	21	51	231	12	**426**
	None										
	Total Unique Cases	**101**	**165**	**168**	**156**	**211**	**159**	**525**	**976**	**258**	**2719**
	Total Involuntary Admissions	**48**	**43**	**67**	**69**	**7**	**36**	**161**	**498**	**81**	**1010**

Source: CIHI DAD

Financial Support by Unique Cases and Involuntary Admissions For 2011

	FINANCIAL SUPPORT	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
UNIQUE CASES	Disability pension	9	8	5	31	<5	14	121	135	<5	**325**
	Employment insurance	<5	<5	<5	11	<5	7	21	21		**66**
	Welfare	15	13	<5	24	<5	18	89	188	<5	**355**
	None of the above	26	26	24	54	5	55	147	238	49	**624**
	Unknown	48	117	135	36	200	65	147	394	207	**1349**
INVOLUNTARY ADMISSIONS	Disability pension	5	<5	<5	18		<5	28	84	<5	**140**
	Employment insurance	<5		<5	<5		<5	8	16		**30**
	Welfare	10	<5		13	<5	8	34	140		**209**
	None of the above	18	7	5	23		15	56	143	16	**283**
	Unknown	22	50	67	24	8	11	76	209	95	**562**
	Total Unique Cases	**101**	**165**	**168**	**156**	**211**	**159**	**525**	**976**	**258**	**2719**
	Total Involuntary Admissions	**56**	**61**	**74**	**79**	**9**	**39**	**202**	**592**	**112**	**1224**

Source: CIHI DAD

Employment Status by Unique Cases and Involuntary Admissions For 2011

	EMPLOYMENT STATUS	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
UNIQUE CASES	Employed - Unknown full or part time	<5	18	25	26	5	15	43	146	10	**290**
	Full-time employment	12	6	11	11	5	21	13	17		**96**
	Part-time employment	<5	<5	<5	7	<5	<5	9	12	8	**46**
	Unemployed	57	52	26	97	37	78	330	429	35	**1141**
	Other	0		9				99	44		**152**
	Unknown	28	87	95	15	162	43	31	328	205	**994**
INVOLUNTARY ADMISSIONS	Employed - Unknown full or part time	<5	6	10	10		5	15	85	6	**138**
	Full-time employment	7	<5	<5	<5		<5	<5	5		**20**
	Part-time employment	<5	<5	<5	<5			<5	7	<5	**21**
	Unemployed	31	11	8	55	<5	19	132	287	20	**564**
	Other	<5		<5				43	21		**66**
	Unknown	14	41	50	10	8	13	8	187	84	**415**
	Total Unique Cases	**101**	**165**	**168**	**156**	**211**	**159**	**525**	**976**	**258**	**2719**
	Total Involuntary Admissions	**56**	**61**	**74**	**79**	**9**	**39**	**202**	**592**	**112**	**1224**

Source: CIHI DAD

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Highest Education Level (Percentages) by Unique Cases and Involuntary Admissions For 2011

	EDUCATION LEVEL	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
UNIQUE CASES	Elementary	5.9%	3.6%	1.2%	3.2%	2.4%	0.6%	13.1%	4.7%	33.0%	**8.3%**
	Some high school	14.9%	4.9%	15.5%	25.0%	8.5%	13.2%	14.5%	10.6%	51.6%	**16.2%**
	High school diploma	9.9%	5.5%	11.9%	28.2%	2.8%	8.8%	13.3%	10.6%	1.2%	**10.3%**
	Non university or university training	10.9%	3.0%	6.6%	13.5%	1.4%	15.1%	7.1%	9.2%	1.2%	**7.5%**
	Non-university completed	7.9%	2.4%	8.9%	7.7%	0.5%	2.5%	10.1%	6.4%		**5.9%**
	University	5.9%	1.2%	6.0%	5.1%	0.5%	3.8%	6.5%	8.1%		**5.4%**
	Unknown	44.6%	79.4%	50.0%	17.3%	83.4%	56.0%	35.4%	50.3%	12.8%	**46.4%**
	None					0.5%			0.2%	0.4%	**0.2%**
INVOLUNTARY ADMISSIONS	Elementary	6.3%	2.3%	0.0%	0.0%		0.0%	13.7%	5.0%	30.9%	**7.5%**
	Some high school	20.8%	7.0%	11.9%	29.0%		13.9%	21.1%	11.5%	50.6%	**17.6%**
	High school diploma	8.3%	2.3%	11.9%	27.5%		5.6%	13.0%	10.6%	2.5%	**10.9%**
	Non university or university training	10.4%	4.7%	7.5%	15.9%		16.7%	8.7%	10.4%	1.2%	**9.5%**
	Non-university completed	6.3%	4.7%	10.5%	5.8%		2.8%	5.6%	6.8%		**5.9%**
	University	0.0%	0.0%	7.5%	2.9%		2.8%	6.2%	9.2%		**6.3%**
	Unknown	47.9%	79.1%	50.8%	18.8%	100.0%	58.3%	31.7%	46.4%	14.8%	**42.2%**
	None										

Source: CIHI DAD

Financial (Percentages) Support by Unique Cases and Involuntary Admissions For 2011

	FINANCIAL SUPPORT	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
UNIQUE CASES	Disability pension	8.9%	4.9%	3.0%	19.9%	0.5%	8.8%	23.1%	13.8%	0.4%	**12.0%**
	Employment insurance	3.0%	0.6%	0.6%	7.1%	0.5%	4.4%	4.0%	2.2%	0.0%	**2.4%**
	Welfare	14.9%	7.9%	1.8%	15.4%	1.9%	11.3%	17.0%	19.3%	0.4%	**13.1%**
	None of the above	25.7%	15.8%	14.3%	34.6%	2.4%	34.6%	28.0%	24.4%	19.0%	**23.0%**
	Unknown	47.5%	70.9%	80.4%	23.1%	94.8%	40.9%	28.0%	40.4%	80.2%	**49.6%**
INVOLUNTARY ADMISSIONS	Disability pension	8.9%	1.6%	1.4%	22.8%	0.0%	5.1%	13.9%	14.2%	0.9%	**11.4%**
	Employment insurance	1.8%	0.0%	1.4%	1.3%	0.0%	7.7%	4.0%	2.7%	0.0%	**2.5%**
	Welfare	17.9%	4.9%	0.0%	16.5%	11.1%	20.5%	16.8%	23.7%	0.0%	**17.1%**
	None of the above	32.1%	11.5%	6.8%	29.1%	0.0%	38.5%	27.7%	24.2%	14.3%	**23.1%**
	Unknown	39.3%	82.0%	90.5%	30.4%	88.9%	28.2%	37.6%	35.3%	84.8%	**45.9%**

Source: CIHI DAD

Employment (Percentages) Status by Unique Cases and Involuntary Admissions For 2011

	EMPLOYMENT STATUS	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
UNIQUE CASES	Employed - Unknown full or part time	2.0%	10.9%	14.9%	16.7%	2.4%	9.4%	8.2%	15.0%	3.9%	**10.7%**
	Full-time employment	11.9%	3.6%	6.6%	7.1%	2.4%	13.2%	2.5%	1.7%	0.0%	**3.5%**
	Part-time employment	2.0%	1.2%	1.2%	4.5%	1.0%	1.3%	1.7%	1.2%	3.1%	**1.7%**
	Unemployed	56.4%	31.5%	15.5%	62.2%	17.5%	49.1%	62.9%	44.0%	13.6%	**42.0%**
	Other	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	18.9%	4.5%	0.0%	**5.6%**
	Unknown	27.7%	52.7%	56.6%	9.6%	76.8%	27.0%	5.9%	33.6%	79.5%	**36.6%**
INVOLUNTARY ADMISSIONS	Employed - Unknown full or part time	1.8%	9.8%	13.5%	12.7%	0.0%	12.8%	7.4%	14.4%	5.4%	**11.3%**
	Full-time employment	12.5%	1.6%	2.7%	2.5%	0.0%	5.1%	0.5%	0.8%	0.0%	**1.6%**
	Part-time employment	3.6%	3.3%	4.1%	2.5%	0.0%	0.0%	1.5%	1.2%	1.8%	**1.7%**
	Unemployed	55.4%	18.0%	10.8%	69.6%	11.1%	48.7%	65.4%	48.5%	17.9%	**46.1%**
	Other	1.8%	0.0%	1.4%	0.0%	0.0%	0.0%	21.3%	3.6%	0.0%	**5.4%**
	Unknown	25.0%	67.2%	67.6%	12.7%	88.9%	33.3%	4.0%	31.6%	75.0%	**33.9%**

Source: CIHI DAD

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Age Levels by Unique Cases and Involuntary Admissions from 2007 to 2011

		UNIQUE CASES									INVOLUNTARY ADMISSION									NS	
FISCAL YEAR	AGE CATEGORY	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	CASES	INV ADM
2007 *	1-9									3										3	
	10-19	<5	11	<5	<5	<5	7	17	27	108	<5	<5	<5	<5	<5	<5	8	12	43	182	77
	20-29	17	19	20	17	16	18	63	189		10	14	11	7		7	36	134		359	219
	30-39	15	22	15	19	15	21	53	149		7	5	8	12	<5	<5	27	85		309	149
	40-49	21	21	22	29	19	29	75	193		11	6	5	10	<5	6	29	99		409	167
	50-59	14	22	17	16	26	24	59	129		5	<5	<5	5		6	21	60		307	103
	60-69	6	12	7	10	13	14	37	44		<5	<5	<5	<5		<5	26	22		143	62
	70-79	8	<5	7	6	<5	<5	12	43		<5	<5	<5	<5	<5	<5	7	14		87	32
	80-89		<5	<5	<5	<5	<5	7	12							<5	5			26	6
	90-99								<5									<5		<5	<5
	2007 Total	83	113	93	101	97	118	323	787	111	40	33	34	45	5	30	159	427	43	1826	816
2008	1-9									<5										<5	
	10-19	<5	10		<5	19	16	31	29	156	<5	<5		<5		6	16	13	60	267	104
	20-29	17	30	26	29	36	24	76	255		8	14	13	13	<5	14	29	157		493	250
	30-39	14	26	22	25	31	18	73	201		7	9	9	13		<5	30	109		410	180
	40-49	27	33	37	36	29	38	109	230		9	11	11	14		12	49	134		539	240
	50-59	21	31	28	27	23	26	92	153		5	6	13	10		<5	27	89		401	154
	60-69	8	11	14	21	14	12	58	87		<5	<5	7	10		<5	39	40		225	103
	70-79	<5	7	6	<5	7	8	25	43				<5	<5			13	12		102	29
	80-89		<5	<5		<5	<5	11	25			<5	<5				6	8		46	16
	90-99							<5	<5											<5	
	2008 Total	93	151	135	144	160	146	476	1025	158	35	45	56	64	<5	43	209	562	60	2488	1076
2009	1-9																				
	10-19	6	15	<5	<5	15	13	33	26	160	<5	<5	<5			6	19	26	51	275	109
	20-29	23	25	23	26	42	32	85	232		12	8	13	14		14	39	155		488	255
	30-39	20	36	27	29	36	28	83	193		5	<5	15	11		11	35	125		452	204
	40-49	28	46	31	29	35	41	91	214		10	12	12	11	<5	7	35	117		515	205
	50-59	21	29	24	21	32	33	86	151		8	8	9	7	<5	<5	29	93		397	158
	60-69	14	13	12	19	13	16	54	101		<5	<5	<5	11			24	52		242	98
	70-79	<5	7	7	6	7	5	22	51			<5	<5	<5			10	27		109	45
	80-89	5	<5	<5	<5	<5	<5	8	26			<5				<5	6	5		51	13
	90-99							<5									<5			<5	<5
	2009 Total	121	172	130	135	183	172	464	994	160	40	39	59	57	<5	42	198	600	51	2531	1088
2010	1-9									<5										<5	
	10-19	<5	8	<5	<5	20	12	33	23	187	<5	<5	<5	<5	<5	6	16	9	74	293	116
	20-29	23	41	24	34	33	34	84	234		13	7	12	19		11	45	165		507	272
	30-39	19	46	33	35	30	21	84	175		8	8	12	11		8	25	111		443	183
	40-49	26	55	32	37	53	28	94	187		14	15	9	14	<5	6	31	107		512	197
	50-59	21	31	28	34	29	26	88	173		9	<5	11	14	<5	<5	24	106		430	173
	60-69	10	12	17	23	19	14	56	76		<5	<5	<5	13		<5	20	38		227	84
	70-79	<5	7	6	6	<5	6	23	40			<5	<5	<5		<5	7	13		96	26
	80-89		<5	<5	<5	<5	<5	10	21					<5			5	<5		40	10
	90-99																				
	2010 Total	106	201	147	174	190	142	472	929	188	50	42	51	76	<5	40	173	552	74	2549	1061
2011	1-9					<5				<5										<5	
	10-19	5	8	7	<5	26	15	50	25	257	<5	<5	5	<5	<5	5	41	17	112	397	189
	20-29	16	30	30	30	42	42	77	212		9	18	19	14	<5	13	45	153		479	272
	30-39	14	32	26	27	39	21	78	202		10	10	11	14	<5	5	26	115		439	192
	40-49	18	41	40	33	37	25	126	187		6	15	17	15	<5	6	42	104		507	207
	50-59	29	30	38	32	42	30	102	193		16	8	12	23	<5	6	23	123		496	212
	60-69	11	19	17	23	17	16	60	95		8	8	10	9	<5	<5	16	58		258	114
	70-79	8	<5	6	<5	5	7	21	45		<5			<5			6	15		99	26
	80-89		<5	<5	<5	<5	<5	11	17					<5		<5	<5	7		41	12
	90-99				<5															<5	
	2011 Total	101	165	168	156	211	159	525	976	258	56	61	74	79	9	39	202	592	112	2719	1224
	Total	504	802	673	710	841	737	2260	4711	875	221	220	274	321	21	194	941	2733	340	12113	5265

Legend:

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

-Count of cases is based on unique HCN's. On an average about 1% of cases have wrong or missing HCN's

Source: CIHI DAD

Nova Scotia Department of Health and Wellness

IPTA REVIEW REPORT

Age Levels (Percentages) by Unique Cases and Involuntary Admissions from 2007 to 2011

		UNIQUE CASES									INVOLUNTARY ADMISSION									NS	
FISCAL YEAR	AGE CATEGORY	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	CASES	INV ADM
2007 *	1-9	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.16%**	**0.00%**
	10-19	2.41%	9.73%	4.30%	2.97%	3.09%	5.93%	5.26%	3.43%	#########	5.00%	9.09%	5.88%	8.89%	#########	6.67%	5.03%	2.81%	#########	**9.97%**	**9.44%**
	20-29	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	0.00%	#########	#########	#########	0.00%	**19.66%**	**26.84%**
	30-39	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**16.92%**	**18.26%**
	40-49	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**22.40%**	**20.47%**
	50-59	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	9.09%	8.82%	#########	0.00%	#########	#########	#########	0.00%	**16.81%**	**12.62%**
	60-69	7.23%	#########	7.53%	9.90%	#########	#########	#########	5.59%	0.00%	7.50%	3.03%	8.82%	8.89%	0.00%	#########	#########	5.15%	0.00%	**7.83%**	**7.60%**
	70-79	9.64%	2.65%	7.53%	5.94%	4.12%	3.39%	3.72%	5.46%	0.00%	5.00%	3.03%	5.88%	6.67%	#########	6.67%	4.40%	3.28%	0.00%	**4.76%**	**3.92%**
	80-89	0.00%	2.65%	1.08%	0.99%	1.03%	0.85%	2.17%	1.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.33%	3.14%	0.00%	0.00%	**1.42%**	**0.74%**
	90-99	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.23%	0.00%	**0.05%**	**0.12%**
	2007 Total	**83**	**113**	**93**	**101**	**97**	**118**	**323**	**787**	**111**	**40**	**33**	**34**	**45**	**5**	**30**	**159**	**427**	**43**	**1826**	**816**
2008	1-9	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.08%**	**0.00%**
	10-19	3.23%	6.62%	0.00%	2.08%	#########	#########	6.51%	2.83%	#########	#########	6.67%	0.00%	3.13%	0.00%	#########	7.66%	2.31%	#########	**10.73%**	**9.67%**
	20-29	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**19.82%**	**23.23%**
	30-39	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	0.00%	6.98%	#########	#########	0.00%	**16.48%**	**16.73%**
	40-49	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	0.00%	#########	#########	#########	0.00%	**21.66%**	**22.30%**
	50-59	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	0.00%	9.30%	#########	#########	0.00%	**16.12%**	**14.31%**
	60-69	8.60%	7.28%	#########	#########	8.75%	8.22%	#########	8.49%	0.00%	5.71%	2.22%	#########	#########	0.00%	9.30%	#########	7.12%	0.00%	**9.04%**	**9.57%**
	70-79	3.23%	4.64%	4.44%	2.08%	4.38%	5.48%	5.25%	4.20%	0.00%	0.00%	0.00%	3.57%	3.13%	0.00%	0.00%	6.22%	2.14%	0.00%	**4.10%**	**2.70%**
	80-89	0.00%	1.99%	1.48%	0.00%	0.63%	2.74%	2.31%	2.44%	0.00%	0.00%	2.22%	1.79%	0.00%	0.00%	0.00%	2.87%	1.42%	0.00%	**1.85%**	**1.49%**
	90-99	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.21%	0.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.12%**	**0.00%**
	2008 Total	**93**	**151**	**135**	**144**	**160**	**146**	**476**	**1025**	**158**	**35**	**45**	**56**	**64**	**<5**	**43**	**209**	**562**	**60**	**2488**	**1076**
2009	1-9	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**
	10-19	4.96%	8.72%	3.08%	2.22%	8.20%	7.56%	7.11%	2.62%	#########	2.50%	7.69%	5.08%	0.00%	0.00%	#########	9.60%	4.33%	#########	**10.87%**	**10.02%**
	20-29	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	0.00%	#########	#########	#########	0.00%	**19.28%**	**23.44%**
	30-39	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	5.13%	#########	#########	0.00%	#########	#########	#########	0.00%	**17.86%**	**18.75%**
	40-49	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**20.35%**	**18.84%**
	50-59	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	7.14%	#########	#########	0.00%	**15.69%**	**14.52%**
	60-69	#########	7.56%	9.23%	#########	7.10%	9.30%	#########	#########	0.00%	#########	7.69%	6.78%	#########	0.00%	0.00%	#########	8.67%	0.00%	**9.56%**	**9.01%**
	70-79	3.31%	4.07%	5.38%	4.44%	3.83%	2.91%	4.74%	5.13%	0.00%	0.00%	5.13%	5.08%	5.26%	0.00%	0.00%	5.05%	4.50%	0.00%	**4.31%**	**4.14%**
	80-89	4.13%	0.58%	1.54%	1.48%	1.64%	2.33%	1.72%	2.62%	0.00%	0.00%	2.56%	0.00%	0.00%	0.00%	2.38%	3.03%	0.83%	0.00%	**2.02%**	**1.19%**
	90-99	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.51%	0.00%	0.00%	**0.08%**	**0.09%**
	2009 Total	**121**	**172**	**130**	**135**	**183**	**172**	**464**	**994**	**160**	**40**	**39**	**59**	**57**	**<5**	**42**	**198**	**600**	**51**	**2531**	**1088**
2010	1-9	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.04%**	**0.00%**
	10-19	2.83%	3.98%	2.72%	1.72%	#########	8.45%	6.99%	2.48%	#########	4.00%	7.14%	5.88%	2.63%	#########	#########	9.25%	1.63%	#########	**11.49%**	**10.93%**
	20-29	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	0.00%	#########	#########	#########	0.00%	**19.89%**	**25.64%**
	30-39	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	0.00%	#########	#########	#########	0.00%	**17.38%**	**17.25%**
	40-49	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**20.09%**	**18.57%**
	50-59	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	9.52%	#########	#########	#########	#########	#########	#########	0.00%	**16.87%**	**16.31%**
	60-69	9.43%	5.97%	#########	#########	#########	9.86%	#########	8.18%	0.00%	8.00%	7.14%	5.88%	#########	0.00%	7.50%	#########	6.88%	0.00%	**8.91%**	**7.92%**
	70-79	3.77%	3.48%	4.08%	3.45%	2.11%	4.23%	4.87%	4.31%	0.00%	0.00%	4.76%	1.96%	1.32%	0.00%	5.00%	4.05%	2.36%	0.00%	**3.77%**	**2.45%**
	80-89	0.00%	0.50%	2.04%	1.15%	1.05%	0.70%	2.12%	2.26%	0.00%	0.00%	0.00%	0.00%	2.63%	0.00%	0.00%	2.89%	0.54%	0.00%	**1.57%**	**0.94%**
	90-99	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**
	2010 Total	**106**	**201**	**147**	**174**	**190**	**142**	**472**	**929**	**188**	**50**	**42**	**51**	**76**	**<5**	**40**	**173**	**552**	**74**	**2549**	**1061**
2011	1-9	0.00%	0.00%	0.00%	0.00%	0.47%	0.00%	0.00%	0.00%	0.39%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.07%**	**0.00%**
	10-19	4.95%	4.85%	4.17%	2.56%	#########	9.43%	9.52%	2.56%	#########	5.36%	3.28%	6.76%	2.53%	#########	#########	#########	2.87%	#########	**14.60%**	**15.44%**
	20-29	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**17.62%**	**22.22%**
	30-39	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**16.15%**	**15.69%**
	40-49	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**18.65%**	**16.91%**
	50-59	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	#########	#########	#########	#########	#########	#########	#########	#########	0.00%	**18.24%**	**17.32%**
	60-69	#########	#########	#########	#########	8.06%	#########	#########	9.73%	0.00%	#########	#########	#########	#########	#########	7.69%	7.92%	9.80%	0.00%	**9.49%**	**9.31%**
	70-79	7.92%	1.82%	3.57%	2.56%	2.37%	4.40%	4.00%	4.61%	0.00%	7.14%	0.00%	0.00%	1.27%	0.00%	0.00%	2.97%	2.53%	0.00%	**3.64%**	**2.12%**
	80-89	0.00%	1.21%	2.38%	1.28%	0.95%	1.89%	2.10%	1.74%	0.00%	0.00%	0.00%	0.00%	1.27%	0.00%	2.56%	1.49%	1.18%	0.00%	**1.51%**	**0.98%**
	90-99	0.00%	0.00%	0.00%	0.64%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.04%**	**0.00%**
	2011 Total	**101**	**165**	**168**	**156**	**211**	**159**	**525**	**976**	**258**	**56**	**61**	**74**	**79**	**9**	**39**	**202**	**592**	**112**	**2719**	**1224**

Legend:
*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:
-Count of cases is based on unique HCN's. On an average about 1% of cases have wrong or missing HCN's

Source: CIHI DAD

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Involuntary Admissions which were Re-Admissions from 2007-2011

FISCALYEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	INV ADM	40	33	34	45	5	30	159	427	43	816
	RE ADM	**<5**	**18**	**5**	**10**	**<5**	**14**	**55**	**43**	**19**	**172**
2008	INV ADM	35	45	56	64	<5	43	209	562	60	1076
	RE ADM	**5**	**22**	**10**	**7**	**14**	**19**	**62**	**87**	**17**	**243**
2009	INV ADM	40	39	59	57	<5	42	198	600	51	1088
	RE ADM	**9**	**20**	**19**	**7**	**26**	**16**	**62**	**68**	**19**	**246**
2010	INV ADM	50	42	51	76	<5	40	173	552	74	1061
	RE ADM	**6**	**21**	**35**	**7**	**6**	**17**	**64**	**62**	**32**	**250**
2011	INV ADM	56	61	74	79	9	39	202	592	112	1224
	RE ADM	**5**	**19**	**13**	**8**	**12**	**15**	**73**	**84**	**72**	**301**
Total Involuntary Admissions		**221**	**220**	**274**	**321**	**21**	**194**	**941**	**2733**	**340**	**5265**
Total Re Admission		**29**	**100**	**82**	**39**	**62**	**81**	**316**	**344**	**159**	**1212**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Re-Admissions and Rate for Involuntary Admissions by Age Groups from 2007-2011

DHA	AGE CATEGORY	FISCAL_YEAR										TOTAL	
		2007 *		2008		2009		2010		2011			
		READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE
DHA 1	10-19		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
	20-29		0.0%	<5	4.3%	<5	3.3%	<5	7.4%		0.0%	<5	3.5%
	30-39	<5	5.0%		0.0%	<5	8.7%		0.0%	<5	12.5%	5	5.4%
	40-49	<5	9.4%	<5	6.7%	<5	5.6%		0.0%		0.0%	7	4.8%
	50-59		0.0%	<5	3.8%	<5	14.3%	<5	11.5%	<5	5.9%	10	7.5%
	60-69		0.0%	<5	10.0%		0.0%	<5	8.3%	<5	6.7%	<5	5.1%
	70-79		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
	80-89						0.0%						0.0%
DHA 1 Total		**<5**	**3.7%**	**5**	**4.4%**	**9**	**6.1%**	**6**	**5.0%**	**5**	**4.3%**	**29**	**4.8%**
DHA 2	10-19	<5	7.7%	<5	25.0%	<5	5.6%		0.0%		0.0%	6	9.5%
	20-29	<5	8.8%	5	11.6%	<5	6.3%	2	4.3%	<5	10.8%	16	8.3%
	30-39	6	17.1%	6	16.7%	<5	8.5%	9	14.3%	<5	8.9%	29	12.8%
	40-49	<5	6.9%	<5	7.5%	7	11.5%	8	10.4%	<5	6.7%	24	9.0%
	50-59	<5	4.3%	<5	6.8%	<5	9.8%	<5	2.6%	5	13.2%	14	7.6%
	60-69	<5	17.6%	<5	7.1%		0.0%		0.0%	<5	7.4%	6	7.1%
	70-79	<5	40.0%		0.0%	<5	16.7%		0.0%		0.0%	<5	11.8%
	80-89		0.0%		0.0%		0.0%	<5	50.0%		0.0%	<5	9.1%
DHA 2 Total		**18**	**11.3%**	**22**	**10.8%**	**20**	**8.8%**	**21**	**8.2%**	**19**	**8.6%**	**100**	**9.4%**
DHA 3	10-19		0.0%				0.0%	<5	20.0%		0.0%	<5	4.5%
	20-29	<5	4.5%	<5	6.9%		0.0%		0.0%	<5	7.9%	6	4.3%
	30-39	<5	10.0%	5	16.7%	18	36.7%	6	14.3%	<5	6.7%	33	19.3%
	40-49	<5	3.3%	<5	2.5%		0.0%	25	45.5%	<5	6.0%	30	14.4%
	50-59		0.0%		0.0%	<5	3.1%	<5	5.9%	<5	8.7%	7	4.3%
	60-69	<5	12.5%		0.0%		0.0%	<5	5.3%	<5	5.0%	<5	3.0%
	70-79		0.0%	<5	18.2%		0.0%		0.0%		0.0%	<5	5.3%
	80-89		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
DHA 3 Total		**5**	**4.5%**	**10**	**5.5%**	**19**	**10.1%**	**35**	**17.1%**	**13**	**5.4%**	**82**	**8.8%**
DHA 4	10-19		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
	20-29	<5	4.8%	<5	6.3%	<5	6.9%	<5	9.1%		0.0%	9	5.7%
	30-39	<5	12.0%		0.0%	<5	12.1%		0.0%	<5	6.7%	9	6.0%
	40-49	<5	5.6%		0.0%	<5	3.0%	<5	2.4%	<5	8.1%	7	3.7%
	50-59	<5	15.0%	<5	13.3%		0.0%	<5	2.7%	<5	7.7%	11	7.5%
	60-69		0.0%	<5	4.2%		0.0%	<5	4.0%		0.0%	<5	1.9%
	70-79	<5	10.0%		0.0%		0.0%		0.0%		0.0%	<5	3.1%
	80-89		0.0%				0.0%		0.0%		0.0%		0.0%
DHA 4 Total		**10**	**7.7%**	**7**	**4.4%**	**7**	**4.6%**	**7**	**3.6%**	**8**	**4.6%**	**39**	**4.8%**
DHA 6	10-19		0.0%		0.0%	5	25.0%	<5	4.8%		0.0%	6	6.2%
	20-29	<5	9.7%	<5	4.2%	6	10.9%	<5	5.0%	<5	3.6%	15	6.6%
	30-39	<5	4.2%	<5	9.3%	7	10.9%	<5	5.3%	<5	2.3%	15	7.0%
	40-49		0.0%	<5	4.7%	<5	4.2%		0.0%	<5	6.6%	8	3.2%
	50-59		0.0%	<5	8.3%	<5	10.5%		0.0%	<5	5.0%	10	4.9%
	60-69		0.0%	<5	14.3%		0.0%	<5	4.0%	<5	4.2%	5	4.9%
	70-79		0.0%		0.0%	<5	18.2%		0.0%	<5	16.7%	<5	9.1%
	80-89		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
DHA 6 Total		**<5**	**2.8%**	**14**	**6.3%**	**26**	**10.2%**	**6**	**2.5%**	**12**	**4.2%**	**62**	**5.4%**
DHA 7	10-19		0.0%	<5	5.9%	<5	7.7%	<5	11.8%	<5	5.6%	5	6.8%
	20-29	<5	17.4%	<5	10.0%	<5	5.7%	<5	2.6%	<5	4.3%	12	6.9%
	30-39		0.0%	5	17.9%	<5	8.8%	<5	12.0%	<5	14.8%	15	10.9%
	40-49	5	11.6%	6	10.7%	6	10.2%	<5	8.6%	<5	3.3%	21	9.4%
	50-59	<5	3.4%	<5	8.6%	<5	9.1%	<5	9.1%	<5	9.5%	15	8.2%
	60-69	<5	5.9%		0.0%		0.0%	<5	15.8%	<5	5.3%	5	6.0%
	70-79	<5	33.3%	<5	10.0%		0.0%	<5	20.0%	<5	22.2%	8	17.8%
	80-89		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
DHA 7 Total		**14**	**9.0%**	**19**	**9.9%**	**16**	**7.5%**	**17**	**9.6%**	**15**	**7.7%**	**81**	**8.7%**
DHA 8	10-19		0.0%		0.0%	<5	5.4%	<5	4.7%	<5	6.8%	8	4.2%
	20-29	6	6.9%	14	14.0%	6	5.9%	11	10.6%	9	8.4%	46	9.2%
	30-39	12	13.8%	13	12.6%	14	12.7%	18	16.1%	12	11.8%	69	13.4%
	40-49	18	17.0%	22	13.6%	23	16.7%	14	10.8%	18	10.7%	95	13.5%
	50-59	10	10.8%	6	5.0%	9	7.4%	9	7.6%	14	10.3%	48	8.2%
	60-69	8	11.3%	6	7.6%	7	9.3%	6	9.2%	11	14.3%	38	10.4%
	70-79	<5	6.3%	<5	3.4%	<5	4.0%	<5	3.3%	<5	13.6%	7	5.7%
	80-89		0.0%		0.0%		0.0%	<5	25.0%	<5	15.4%	5	8.9%
DHA 8 Total		**55**	**11.3%**	**62**	**9.7%**	**62**	**10.0%**	**64**	**10.4%**	**73**	**10.7%**	**316**	**10.4%**

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Re-Admissions and Rate for Involuntary Admissions by Age Groups from 2007-2011

DHA	AGE CATEGORY	FISCAL_YEAR										TOTAL	
		2007 *		2008		2009		2010		2011			
		READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE
DHA 9	10-19	<5	3.4%	<5	2.7%	<5	6.5%	<5	4.2%	<5	9.1%	8	5.2%
	20-29	20	7.0%	28	8.5%	21	7.4%	18	6.3%	28	10.3%	115	7.9%
	30-39	7	3.4%	17	6.7%	16	6.8%	11	5.4%	16	6.6%	67	5.9%
	40-49	11	4.5%	21	7.7%	17	6.5%	12	5.3%	15	6.8%	76	6.2%
	50-59	<5	1.7%	13	6.8%	8	4.5%	14	6.5%	15	6.3%	53	5.3%
	60-69		0.0%	<5	3.9%	<5	1.8%	<5	3.4%	5	4.7%	14	3.0%
	70-79	<5	1.5%	<5	6.3%	<5	1.6%	<5	4.3%	<5	4.0%	9	3.3%
	80-89		0.0%		0.0%	<5	3.6%	<5	4.5%		0.0%	<5	1.7%
DHA 9 Total		**43**	**4.0%**	**87**	**6.9%**	**68**	**5.7%**	**62**	**5.6%**	**84**	**7.1%**	**344**	**5.9%**
IWK	1-9		0.0%		0.0%				0.0%		0.0%		0.0%
	10-19	19	11.9%	17	7.7%	19	9.2%	32	13.4%	72	18.6%	159	13.1%
IWK Total		**19**	**11.7%**	**17**	**7.6%**	**19**	**9.2%**	**32**	**13.3%**	**72**	**18.6%**	**159**	**13.0%**
Nova Scotia		**172**	**6.8%**	**243**	**7.6%**	**246**	**7.7%**	**250**	**7.9%**	**301**	**8.6%**	**1212**	**7.8%**

Legend:

Source: CIHI DAD

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Re-Admissions and Rate for Involuntary Admissions by Gender from 2007-2011

DHA	GENDER	FISCAL_YEAR										TOTAL READM	TOTAL RATE
		2007 *		2008		2009		2010		2011			
		READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE		
DHA 1	F	<5	5.6%	<5	5.0%	5	7.9%	<5	6.4%	<5	3.6%	17	5.7%
	M	<5	1.9%	<5	3.8%	<5	4.8%	<5	3.5%	<5	5.0%	12	3.9%
DHA 1 Total		<5	**3.7%**	**5**	**4.4%**	**9**	**6.1%**	**6**	**5.0%**	**5**	**4.3%**	**29**	**4.8%**
DHA 2	F	12	14.6%	8	7.1%	11	9.8%	12	9.1%	12	9.8%	55	9.8%
	M	6	7.8%	14	15.4%	9	7.9%	9	7.3%	7	7.1%	45	8.9%
DHA 2 Total		**18**	**11.3%**	**22**	**10.8%**	**20**	**8.9%**	**21**	**8.2%**	**19**	**8.6%**	**100**	**9.4%**
DHA 3	F	<5	3.2%	9	11.5%	16	15.0%	28	23.9%	5	3.6%	60	11.9%
	M	<5	6.1%	<5	1.0%	<5	3.7%	7	8.0%	8	7.9%	22	5.2%
DHA 3 Total		**5**	**4.5%**	**10**	**5.5%**	**19**	**10.1%**	**35**	**17.1%**	**13**	**5.4%**	**82**	**8.8%**
DHA 4	F	6	9.2%	<5	1.1%	<5	2.6%	<5	3.4%	<5	4.6%	16	3.9%
	M	<5	6.2%	6	8.7%	5	6.8%	<5	3.8%	<5	4.7%	23	5.8%
DHA 4 Total		**10**	**7.7%**	**7**	**4.4%**	**7**	**4.6%**	**7**	**3.6%**	**8**	**4.6%**	**39**	**4.8%**
DHA 6	F	<5	4.7%	11	8.8%	15	11.2%	<5	0.8%	9	6.3%	40	6.6%
	M		0.0%	<5	3.1%	11	9.2%	5	4.2%	<5	2.2%	22	4.1%
DHA 6 Total		<5	**2.8%**	**14**	**6.3%**	**26**	**10.2%**	**6**	**2.5%**	**12**	**4.2%**	**62**	**5.4%**
DHA 7	F	6	8.1%	13	13.7%	<5	3.1%	8	10.1%	11	11.3%	41	9.3%
	M	8	9.9%	6	6.2%	13	11.2%	9	9.1%	<5	4.1%	40	8.2%
DHA 7 Total		**14**	**9.0%**	**19**	**9.9%**	**16**	**7.5%**	**17**	**9.6%**	**15**	**7.7%**	**81**	**8.7%**
DHA 8	F	28	13.4%	33	10.3%	29	10.2%	31	10.5%	44	13.3%	165	11.5%
	M	27	9.7%	29	9.1%	33	9.9%	33	10.3%	29	8.2%	151	9.4%
DHA 8 Total		**55**	**11.3%**	**62**	**9.7%**	**62**	**10.0%**	**64**	**10.4%**	**73**	**10.7%**	**316**	**10.4%**
DHA 9	F	23	4.2%	51	7.5%	34	5.4%	26	4.7%	51	8.2%	185	6.1%
	M	20	3.8%	36	6.1%	34	6.1%	36	6.4%	33	5.9%	159	5.7%
DHA 9 Total		**43**	**4.0%**	**87**	**6.9%**	**68**	**5.7%**	**62**	**5.6%**	**84**	**7.1%**	**344**	**5.9%**
IWK	F	11	11.6%	6	5.1%	12	10.6%	14	12.6%	54	21.3%	97	14.1%
	M	8	11.8%	11	10.5%	7	7.5%	18	14.0%	18	13.3%	62	11.7%
IWK Total		**19**	**11.7%**	**17**	**7.6%**	**19**	**9.2%**	**32**	**13.3%**	**72**	**18.6%**	**159**	**13.0%**
Nova Scotia		**172**	**6.8%**	**243**	**7.6%**	**246**	**7.7%**	**250**	**7.9%**	**301**	**8.7%**	**1212**	**7.8%**

Legend:
*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Source: CIHI DAD

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Total and Average Voluntary and Involuntary Days from 2007-2011

FISCAL YEAR	STAY	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	VOLUNTARY ONLY	780	1,152	467	999	1,631	993	3,734	7,830	1,229	18,815
	VOLUNTARY AND INVOLUNTARY	573	170	132	609	0	300	2,488	7,169	571	12,012
	AVG. VOLUNTARY ONLY	12	10	6	12	12	9	12	14	12	12
	AVG. VOLUNTARY AND INVOLUNTARY	29	15	7	24		15	26	31	20	26
2008	VOLUNTARY ONLY	1,384	1,759	619	1,276	2,220	1,376	6,045	17,719	2,369	34,767
	VOLUNTARY AND INVOLUNTARY	550	484	408	982	0	493	4,229	18,427	698	26,271
	AVG. VOLUNTARY ONLY	18	11	5	14	10	9	14	26	16	17
	AVG. VOLUNTARY AND INVOLUNTARY	22	19	11	23		20	30	47	16	36
2009	VOLUNTARY ONLY	1,220	1,829	458	883	2,704	1,494	6,755	16,155	2,268	33,766
	VOLUNTARY AND INVOLUNTARY	485	665	366	1,924	<5	205	3,842	25,171	1,917	34,579
	AVG. VOLUNTARY ONLY	12	10	<5	9	11	9	16	28	15	16
	AVG. VOLUNTARY AND INVOLUNTARY	22	27	9	60	<5	12	32	63	55	50
2010	VOLUNTARY ONLY	1,050	1,668	1,081	1,448	2,177	1,251	7,254	19,908	1,841	37,678
	VOLUNTARY AND INVOLUNTARY	804	640	284	1,008	<5	436	4,513	17,735	1,292	26,716
	AVG. VOLUNTARY ONLY	15	8	7	12	9	9	16	36	12	18
	AVG. VOLUNTARY AND INVOLUNTARY	32	25	8	26	<5	19	38	51	26	40
2011	VOLUNTARY ONLY	832	1,269	715	1,069	2,831	1,339	7,729	19,283	2,684	37,751
	VOLUNTARY AND INVOLUNTARY	1,008	582	515	1,642	0	302	2,681	22,474	1,347	30,551
	AVG. VOLUNTARY ONLY	14	8	<5	11	10	9	16	33	10	17
	AVG. VOLUNTARY AND INVOLUNTARY	23	15	9	36		12	21	56	31	39

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

- SEPS with Total Stay/Involuntary Stay more than 1000 days are excluded from the calculation. These represent less than 0.2% of the total SEPS.

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Involuntary Admissions through Emergency Departments from 2007-2011

FISCAL YEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	TOTAL INVOLUNTARY ADMISSION	**40**	**33**	**34**	**45**	**5**	**30**	**159**	**427**	**43**	**816**
	CLINIC	<5						<5	24	<5	**29**
	DIRECT	10	<5	20	13	<5	17	5	156	5	**231**
	EMERGENCY	29	29	14	32	<5	13	151	247	37	**556**
2008	TOTAL INVOLUNTARY ADMISSION	**35**	**45**	**56**	**64**	**<5**	**43**	**209**	**562**	**60**	**1076**
	CLINIC				<5			10	31	<5	**46**
	DIRECT	8	8	36	28		15	<5	193	6	**297**
	EMERGENCY	27	37	20	35	<5	28	196	338	50	**733**
2009	TOTAL INVOLUNTARY ADMISSION	**40**	**39**	**59**	**57**	**<5**	**42**	**198**	**600**	**51**	**1088**
	CLINIC							11	14	<5	**26**
	DIRECT	12	7	39	23		13	<5	199	8	**305**
	EMERGENCY	28	32	20	34	<5	29	183	387	42	**757**
2010	TOTAL INVOLUNTARY ADMISSION	**50**	**42**	**51**	**76**	**<5**	**40**	**173**	**552**	**74**	**1061**
	CLINIC	<5			<5			11	21	<5	**36**
	DIRECT	21	7	29	32		15	<5	155	9	**270**
	EMERGENCY	27	35	22	43	<5	25	160	376	64	**755**
2011	TOTAL INVOLUNTARY ADMISSION	**56**	**61**	**74**	**79**	**9**	**39**	**202**	**592**	**112**	**1224**
	CLINIC				<5			13	13	10	**37**
	DIRECT	21	13	43	36	<5	12		197	14	**339**
	EMERGENCY	35	48	31	42	6	27	189	382	88	**848**
	Total Involuntary Admissions	**221**	**220**	**274**	**321**	**21**	**194**	**941**	**2733**	**340**	**5265**
	Total Emergency Dept. Admissions	**146**	**181**	**107**	**186**	**17**	**122**	**879**	**1730**	**281**	**3649**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Involuntary Admissions through Emergency Departments (Percentages) from 2007-2011

FISCAL YEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	TOTAL INVOLUNTARY ADMISSION	**40**	**33**	**34**	**45**	**5**	**30**	**159**	**427**	**43**	**816**
	CLINIC	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	1.9%	5.6%	2.3%	**3.6%**
	DIRECT	25.0%	12.1%	58.8%	28.9%	20.0%	56.7%	3.1%	36.5%	11.6%	**28.3%**
	EMERGENCY	72.5%	87.9%	41.2%	71.1%	80.0%	43.3%	95.0%	57.9%	86.1%	**68.1%**
2008	TOTAL INVOLUNTARY ADMISSION	**35**	**45**	**56**	**64**	**<5**	**43**	**209**	**562**	**60**	**1076**
	CLINIC	0.0%	0.0%	0.0%	1.6%	0.0%	0.0%	4.8%	5.5%	6.7%	**4.3%**
	DIRECT	22.9%	17.8%	64.3%	43.8%	0.0%	34.9%	1.4%	34.3%	10.0%	**27.6%**
	EMERGENCY	77.1%	82.2%	35.7%	54.7%	100.0%	65.1%	93.8%	60.1%	83.3%	**68.1%**
2009	TOTAL INVOLUNTARY ADMISSION	**40**	**39**	**59**	**57**	**<5**	**42**	**198**	**600**	**51**	**1088**
	CLINIC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.6%	2.3%	2.0%	**2.4%**
	DIRECT	30.0%	18.0%	66.1%	40.4%	0.0%	31.0%	2.0%	33.2%	15.7%	**28.0%**
	EMERGENCY	70.0%	82.1%	33.9%	59.7%	100.0%	69.1%	92.4%	64.5%	82.4%	**69.6%**
2010	TOTAL INVOLUNTARY ADMISSION	**50**	**42**	**51**	**76**	**<5**	**40**	**173**	**552**	**74**	**1061**
	CLINIC	4.0%	0.0%	0.0%	1.3%	0.0%	0.0%	6.4%	3.8%	1.4%	**3.4%**
	DIRECT	42.0%	16.7%	56.9%	42.1%	0.0%	37.5%	1.2%	28.1%	12.2%	**25.5%**
	EMERGENCY	54.0%	83.3%	43.1%	56.6%	100.0%	62.5%	92.5%	68.1%	86.5%	**71.2%**
2011	TOTAL INVOLUNTARY ADMISSION	**56**	**61**	**74**	**79**	**9**	**39**	**202**	**592**	**112**	**1224**
	CLINIC	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	6.4%	2.2%	8.9%	**3.0%**
	DIRECT	37.5%	21.3%	58.1%	45.6%	33.3%	30.8%	0.0%	33.3%	12.5%	**27.7%**
	EMERGENCY	62.5%	78.7%	41.9%	53.2%	66.7%	69.2%	93.6%	64.5%	78.6%	**69.3%**
	Total Involuntary Admissions	**221**	**220**	**274**	**321**	**21**	**194**	**941**	**2733**	**340**	**5265**
	Total Emergency Dept. Admissions	**146**	**181**	**107**	**186**	**17**	**122**	**879**	**1730**	**281**	**3649**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness

IPTA REVIEW REPORT

Average and Total Stay for Top 10 Diagnosis for Involuntary Admissions from 2007-2011

FISCAL YEAR	TOP 5 DIAGNOSIS	SEPS	AVG STAY	TOTAL STAY
2007 *	Paranoid schizophrenia	105	53.1	5577
	Unspecified nonorganic psychosis	87	24.7	2152
	Adjustment disorders	74	4.6	337
	Bipolar affective disorder, current episode manic without psychotic symptoms	51	24.6	1254
	Schizoaffective disorder, mixed type	40	42.7	1708
	Bipolar affective disorder, current episode manic with psychotic symptoms	37	37.1	1373
	Severe depressive episode without psychotic symptoms	21	24.6	517
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	21	13.5	283
	Bipolar affective disorder, unspecified	15	23.3	350
	Delusional disorder	15	58.4	876
2008	Paranoid schizophrenia	138	61.1	8429
	Unspecified nonorganic psychosis	103	23.4	2415
	Adjustment disorders	90	6.6	592
	Schizoaffective disorder, mixed type	66	61.9	4085
	Bipolar affective disorder, current episode manic without psychotic symptoms	62	20.1	1248
	Bipolar affective disorder, current episode manic with psychotic symptoms	52	26.5	1379
	Bipolar affective disorder, unspecified	39	20.6	804
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	28	<5	103
	Severe depressive episode without psychotic symptoms	22	40.6	894
	Delusional disorder	20	19.4	388
2009	Paranoid schizophrenia	132	53.2	7028
	Unspecified nonorganic psychosis	125	35.7	4462
	Adjustment disorders	94	<5	460
	Schizoaffective disorder, mixed type	78	93	7253
	Bipolar affective disorder, current episode manic with psychotic symptoms	58	45.9	2662
	Bipolar affective disorder, current episode manic without psychotic symptoms	56	20.9	1171
	Schizophrenia, unspecified	36	61.6	2219
	Bipolar affective disorder, unspecified	23	22	506
	Severe depressive episode without psychotic symptoms	19	18.1	343
	Mental and behavioural disorders due to use of alcohol, harmful use	19	<5	38
	Schizoaffective disorder, unspecified	19	51.4	976
2010	Paranoid schizophrenia	142	53.4	7576
	Unspecified nonorganic psychosis	131	29.2	3828
	Adjustment disorders	102	5.5	558
	Schizoaffective disorder, mixed type	78	57.4	4480
	Bipolar affective disorder, current episode manic without psychotic symptoms	68	28.4	1930
	Bipolar affective disorder, current episode manic with psychotic symptoms	38	35.5	1348
	Schizophrenia, unspecified	34	47.7	1621
	Unspecified mood [affective] disorder	25	10	251
	Bipolar affective disorder, unspecified	23	39.9	917
	Other mixed disorders of conduct and emotions	22	3.6	80
2011	Paranoid schizophrenia	150	57.5	8626
	Unspecified nonorganic psychosis	149	24.9	3710
	Adjustment disorders	135	5.5	746
	Bipolar affective disorder, current episode manic without psychotic symptoms	78	22	1715
	Schizoaffective disorder, mixed type	59	68.9	4063
	Bipolar affective disorder, current episode manic with psychotic symptoms	51	39	1990
	Schizophrenia, unspecified	33	43.1	1423
	Bipolar affective disorder, unspecified	29	43.6	1264
	Severe depressive episode without psychotic symptoms	26	21.2	551
	Delusional disorder	23	25.4	584

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year

Note:

- SEPS with Total Stay/Involuntary Stay more than 1000 days are excluded from the calculation. These represent less than 0.2% of the total SEPS.

For privacy reasons values less than 5 have been suppressed

Nova Scotia Department of Health and Wellness

IPTA REVIEW REPORT

Average and Total Stay for Top 10 Diagnosis for Admissions from 2007-2011

FISCAL YEAR	TOP 5 DIAGNOSIS	SEPS	AVG STAY	TOTAL STAY
2007 *	Adjustment disorders	279	5.4	1511
	Paranoid schizophrenia	210	66.1	13874
	Unspecified nonorganic psychosis	166	26.7	4425
	Recurrent depressive disorder, current episode severe without psychotic symptoms	104	21.5	2233
	Severe depressive episode without psychotic symptoms	102	41.6	4245
	Depressive episode, unspecified	92	16.3	1502
	Schizoaffective disorder, mixed type	89	51.1	4552
	Bipolar affective disorder, current episode manic without psychotic symptoms	74	26.6	1970
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	71	7.5	530
	Unspecified mood [affective] disorder	51	26.8	1367
2008	Adjustment disorders	341	7.1	2426
	Paranoid schizophrenia	270	48.8	13189
	Unspecified nonorganic psychosis	182	26.2	4764
	Depressive episode, unspecified	153	7.7	1174
	Severe depressive episode without psychotic symptoms	145	18.9	2735
	Schizoaffective disorder, mixed type	115	51.1	5874
	Bipolar affective disorder, unspecified	108	24.7	2664
	Unspecified mood [affective] disorder	87	10.9	948
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	85	<5	400
	Bipolar affective disorder, current episode manic without psychotic symptoms	81	20.5	1659
2009	Recurrent depressive disorder, current episode severe without psychotic symptoms	81	21.8	1769
	Adjustment disorders	432	7.5	3221
	Paranoid schizophrenia	257	41.9	10759
	Unspecified nonorganic psychosis	190	30.5	5793
	Schizoaffective disorder, mixed type	131	66.5	8713
	Severe depressive episode without psychotic symptoms	125	17.6	2204
	Depressive episode, unspecified	114	8.9	1016
	Recurrent depressive disorder, current episode severe without psychotic symptoms	103	15.8	1629
	Bipolar affective disorder, unspecified	83	14.1	1168
	Bipolar affective disorder, current episode manic without psychotic symptoms	79	22.2	1751
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	73	6	437
2010	Adjustment disorders	458	5.6	2557
	Paranoid schizophrenia	279	43	11990
	Unspecified nonorganic psychosis	198	25.8	5100
	Schizoaffective disorder, mixed type	130	58.6	7613
	Depressive episode, unspecified	125	12	1499
	Severe depressive episode without psychotic symptoms	98	24.9	2444
	Recurrent depressive disorder, current episode severe without psychotic symptoms	98	23.4	2294
	Bipolar affective disorder, current episode manic without psychotic symptoms	88	24.6	2163
	Unspecified mood [affective] disorder	84	12.3	1032
	Bipolar affective disorder, unspecified	74	28.7	2122
2011	Adjustment disorders	554	5.4	2984
	Paranoid schizophrenia	262	54.7	14330
	Unspecified nonorganic psychosis	240	24.6	5896
	Depressive episode, unspecified	178	10.9	1934
	Severe depressive episode without psychotic symptoms	132	18.4	2427
	Schizoaffective disorder, mixed type	108	55	5940
	Recurrent depressive disorder, current episode severe without psychotic symptoms	108	20.5	2213
	Bipolar affective disorder, current episode manic without psychotic symptoms	93	21.9	2037
	Bipolar affective disorder, unspecified	81	25.4	2059
	Schizophrenia, unspecified	70	36.9	2582

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year

Note:

- SEPS with Total Stay/Involuntary Stay more than 1000 days are excluded from the calculation. These represent less than 0.2% of the total SEPS.

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Total and Average Stay with Average Involuntary Stay Ratio from 2007-2011

FISCAL YEAR	STAY	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	TOTAL DAYS	1,850	1,826	751	1,953	1,937	2,351	10,999	54,507	3,572	79,746
	AVG TOTAL DAYS	18	12	7	15	14	16	23	52	22	32
	TOTAL DAYS FOR SEPS WITH INV	990	480	274	836	198	1,007	6,208	34,490	1,546	46,029
	AVG. INV STAY RATIO ‡	74.7%	82.8%	69.6%	68.0%	100.0%	56.3%	61.7%	68.8%	65.4%	67.8%
2008	TOTAL DAYS	2,138	3,048	1,183	2,829	2,317	2,133	13,257	43,319	4,477	74,701
	AVG TOTAL DAYS	19	15	7	18	10	11	21	35	21	24
	TOTAL DAYS FOR SEPS WITH INV	690	747	559	1,321	<5	624	7,154	23,881	1,696	36,674
	AVG. INV STAY RATIO ‡	75.7%	69.3%	70.0%	64.4%	100.0%	67.5%	68.0%	69.1%	69.0%	68.8%
2009	TOTAL DAYS	1,906	3,661	1,217	3,667	2,925	2,328	12,373	43,383	4,757	76,217
	AVG TOTAL DAYS	13	16	7	25	12	11	20	37	23	24
	TOTAL DAYS FOR SEPS WITH INV	681	1,109	608	2,777	8	376	5,451	27,220	2,242	40,472
	AVG. INV STAY RATIO ‡	75.3%	73.4%	67.8%	63.1%	62.5%	77.8%	63.1%	69.6%	59.6%	68.1%
2010	TOTAL DAYS	2,159	2,456	1,441	3,069	2,185	2,024	12,899	42,105	3,757	72,095
	AVG TOTAL DAYS	18	10	7	16	9	12	21	39	16	23
	TOTAL DAYS FOR SEPS WITH INV	1,086	768	343	1,609	6	770	5,262	22,177	1,775	33,796
	AVG. INV STAY RATIO ‡	78.4%	66.8%	73.8%	74.0%	75.0%	69.0%	58.1%	75.1%	69.8%	71.4%
2011	TOTAL DAYS	2,274	2,688	1,324	3,300	2,936	1,891	11,769	47,239	4,959	78,380
	AVG TOTAL DAYS	20	12	6	19	10	11	17	41	13	23
	TOTAL DAYS FOR SEPS WITH INV	1,392	1,409	606	2,217	49	463	3,641	27,660	2,170	39,607
	AVG. INV STAY RATIO ‡	66.9%	66.8%	77.5%	70.3%	100.0%	66.0%	64.2%	74.3%	84.7%	72.8%

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

‡ Calculations for involuntary Stay ratio for each Admission:

$$\frac{\text{Involuntary Stay days}}{\text{Total days}} \times 100\%$$

"AVG. INV STAY RATIO" represents the average of all these ratios for admissions which had involuntrary days.

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Involuntary Admissions and Re-Admissions from 2007-2011

FISCALYEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	INV ADM	40	33	34	45	5	30	159	427	43	816
	RE ADM	**<5**	**18**	**5**	**10**	**<5**	**14**	**55**	**43**	**19**	**172**
2008	INV ADM	35	45	56	64	<5	43	209	562	60	1076
	RE ADM	**5**	**22**	**10**	**7**	**14**	**19**	**62**	**87**	**17**	**243**
2009	INV ADM	40	39	59	57	<5	42	198	600	51	1088
	RE ADM	**9**	**20**	**19**	**7**	**26**	**16**	**62**	**68**	**19**	**246**
2010	INV ADM	50	42	51	76	<5	40	173	552	74	1061
	RE ADM	**6**	**21**	**35**	**7**	**6**	**17**	**64**	**62**	**32**	**250**
2011	INV ADM	56	61	74	79	9	39	202	592	112	1224
	RE ADM	**5**	**19**	**13**	**8**	**12**	**15**	**73**	**84**	**72**	**301**
Total Involuntary Admissions		**221**	**220**	**274**	**321**	**21**	**194**	**941**	**2733**	**340**	**5265**
Total Re Admission		**29**	**100**	**82**	**39**	**62**	**81**	**316**	**344**	**159**	**1212**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note: Readmission is defined as readmissions <= 28 days with the same or related diagnosis

Re-Admissions and Re-Admission Rate for InVoluntary Admissions from 2007-2011

FISCALYEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	INV ADM	40	33	34	45	5	30	159	427	43	816
	RE ADM	<5	<5	<5	<5		<5	15	22	<5	48
	RATE	<5	<5	<5	<5	**0.0%**	**<5**	**8.6%**	**4.9%**	**<5**	**5.6%**
2008	INV ADM	35	45	56	64	<5	43	209	562	60	1076
	RE ADM	<5	6	<5	<5		<5	25	28	7	75
		<5	**11.8%**	<5	<5	**<5**	<5	**10.7%**	**4.7%**	**10.4%**	**6.5%**
2009	INV ADM	40	39	59	57	<5	42	198	600	51	1088
	RE ADM	<5	6	<5	<5		<5	22	36	<5	76
		<5	**13.3%**	<5	<5	<5	<5	**10.0%**	**5.7%**	**<5**	**6.5%**
2010	INV ADM	50	42	51	76	<5	40	173	552	74	1061
	RE ADM	<5	<5	<5	5		7	20	33	7	80
		<5	<5	<5	**6.2%**	<5	**14.9%**	**10.4%**	**5.6%**	**8.6%**	**7.0%**
2011	INV ADM	56	61	74	79	9	39	202	592	112	1224
	RE ADM	<5	9	<5	6		<5	23	40	18	106
		<5	**12.9%**	<5	**7.1%**	**0.0%**	<5	**10.2%**	**6.3%**	**13.8%**	**8.0%**
Total Involuntary Admissions		**221**	**220**	**274**	**321**	**21**	**194**	**941**	**2733**	**340**	**5265**
Total Re Admission		**11**	**26**	**13**	**18**		**16**	**105**	**159**	**37**	**385**
Rate		**4.7%**	**10.6%**	**4.5%**	**5.3%**	**0.0%**	**7.6%**	**10.0%**	**5.5%**	**9.8%**	**6.8%**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures

Note: Readmission is defined as readmissions <= 28 days with the same or related diagnosis

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Referral Sources for Involuntary Admissions for 2011

FISCALYEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
Medical Therapist	TOTAL SEPS	65	29	175	60	6	40	236	466	207	1284
	TOTAL INVOLUNTARY ADMISSION	**34**	**<5**	**51**	**30**	**<5**	**7**	**65**	**243**	**75**	**510**
Law Enforcement	TOTAL SEPS	21	44	17	38	11	22	88	144	30	415
	TOTAL INVOLUNTARY ADMISSION	**13**	**28**	**12**	**25**	**<5**	**11**	**56**	**111**	**9**	**266**
Community Agency	TOTAL SEPS	<5	<5	<5	<5	<5	<5	11	20	7	47
	TOTAL INVOLUNTARY ADMISSION	**<5**		**<5**				**5**	**7**	**<5**	**17**
Self , Family, Friends, Colleagues	TOTAL SEPS	27	134	18	66	228	111	346	513	127	1570
	TOTAL INVOLUNTARY ADMISSION	**7**	**26**	**<5**	**18**	**<5**	**13**	**76**	**213**	**23**	**383**
Other	TOTAL SEPS		7	26	6	26	19	<5	35	13	135
	TOTAL INVOLUNTARY ADMISSION		**<5**	**6**	**<5**	**<5**	**8**		**18**	**<5**	**42**
Unknown	TOTAL SEPS		5	<5	<5	11	<5		<5	<5	30
	TOTAL INVOLUNTARY ADMISSION		**<5**	**<5**	**<5**					**<5**	**6**
	Total SEPS	**116**	**220**	**240**	**174**	**283**	**195**	**684**	**1181**	**388**	**3481**
	Total Involuntary Admissions	**56**	**61**	**74**	**79**	**9**	**39**	**202**	**592**	**112**	**1224**

Source: CIHI DAD

Total Seperations for Referral Sources (Percentages) for 2011

FISCALYEAR	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
Medical Therapist	56.0%	13.2%	72.9%	34.5%	2.1%	20.5%	34.5%	39.5%	53.4%	36.9%
Law Enforcement	18.1%	20.0%	7.1%	21.8%	3.9%	11.3%	12.9%	12.2%	7.7%	11.9%
Community Agency	2.6%	0.5%	0.4%	0.6%	0.4%	1.0%	1.6%	1.7%	1.8%	1.4%
Self , Family, Friends, Colleagues	23.3%	60.9%	7.5%	37.9%	80.6%	56.9%	50.6%	43.4%	32.7%	45.1%
Other	0.0%	3.2%	10.8%	3.5%	9.2%	9.7%	0.4%	3.0%	3.4%	3.9%
Unknown	0.0%	2.3%	1.3%	1.7%	3.9%	0.5%	0.0%	0.3%	1.0%	0.9%

Source: CIHI DAD

Total Involuntary Admissions for Referral Sources (Percentages) for 2011

FISCALYEAR	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
Medical Therapist	60.7%	6.6%	68.9%	38.0%	11.1%	18.0%	32.2%	41.1%	67.0%	41.7%
Law Enforcement	23.2%	45.9%	16.2%	31.7%	11.1%	28.2%	27.7%	18.8%	8.0%	21.7%
Community Agency	3.6%	0.0%	1.4%	0.0%	0.0%	0.0%	2.5%	1.2%	1.8%	1.4%
Self , Family, Friends, Colleagues	12.5%	42.6%	4.1%	22.8%	44.4%	33.3%	37.6%	36.0%	20.5%	31.3%
Other	0.0%	1.6%	8.1%	5.1%	33.3%	20.5%	0.0%	3.0%	1.8%	3.4%
Unknown	0.0%	3.3%	1.4%	2.5%	0.0%	0.0%	0.0%	0.0%	0.9%	0.5%

Source: CIHI DAD

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Re-Admissions and Rate for Involuntary Admissions by Age Groups from 2007-2011

DHA	AGE CATEGORY	FISCAL_YEAR										TOTAL	
		2007 *		2008		2009		2010		2011			
		READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE
DHA 1	10-19		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
	20-29		0.0%	<5			0.0%		0.0%		0.0%	<5	
	30-39		0.0%		0.0%		0.0%		0.0%	<5		<5	
	40-49	<5		<5			0.0%		0.0%		0.0%	<5	
	50-59		0.0%		0.0%	<5		<5		<5		<5	
	60-69		0.0%	<5	50.0%		0.0%		0.0%	<5		<5	
	70-79		0.0%								0.0%		0.0%
	80-89						0.0%						0.0%
DHA 1 Total		**<5**		**<5**		**<5**		**<5**		**<5**		**11**	**5.0%**
DHA 2	10-19		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
	20-29	<5		<5		<5			0.0%	<5		7	11.5%
	30-39		0.0%	<5			0.0%		0.0%	<5		<5	
	40-49		0.0%	<5		<5		<5		<5		8	13.6%
	50-59		0.0%		0.0%	<5		<5		<5		7	24.1%
	60-69		0.0%		0.0%		0.0%		0.0%	<5		<5	
	70-79		0.0%				0.0%		0.0%				0.0%
	80-89				0.0%		0.0%						0.0%
DHA 2 Total		**<5**		**6**	**13.3%**	**6**	**15.4%**	**<5**		**9**	**14.8%**	**26**	**11.8%**
DHA 3	10-19		0.0%				0.0%	<5			0.0%	<5	
	20-29		0.0%	<5			0.0%		0.0%	<5		<5	
	30-39		0.0%		0.0%	<5			0.0%		0.0%	<5	
	40-49		0.0%		0.0%		0.0%	<5		<5		<5	
	50-59		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
	60-69	<5			0.0%		0.0%		0.0%	<5		<5	
	70-79		0.0%		0.0%		0.0%		0.0%				0.0%
	80-89				0.0%								0.0%
DHA 3 Total		**<5**		**<5**		**<5**		**<5**		**<5**		**13**	**4.7%**
DHA 4	10-19		0.0%		0.0%				0.0%		0.0%		0.0%
	20-29	<5		<5		<5		<5			0.0%	5	7.5%
	30-39	<5			0.0%	<5			0.0%	<5		5	8.2%
	40-49		0.0%		0.0%		0.0%	<5		<5		<5	
	50-59		0.0%		0.0%		0.0%	<5		<5		<5	
	60-69		0.0%		0.0%		0.0%	<5			0.0%	<5	
	70-79		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
	80-89								0.0%		0.0%		0.0%
DHA 4 Total		**<5**		**<5**		**<5**		**5**		**6**	**7.6%**	**18**	**5.6%**
DHA 6	10-19		0.0%						0.0%		0.0%		0.0%
	20-29				0.0%						0.0%		0.0%
	30-39		0.0%								0.0%		0.0%
	40-49		0.0%				0.0%		0.0%		0.0%		0.0%
	50-59						0.0%		0.0%		0.0%		0.0%
	60-69										0.0%		0.0%
	70-79		0.0%										0.0%
	80-89		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
DHA 6 Total			**0.0%**		**0.0%**		**0.0%**		**0.0%**		**0.0%**		**0.0%**
DHA 7	10-19		0.0%		0.0%		0.0%	<5			0.0%	<5	
	20-29		0.0%	<5		<5			0.0%		0.0%	<5	
	30-39		0.0%		0.0%	<5		<5			0.0%	<5	
	40-49		0.0%	<5			0.0%	<5		<5		5	13.5%
	50-59		0.0%		0.0%	<5			0.0%	<5		<5	
	60-69		0.0%		0.0%			<5			0.0%	<5	
	70-79	<5							0.0%			<5	
	80-89		0.0%				0.0%				0.0%		0.0%
DHA 7 Total		**<5**		**<5**		**<5**		**7**	**17.5%**	**<5**		**16**	**8.3%**
DHA 8	10-19		0.0%		0.0%	**<5**			0.0%	<5		<5	
	20-29	<5		5	17.2%	**<5**		7	15.6%	5	11.1%	24	12.4%
	30-39	<5		5	16.7%	**<5**		6	24.0%	<5		21	14.7%
	40-49	<5		7	14.3%	10	28.6%	<5		5	11.9%	26	14.0%
	50-59	<5		<5		**<5**		<5		<5		14	11.3%
	60-69	<5		5	12.8%	**<5**		<5		<5		13	10.4%
	70-79	<5			0.0%		0.0%		0.0%	<5		<5	
	80-89		0.0%		0.0%		0.0%	<5			0.0%	<5	
DHA 8 Total		**15**	**9.4%**	**25**	**12.0%**	**22**	**11.1%**	**20**	**11.6%**	**23**	**11.4%**	**105**	**11.2%**

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Re-Admissions and Rate for Involuntary Admissions by Age Groups from 2007-2011

DHA	AGE CATEGORY	FISCAL_YEAR										TOTAL	
		2007 *		2008		2009		2010		2011			
		READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE
DHA 9	10-19	<5			0.0%	**<5**		**<5**		**<5**	5.9%	5	6.5%
	20-29	12	9.0%	6	3.8%	12	7.7%	12	7.3%	16	10.5%	58	7.6%
	30-39	<5		8	7.3%	**<5**		5	4.5%	8	7.0%	28	5.1%
	40-49	5	5.1%	5	3.7%	11	9.4%	6	5.6%	5	4.8%	32	5.7%
	50-59	<5		7	7.9%	**<5**		**<5**		7	5.7%	23	4.9%
	60-69		0.0%	<5		**<5**		**<5**		**<5**	5.2%	9	4.3%
	70-79		0.0%	<5		**<5**		**<5**			0.0%	**<5**	4.9%
	80-89				0.0%		0.0%		0.0%		0.0%		0.0%
DHA 9 Total		**22**	**5.2%**	**28**	**5.0%**	**36**	**6.0%**	**33**	**6.0%**	**40**	**6.8%**	**159**	**5.8%**
IWK	1-9		0.0%		0.0%				0.0%		0.0%		0.0%
	10-19	<5		7	11.7%	**<5**		7	9.5%	18	16.1%	37	10.9%
IWK Total		**<5**		**7**	**11.7%**	**<5**		**7**	**9.5%**	**18**	**16.1%**	**37**	**10.9%**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007

Note: Readmission is defined as readmissions <= 28 days with the same or related diagnosis

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Re-Admissions and Rate for Involuntary Admissions by Gender from 2007-2011

DHA	GENDER	FISCAL_YEAR										TOTAL READM	TOTAL RATE
		2007 *		2008		2009		2010		2011			
		READM	RATE	READM	RATE	READM	RATE	READM	RATE	READM	RATE		
DHA 1	F	<5		<5			0.0%	<5		<5		7	6.7%
	M		0.0%	<5		<5			0.0%	<5		<5	
DHA 1 Total		<5		<5		<5		<5		<5		**11**	**5.0%**
DHA 2	F		0.0%	<5		<5		<5		5	15.6%	13	12.3%
	M	<5		5	25.0%	<5		<5		<5		13	11.4%
DHA 2 Total		<5		**6**	**13.3%**	**6**	**15.4%**	<5		**9**	**14.8%**	**26**	**11.8%**
DHA 3	F		0.0%	<5		<5		<5		<5		9	6.0%
	M	<5			0.0%	<5			0.0%	<5		<5	
DHA 3 Total		<5		<5		<5		<5		<5		**13**	**4.7%**
DHA 4	F	<5			0.0%		0.0%	<5		<5		8	5.0%
	M	<5		<5		<5		<5		<5		10	6.3%
DHA 4 Total		<5		<5		<5		**5**	**6.6%**	**6**	**7.6%**	**18**	**5.6%**
DHA 6	F		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
	M		0.0%		0.0%				0.0%		0.0%		0.0%
DHA 6 Total			**0.0%**		**0.0%**		**0.0%**		**0.0%**		**0.0%**		**0.0%**
DHA 7	F		0.0%	<5		<5		<5		<5		7	8.2%
	M	<5		<5		<5		<5			0.0%	9	8.3%
DHA 7 Total		<5		<5		<5		**7**	**17.5%**	<5		**16**	**8.3%**
DHA 8	F	8	11.9%	14	15.2%	9	11.0%	8	13.3%	10	11.8%	49	12.7%
	M	7	7.6%	11	9.4%	13	11.2%	12	10.6%	13	11.1%	56	10.1%
DHA 8 Total		**15**	**9.4%**	**25**	**12.0%**	**22**	**11.1%**	**20**	**11.6%**	**23**	**11.4%**	**105**	**11.2%**
DHA 9	F	13	6.6%	17	6.0%	19	6.3%	12	4.7%	24	8.1%	85	6.3%
	M	9	3.9%	11	3.9%	17	5.7%	21	7.1%	16	5.4%	74	5.3%
DHA 9 Total		**22**	**5.2%**	**28**	**5.0%**	**36**	**6.0%**	**33**	**6.0%**	**40**	**6.8%**	**159**	**5.8%**
IWK	F	<5		<5			0.0%	<5		11	20.4%	18	12.0%
	M	<5		5	13.2%	<5		<5		7	12.1%	19	10.0%
IWK Total		<5		**7**	**11.7%**	<5		**7**	**9.5%**	**18**	**16.1%**	**37**	**10.9%**
Nova Scotia		**48**	**5.9%**	**75**	**7.0%**	**76**	**7.0%**	**80**	**7.5%**	**106**	**8.7%**	**385**	**7.3%**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note: Readmission is defined as readmissions <= 28 days with the same or related diagnosis

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Total Voluntary and Involuntary Days from 2007-2011

FISCAL YEAR	STAY	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	VOLUNTARY ONLY	780	1,152	467	999	1,631	993	3,734	7,830	1,229	18,815
	INVOLUNTARY ONLY	267	257	114	206	198	177	1,903	18,366	401	21,889
	VOLUNTARY AND INVOLUNTARY	573	170	132	609	0	300	2,488	7,169	571	12,012
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	299	85	85	257	0	121	1,179	3,775	269	6,070
2008	VOLUNTARY ONLY	1,384	1,759	619	1,276	2,220	1,376	6,045	17,719	2,369	34,767
	INVOLUNTARY ONLY	72	239	131	331	<5	125	1,602	4,141	400	7,043
	VOLUNTARY AND INVOLUNTARY	550	484	408	982	0	493	4,229	18,427	698	26,271
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	409	241	280	544	0	185	2,511	8,191	470	12,831
2009	VOLUNTARY ONLY	1,220	1,829	458	883	2,704	1,494	6,755	16,155	2,268	33,766
	INVOLUNTARY ONLY	195	114	55	498	<5	168	1,415	2,008	309	4,766
	VOLUNTARY AND INVOLUNTARY	485	665	366	1,924	<5	205	3,842	25,171	1,917	34,579
	INVOLUNTARY ONLY FOR ONES WITH BOTH	370	403	259	580	<5	78	1,448	9,486	722	13,347
2010	VOLUNTARY ONLY	1,050	1,668	1,081	1,448	2,177	1,251	7,254	19,908	1,841	37,678
	INVOLUNTARY ONLY	278	62	59	377	<5	200	632	4,349	446	6,405
	VOLUNTARY AND INVOLUNTARY	804	640	284	1,008	<5	436	4,513	17,735	1,292	26,716
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	541	353	196	590	<5	267	1,425	8,490	690	12,553
2011	VOLUNTARY ONLY	832	1,269	715	1,069	2,831	1,339	7,729	19,283	2,684	37,751
	INVOLUNTARY ONLY	340	440	91	567	49	134	704	4,276	800	7,401
	VOLUNTARY AND INVOLUNTARY	1,008	582	515	1,642	0	302	2,681	22,474	1,347	30,551
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	630	321	402	736	0	157	1,117	9,709	695	13,767

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

- SEPS with Total Stay/Involuntary Stay more than 1000 days are excluded from the calculation. These represent less than 0.2% of the total SEPS.
- For calculation Separations have been grouped into one of the following three categories
  - Separations with Involuntary Stay only
  - Separations with Voluntary Stay only
  - Separations with both Involuntary and Voluntary Stay

Average Voluntary and Involuntary Days from 2007-2011

FISCAL YEAR	STAY	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	VOLUNTARY ONLY	12	10	6	12	12	9	12	14	12	12
	INVOLUNTARY ONLY	13	11	9	10	28	13	23	66	15	45
	VOLUNTARY AND INVOLUNTARY	29	15	7	24		15	26	31	20	26
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	15	8	5	10		6	12	16	9	13
2008	VOLUNTARY ONLY	18	11	5	14	10	9	14	26	16	17
	INVOLUNTARY ONLY	9	14	7	17	<5	7	24	25	18	21
	VOLUNTARY AND INVOLUNTARY	22	19	11	23		20	30	47	16	36
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	16	9	8	13		7	18	21	10	17
2009	VOLUNTARY ONLY	12	10	<5	9	11	9	16	28	15	16
	INVOLUNTARY ONLY	12	9	<5	22	<5	7	18	11	16	13
	VOLUNTARY AND INVOLUNTARY	22	27	9	60	<5	12	32	63	55	50
	INVOLUNTARY ONLY FOR ONES WITH BOTH	17	16	6	18	<5	5	12	24	21	19
2010	VOLUNTARY ONLY	15	8	7	12	9	9	16	36	12	18
	INVOLUNTARY ONLY	12	<5	5	10	<5	15	12	22	16	17
	VOLUNTARY AND INVOLUNTARY	32	25	8	26	<5	19	38	51	26	40
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	22	14	5	15	<5	12	12	24	14	19
2011	VOLUNTARY ONLY	14	8	<5	11	10	9	16	33	10	17
	INVOLUNTARY ONLY	26	20	6	19	5	12	10	23	11	17
	VOLUNTARY AND INVOLUNTARY	23	15	9	36		12	21	56	31	39
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	15	8	7	16		6	9	24	16	18

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

- SEPS with Total Stay/Involuntary Stay more than 1000 days are excluded from the calculation. These represent less than 0.2% of the total SEPS.
- For calculation Separations have been grouped into one of the following three categories
  - Separations with Involuntary Stay only
  - Separations with Voluntary Stay only
  - Separations with both Involuntary and Voluntary Stay

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Median Voluntary and Involuntary Days from 2007-2011

FISCAL YEAR	STAY	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	VOLUNTARY ONLY	7	6	<5	8	<5	7	8	5	7	6
	INVOLUNTARY ONLY	11	5	5	<5	12	8	7	7	8	7
	VOLUNTARY AND INVOLUNTARY	9	7	<5	19	.	10	15	17	8	13
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	<5	<5	<5	<5	.	<5	<5	6	<5	<5
2008	VOLUNTARY ONLY	8	7	<5	9	6	6	7	5	9	6
	INVOLUNTARY ONLY	<5	7	<5	<5	<5	<5	<5	<5	15	<5
	VOLUNTARY AND INVOLUNTARY	15	10	8	16	.	13	17	21	10	16
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	12	<5	<5	<5	.	<5	<5	9	<5	5
2009	VOLUNTARY ONLY	7	6	<5	5	5	7	8	5	10	6
	INVOLUNTARY ONLY	6	<5	<5	<5	<5	<5	<5	<5	<5	<5
	VOLUNTARY AND INVOLUNTARY	7	19	6	18	<5	8	15	27	14	18
	INVOLUNTARY ONLY FOR ONES WITH BOTH	<5	12	<5	<5	<5	<5	<5	13	<5	6
2010	VOLUNTARY ONLY	8	5	<5	5	6	6	9	5	6	6
	INVOLUNTARY ONLY	<5	<5	<5	<5	<5	11	6	<5	<5	<5
	VOLUNTARY AND INVOLUNTARY	14	15	7	14	<5	12	16	27	12	19
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	<5	6	<5	<5	<5	<5	<5	16	<5	7
2011	VOLUNTARY ONLY	6	6	<5	5	<5	5	7	6	6	6
	INVOLUNTARY ONLY	5	10	<5	8	<5	10	<5	<5	<5	<5
	VOLUNTARY AND INVOLUNTARY	14	11	6	13	.	6	10	24	13	15
	INVOLUNTARY ONLY FOR SEPS WITH BOTH	<5	<5	<5	<5	.	<5	<5	14	6	6

Legend: **Source: CIHI DAD**

***Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

- SEPS with Total Stay/Involuntary Stay more than 1000 days are excluded from the calculation. These represent less than 0.2% of the total SEPS.
- For calculation Separations have been grouped into one of the following three categories
  - Separations with Involuntary Stay only
  - Separations with Voluntary Stay only
  - Separations with both Involuntary and Voluntary Stay

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Total Stay less <=72 Hrs for Involuntary Admissions by DHA from 2007-2011

FISCALYEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	INV ADM	40	33	34	45	5	30	159	427	43	816
	STAY <=72 HRS	**9**	**13**	**11**	**12**	**<5**	**<5**	**34**	**145**	**14**	**243**
2008	INV ADM	35	45	56	64	<5	43	209	562	60	1076
	STAY <=72 HRS	**6**	**12**	**11**	**15**	**<5**	**10**	**37**	**169**	**14**	**276**
2009	INV ADM	40	39	59	57	<5	42	198	600	51	1088
	STAY <=72 HRS	**13**	**9**	**24**	**15**	**0**	**16**	**39**	**165**	**16**	**297**
2010	INV ADM	50	42	51	76	<5	40	173	552	74	1061
	STAY <=72 HRS	**21**	**12**	**21**	**26**	**<5**	**6**	**32**	**126**	**22**	**268**
2011	INV ADM	56	61	74	79	9	39	202	592	112	1224
	STAY <=72 HRS	**13**	**13**	**25**	**17**	**6**	**11**	**48**	**145**	**45**	**323**
Total Involuntary Admissions		**221**	**220**	**274**	**321**	**21**	**194**	**941**	**2733**	**340**	**5265**
Total Re Admission		**62**	**59**	**92**	**85**	**12**	**46**	**190**	**750**	**111**	**1407**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Total Stay less <=72 Hrs Rate for Involuntary Admissions by DHA from 2007-2011

FISCALYEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	INV ADM	40	33	34	45	5	30	159	427	43	816
	STAY <=72 HRS	**22.5%**	**39.4%**	**32.4%**	**26.7%**	**40.0%**	**10.0%**	**21.4%**	**34.0%**	**32.6%**	**29.8%**
2008	INV ADM	35	45	56	64	<5	43	209	562	60	1076
	STAY <=72 HRS	**17.1%**	**26.7%**	**19.6%**	**23.4%**		**23.3%**	**17.7%**	**30.1%**	**23.3%**	**25.7%**
2009	INV ADM	40	39	59	57	<5	42	198	600	51	1088
	STAY <=72 HRS	**32.5%**	**23.1%**	**40.7%**	**26.3%**	**0.0%**	**38.1%**	**19.7%**	**27.5%**	**31.4%**	**27.3%**
2010	INV ADM	50	42	51	76	<5	40	173	552	74	1061
	STAY <=72 HRS	**42.0%**	**28.6%**	**41.2%**	**34.2%**		**15.0%**	**18.5%**	**22.8%**	**29.7%**	**25.3%**
2011	INV ADM	56	61	74	79	9	39	202	592	112	1224
	STAY <=72 HRS	**23.2%**	**21.3%**	**33.8%**	**21.5%**	**66.7%**	**28.2%**	**23.8%**	**24.5%**	**40.2%**	**26.4%**
Total Involuntary Admissions		**221**	**220**	**274**	**321**	**21**	**194**	**941**	**2733**	**340**	**5265**
Total Re Admission		**28.1%**	**26.8%**	**33.6%**	**26.5%**	**57.1%**	**23.7%**	**20.2%**	**27.4%**	**32.6%**	**26.7%**

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness

IPTA REVIEW REPORT

Average, Median and Total Stay for Top 10 Diagnosis for Involuntary Admissions from 2007-2011

FISCAL YEAR	TOP 5 DIAGNOSIS	SEPS	MEDIAN STAY	AVG STAY	TOTAL STAY
2007 *	Paranoid schizophrenia	105	27	53	5577
	Unspecified nonorganic psychosis	87	14	25	2152
	Adjustment disorders	74	<5	5	337
	Bipolar affective disorder, current episode manic without psychotic symptoms	51	17	25	1254
	Schizoaffective disorder, mixed type	40	36	43	1708
	Bipolar affective disorder, current episode manic with psychotic symptoms	37	24	37	1373
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	21	<5	13	283
	Severe depressive episode without psychotic symptoms	21	11	25	517
	Bipolar affective disorder, unspecified	15	13	23	350
	Delusional disorder	15	7	58	876
2008	Paranoid schizophrenia	138	30	61	8429
	Unspecified nonorganic psychosis	103	12	23	2415
	Adjustment disorders	90	<5	7	592
	Schizoaffective disorder, mixed type	66	37	62	4085
	Bipolar affective disorder, current episode manic without psychotic symptoms	62	14	20	1248
	Bipolar affective disorder, current episode manic with psychotic symptoms	52	18	27	1379
	Bipolar affective disorder, unspecified	39	15	21	804
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	28	<5	<5	103
	Severe depressive episode without psychotic symptoms	22	7	41	894
	Delusional disorder	20	13	19	388
2009	Paranoid schizophrenia	132	30	53	7028
	Unspecified nonorganic psychosis	125	11	36	4462
	Adjustment disorders	94	<5	5	460
	Schizoaffective disorder, mixed type	78	44	93	7253
	Bipolar affective disorder, current episode manic with psychotic symptoms	58	27	46	2662
	Bipolar affective disorder, current episode manic without psychotic symptoms	56	15	21	1171
	Schizophrenia, unspecified	36	17	62	2219
	Bipolar affective disorder, unspecified	23	13	22	506
	Mental and behavioural disorders due to use of alcohol, harmful use	19	<5	<5	38
	Schizoaffective disorder, unspecified	19	36	51	976
2010	Paranoid schizophrenia	142	28	53	7576
	Unspecified nonorganic psychosis	131	11	29	3828
	Adjustment disorders	102	<5	5	558
	Schizoaffective disorder, mixed type	78	42	57	4480
	Bipolar affective disorder, current episode manic without psychotic symptoms	68	24	28	1930
	Bipolar affective disorder, current episode manic with psychotic symptoms	38	21	35	1348
	Schizophrenia, unspecified	34	26	48	1621
	Unspecified mood [affective] disorder	25	<5	10	251
	Bipolar affective disorder, unspecified	23	13	40	917
2011	Paranoid schizophrenia	150	21	58	8626
	Unspecified nonorganic psychosis	149	11	25	3710
	Adjustment disorders	135	<5	6	746
	Bipolar affective disorder, current episode manic without psychotic symptoms	78	19	22	1715
	Schizoaffective disorder, mixed type	59	31	69	4063
	Bipolar affective disorder, current episode manic with psychotic symptoms	51	21	39	1990
	Schizophrenia, unspecified	33	18	43	1423
	Bipolar affective disorder, unspecified	29	10	44	1264
	Severe depressive episode without psychotic symptoms	26	6	21	551
	Delusional disorder	23	15	25	584

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

- SEPS with Total Stay/Involuntary Stay more than 1000 days are excluded from the calculation. These represent less than 0.2% of the total SEPS.

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Average, Median and Total Stay for Top 10 Pre-Admit Comorbidity for Involuntary Admissions from 2007-2011

FISCAL YEAR	TOP 5 DIAGNOSIS	SEPS	MEDIAN STAY	AVG STAY	TOTAL STAY
2007 *	Emotionally unstable personality disorder	64	<5	10.42	667
	Mental and behavioural disorders due to use of alcohol, harmful use	40	5	25.13	1005
	Mental and behavioural disorders due to use of cannabinoids, harmful use	38	6	40.29	1531
	Problem related to housing and economic circumstances, unspecified	34	7.5	15.44	525
	Dissocial personality disorder	31	<5	9.9	307
	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, harmful use	30	6	14.77	443
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	27	5	10.33	279
	Problem related to primary support group, unspecified	26	8	16	416
	Accentuation of personality traits	22	<5	13.55	298
	Adjustment disorders	22	<5	11.5	253
2008	Accentuation of personality traits	113	5	28.64	3236
	Mental and behavioural disorders due to use of cannabinoids, harmful use	56	15	29	1624
	Emotionally unstable personality disorder	52	6	12.58	654
	Mental and behavioural disorders due to use of alcohol, harmful use	46	7	23.67	1089
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	37	6	25.38	939
	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, harmful use	35	16	37.29	1305
	Dissocial personality disorder	26	<5	13.31	346
	Type 2 diabetes mellitus without (mention of) complications	24	29	71.96	1727
	Mental and behavioural disorders due to use of cannabinoids, dependence syndrome	22	8.5	22.77	501
	Poisoning by benzodiazepines	20	<5	14.15	283
2009	Accentuation of personality traits	117	8	32.31	3780
	Mental and behavioural disorders due to use of alcohol, harmful use	64	6	23.58	1509
	Mental and behavioural disorders due to use of cannabinoids, harmful use	63	8	24.41	1538
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	48	6	15.65	751
	Emotionally unstable personality disorder	45	<5	6.96	313
	Poisoning by benzodiazepines	33	<5	10.45	345
	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, harmful use	25	6	33	825
	Dissocial personality disorder	23	5	12.04	277
	Personality disorder, unspecified	22	8.5	26	572
	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, dependence syndrome	21	13	18.81	395
	Mental and behavioural disorders due to use of cannabinoids, dependence syndrome	21	6	18.67	392
2010	Accentuation of personality traits	125	11	40.1	5012
	Mental and behavioural disorders due to use of cannabinoids, harmful use	56	18.5	28.8	1613
	Mental and behavioural disorders due to use of alcohol, harmful use	48	8.5	41.17	1976
	Emotionally unstable personality disorder	43	5	17.81	766
	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, harmful use	39	7	77.69	3030
	Mental and behavioural disorders due to use of cannabinoids, dependence syndrome	29	12	29.97	869
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	28	10.5	30.71	860
	Adjustment disorders	22	<5	23.09	508
	Personal history of noncompliance with medical treatment and regimen	21	31	41.19	865
	Poisoning by benzodiazepines	18	<5	8.78	158
	Unspecified nonorganic psychosis	18	22	38.17	687
2011	Accentuation of personality traits	130	17.5	44.53	5789
	Mental and behavioural disorders due to use of cannabinoids, harmful use	71	14	37.07	2632
	Emotionally unstable personality disorder	42	6	14.79	621
	Mental and behavioural disorders due to use of alcohol, harmful use	42	6.5	33.83	1421
	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, harmful use	40	11.5	25.68	1027
	Mental and behavioural disorders due to use of alcohol, dependence syndrome	28	<5	12.96	363
	Mental and behavioural disorders due to use of cannabinoids, dependence syndrome	28	5	12.21	342
	Personality disorder, unspecified	26	17.5	32.5	845
	Adjustment disorders	24	5	9.58	230
	Poisoning by benzodiazepines	21	<5	6.76	142

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Note:

- SEPS with Total Stay/Involuntary Stay more than 1000 days are excluded from the calculation. These represent less than 0.2% of the total SEPS.
- Pre-Admit Comorbidity or Diagnosis Type 1 are conditions that existed prior to admission and satisfy the requirements for determining comorbidity.

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Transfers From and Transfers To for Involuntary Admissions from 2007-2011

FISCALYEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	INV ADM	**40**	**33**	**34**	**45**	**5**	**30**	**159**	**427**	**43**	**816**
	TRANSFER FROM	21	13	39	36	<5	34	66	620	146	978
	TRANSFER TO	<5	0	7	7	<5	7	30	93	<5	155
2008	INV ADM	**35**	**45**	**56**	**64**	**<5**	**43**	**209**	**562**	**60**	**1076**
	TRANSFER FROM	25	18	83	61	8	35	83	719	194	1226
	TRANSFER TO	<5	<5	11	10	<5	7	35	109	<5	182
2009	INV ADM	**40**	**39**	**59**	**57**	**<5**	**42**	**198**	**600**	**51**	**1088**
	TRANSFER FROM	33	18	71	40	13	38	77	579	176	1045
	TRANSFER TO	<5	<5	15	14	<5	5	33	139	7	223
2010	INV ADM	**50**	**42**	**51**	**76**	**<5**	**40**	**173**	**552**	**74**	**1061**
	TRANSFER FROM	28	19	70	56	11	31	94	362	209	880
	TRANSFER TO	9	<5	9	18	<5	6	27	104	8	188
2011	INV ADM	**56**	**61**	**74**	**79**	**9**	**39**	**202**	**592**	**112**	**1224**
	TRANSFER FROM	33	26	104	64	11	37	88	455	354	1172
	TRANSFER TO	8	<5	15	19	9	<5	22	149	15	242

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Transfers From and To Rate for InVoluntary Admissions from 2007-2011

FISCALYEAR	TYPE	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2007 *	INV ADM	**40**	**33**	**34**	**45**	**5**	**30**	**159**	**427**	**43**	**816**
	TRANSFER FROM	52.5%	39.4%	114.7%	80.0%	60.0%	113.3%	41.5%	145.2%	339.5%	119.9%
	TRANSFER TO	10.0%	0.0%	20.6%	15.6%	80.0%	23.3%	18.9%	21.8%	7.0%	19.0%
2008	INV ADM	**35**	**45**	**56**	**64**	**<5**	**43**	**209**	**562**	**60**	**1076**
	TRANSFER FROM	71.4%	40.0%	148.2%	95.3%	400.0%	81.4%	39.7%	127.9%	323.3%	113.9%
	TRANSFER TO	8.6%	2.2%	19.6%	15.6%	100.0%	16.3%	16.7%	19.4%	6.7%	16.9%
2009	INV ADM	**40**	**39**	**59**	**57**	**<5**	**42**	**198**	**600**	**51**	**1088**
	TRANSFER FROM	82.5%	46.2%	120.3%	70.2%	650.0%	90.5%	38.9%	96.5%	345.1%	96.0%
	TRANSFER TO	10.0%	10.3%	25.4%	24.6%	100.0%	11.9%	16.7%	23.2%	13.7%	20.5%
2010	INV ADM	**50**	**42**	**51**	**76**	**<5**	**40**	**173**	**552**	**74**	**1061**
	TRANSFER FROM	56.0%	45.2%	137.3%	73.7%	366.7%	77.5%	54.3%	65.6%	282.4%	82.9%
	TRANSFER TO	18.0%	9.5%	17.6%	23.7%	100.0%	15.0%	15.6%	18.8%	10.8%	17.7%
2011	INV ADM	**56**	**61**	**74**	**79**	**9**	**39**	**202**	**592**	**112**	**1224**
	TRANSFER FROM	58.9%	42.6%	140.5%	81.0%	122.2%	94.9%	43.6%	76.9%	316.1%	95.8%
	TRANSFER TO	14.3%	3.3%	20.3%	24.1%	100.0%	7.7%	10.9%	25.2%	13.4%	19.8%

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Involuntary Assessments for Involuntary Admissions for 2011

DHA	TOTAL SEPERATIONS	INVOLUNTARY ADMISSIONS	INVOLUNTARY ASSESSMENTS	RATE*
DHA 1	116	56	47	83.9%
DHA 2	220	61	13	21.3%
DHA 3	240	74	65	87.8%
DHA 4	174	79	53	67.1%
DHA 6	283	9	5	55.6%
DHA 7	195	39	32	82.1%
DHA 8	684	202	198	98.0%
DHA 9	1181	592	427	72.1%
IWK	388	112	94	83.9%
NS	**3481**	**1224**	**934**	**76.3%**

Legend: **Source: CIHI DAD**

*Rate of Involuntary Assesments for Involuntary Admissions .

Note:

*Involuntary Assesments have been recorded for 2011 only .

AWOL for Involuntary Admissions for 2011

DHA	TOTAL SEPERATIONS	INVOLUNTARY ADMISSIONS	AWOL	RATE*
DHA 1	116	56	<5	5.4%
DHA 2	220	61	<5	1.6%
DHA 3	240	74	<5	4.1%
DHA 4	174	79	<5	2.5%
DHA 6	283	9		
DHA 7	195	39		
DHA 8	684	202	14	6.9%
DHA 9	1181	592	28	4.7%
IWK	388	112	<5	3.6%
NS	**3481**	**1224**	**55**	**4.5%**

Legend: **Source: CIHI DAD**

*Rate of AWOL for Involuntary Admissions .

Note:

*AWOLs have been recorded for 2011 only .

For privacy reasons values
less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Discharge Disposition and Rate for Involuntary Admissions from 2007-2011

DHA	Discharge Disposition	FISCAL YEAR									
		2007 *		2008		2009		2010		2011	
		SEPS	RATE	SEPS	RATE	SEPS	RATE	SEPS	RATE	SEPS	RATE
DHA 1	Did Not Return From Pass									1	1.8%
	Discharged Home	48	85.7%	29	82.9%	33	82.5%	39	78.0%	42	75.0%
	Discharged to a Home Setting with Support Services	3	5.4%			1	2.5%			1	1.8%
	Signed Out (Against Medical Advice)	3	5.4%	3	8.6%	3	7.5%	2	4.0%	3	5.4%
	Transferred to a Long Term Care Facility			1	2.9%	1	2.5%				
	Transferred to Another Facility	2	3.6%	2	5.7%	2	5.0%	9	18.0%	7	12.5%
	Transferred to Other									2	3.6%
DHA 2	Did Not Return From Pass										
	Discharged Home	42	95.5%	43	95.6%	35	89.7%	38	90.5%	58	95.1%
	Discharged to a Home Setting with Support Services										
	Signed Out (Against Medical Advice)									1	1.6%
	Transferred to a Long Term Care Facility	1	2.3%			2	5.1%	1	2.4%		
	Transferred to Another Facility	1	2.3%	1	2.2%	2	5.1%	2	4.8%	2	3.3%
	Transferred to Other			1	2.2%			1	2.4%		
DHA 3	Did Not Return From Pass										
	Discharged Home	34	79.1%	44	78.6%	42	71.2%	42	82.4%	56	75.7%
	Discharged to a Home Setting with Support Services					2	3.4%				
	Signed Out (Against Medical Advice)	2	4.7%	1	1.8%	1	1.7%			3	4.1%
	Transferred to a Long Term Care Facility	2	4.7%	1	1.8%	1	1.7%				
	Transferred to Another Facility	5	11.6%	10	17.9%	12	20.3%	9	17.6%	15	20.3%
	Transferred to Other					1	1.7%				
DHA 4	Did Not Return From Pass			1	1.6%			1	1.3%		
	Discharged Home	46	79.3%	51	79.7%	42	73.7%	51	67.1%	58	73.4%
	Discharged to a Home Setting with Support Services	1	1.7%			2	3.5%	3	3.9%	5	6.3%
	Signed Out (Against Medical Advice)	5	8.6%	2	3.1%	1	1.8%	6	7.9%	2	2.5%
	Transferred to a Long Term Care Facility	1	1.7%					2	2.6%		
	Transferred to Another Facility	1	1.7%	5	7.8%	9	15.8%	9	11.8%	9	11.4%
	Transferred to Other	4	6.9%	5	7.8%	3	5.3%	4	5.3%	5	6.3%
DHA 6	Did Not Return From Pass										
	Discharged Home	1	20.0%								
	Discharged to a Home Setting with Support Services										
	Signed Out (Against Medical Advice)										
	Transferred to a Long Term Care Facility	1	20.0%								
	Transferred to Another Facility	3	60.0%	2	##########	2	##########	3	##########	9	100.0%
	Transferred to Other										
DHA 7	Did Not Return From Pass					1	2.4%				
	Discharged Home	28	75.7%	36	83.7%	34	81.0%	33	82.5%	36	92.3%
	Discharged to a Home Setting with Support Services	4	10.8%	3	7.0%	2	4.8%	1	2.5%	1	2.6%
	Signed Out (Against Medical Advice)	1	2.7%			1	2.4%	1	2.5%		
	Transferred to a Long Term Care Facility	1	2.7%					1	2.5%		
	Transferred to Another Facility	3	8.1%	2	4.7%	2	4.8%	4	10.0%	2	5.1%
	Transferred to Other			2	4.7%	2	4.8%				
DHA 8	Did Not Return From Pass										
	Discharged Home	143	71.5%	163	78.0%	149	75.3%	133	76.9%	166	82.2%
	Discharged to a Home Setting with Support Services	10	5.0%	7	3.3%	8	4.0%	11	6.4%	10	5.0%
	Signed Out (Against Medical Advice)	15	7.5%	11	5.3%	14	7.1%	12	6.9%	14	6.9%
	Transferred to a Long Term Care Facility	24	12.0%	22	10.5%	18	9.1%	8	4.6%	6	3.0%
	Transferred to Another Facility	1	0.5%	3	1.4%	6	3.0%	4	2.3%	3	1.5%
	Transferred to Other	7	3.5%	3	1.4%	2	1.0%	4	2.3%	3	1.5%
DHA 9	Did Not Return From Pass			9	1.6%	12	2.0%	11	2.0%	25	4.2%
	Discharged Home	398	74.7%	415	73.8%	419	69.8%	412	74.6%	388	65.5%
	Discharged to a Home Setting with Support Services	20	3.8%	13	2.3%	24	4.0%	14	2.5%	10	1.7%
	Signed Out (Against Medical Advice)	20	3.8%	28	5.0%	27	4.5%	25	4.5%	29	4.9%
	Transferred to a Long Term Care Facility	10	1.9%	6	1.1%	9	1.5%	6	1.1%	11	1.9%
	Transferred to Another Facility	81	15.2%	81	14.4%	102	17.0%	82	14.9%	122	20.6%
	Transferred to Other	4	0.8%	9	1.6%	6	1.0%	2	0.4%	6	1.0%
IWK	Did Not Return From Pass										
	Discharged Home	49	89.1%	54	90.0%	41	80.4%	64	86.5%	93	83.0%
	Discharged to a Home Setting with Support Services					1	2.0%	2	2.7%	2	1.8%
	Signed Out (Against Medical Advice)	3	5.5%	2	3.3%	3	5.9%	2	2.7%	4	3.6%
	Transferred to a Long Term Care Facility										
	Transferred to Another Facility										
	Transferred to Other	3	5.5%	4	6.7%	3	5.9%	6	8.1%	12	10.7%

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007. Figures for 2007 represent partial year only .

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Total Seperations, Unique Patients and Involuntary Admissions from 2007-2011 *

Certified prior to undergoing Observation | Involuntary Admissions

DHA	TYPE	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	DHA Total
DHA 1	SEPS	128	137	102	119	150	151	141	113	147	121	116	**604**
	CASES	103	116	89	98	127	128	114	93	121	106	101	**504**
	INV ADM	28	20	28	23	34	32	**56**	**35**	**40**	**50**	**56**	**221**
DHA 2	SEPS	299	236	277	314	256	222	225	203	226	256	220	**1064**
	CASES	230	180	205	225	187	175	177	151	172	201	165	**802**
	INV ADM	57	57	60	49	47	62	**44**	**45**	**39**	**42**	**61**	**220**
DHA 3	SEPS	197	225	224	192	181	201	150	182	189	205	240	**928**
	CASES	159	194	188	168	149	163	123	135	130	147	168	**673**
	INV ADM	49	53	60	42	44	42	**43**	**56**	**59**	**51**	**74**	**274**
DHA 4	SEPS	217	247	270	236	191	164	187	160	151	195	174	**810**
	CASES	183	206	217	194	164	129	148	144	135	174	156	**710**
	INV ADM	82	64	77	65	45	51	**58**	**64**	**57**	**76**	**79**	**321**
DHA 5	SEPS												
	CASES												
	INV ADM												
DHA 6	SEPS	247	294	237	284	348	312	211	221	254	242	283	**1143**
	CASES	195	214	195	218	250	232	159	160	183	190	211	**841**
	INV ADM	0	0	0	0	0	0	**5**	**<5**	**<5**	**<5**	**9**	**21**
DHA 7	SEPS	177	154	185	152	202	185	197	192	213	178	195	**933**
	CASES	138	127	139	121	160	143	158	146	172	142	159	**737**
	INV ADM	35	36	36	25	38	24	**37**	**43**	**42**	**40**	**39**	**194**
DHA 8	SEPS	898	913	934	933	776	753	665	639	618	615	684	**3044**
	CASES	593	608	636	631	536	530	475	476	464	472	525	**2260**
	INV ADM	137	137	142	157	158	201	**200**	**209**	**198**	**173**	**202**	**941**
DHA 9	SEPS	1470	1231	1144	1153	1170	1183	1369	1269	1190	1111	1181	**5832**
	CASES	1059	947	892	897	860	840	927	1025	994	929	976	**4711**
	INV ADM	366	352	392	333	405	433	**533**	**562**	**600**	**552**	**592**	**2733**
IWK	SEPS	179	221	206	146	155	219	220	223	207	240	388	**1221**
	CASES	149	174	166	115	136	166	163	158	160	188	258	**875**
	INV ADM	29	43	38	29	38	40	**55**	**60**	**51**	**74**	**112**	**340**
Total SEPS For Year		3812	3658	3579	3529	3429	3390	**3365**	**3202**	**3195**	**3163**	**3481**	**15579**
Total CASES For Year		2809	2766	2727	2667	2569	2506	**2444**	**2488**	**2531**	**2549**	**2719**	**12113**
Total INV ADM For Year		783	762	833	723	809	885	**1031**	**1076**	**1088**	**1061**	**1224**	**5265**

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007.
Figures prior to this date represent cases certified prior to undergoing observations
Figures for 2007 represent both these certified cases and involuntary admissions .

Note:

-Post July 3, 2007 'Involuntary admissions' are not necessarily similar to 'Certified prior to undergoing admission cases'.
Conclusions based on comparison of these two different methodologies may not be accurate .

-Count of cases is based on unique HCN's. On an average about 1% of cases have wrong or missing HCN's

For privacy reasons values less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Total Seperations, Unique Patients and Percentage Involuntary Admissions from 2007-2011*

Certified prior to undergoing Observation | Involuntary Admissions

DHA	TYPE	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	DHA Total
DHA 1	SEPS	128	137	102	119	150	151	141	113	147	121	116	604
	CASES	103	116	89	98	127	128	114	93	121	106	101	504
	INV ADM	21.9%	14.6%	27.5%	19.3%	22.7%	21.2%	39.7%	31.0%	27.2%	41.3%	48.3%	36.6%
DHA 2	SEPS	299	236	277	314	256	222	225	203	226	256	220	1064
	CASES	230	180	205	225	187	175	177	151	172	201	165	802
	INV ADM	19.1%	24.2%	21.7%	15.6%	18.4%	27.9%	19.6%	22.2%	17.3%	16.4%	27.7%	20.7%
DHA 3	SEPS	197	225	224	192	181	201	150	182	189	205	240	928
	CASES	159	194	188	168	149	163	123	135	130	147	168	673
	INV ADM	24.9%	23.6%	26.8%	21.9%	24.3%	20.9%	28.7%	30.8%	31.2%	24.9%	30.8%	29.5%
DHA 4	SEPS	217	247	270	236	191	164	187	160	151	195	174	810
	CASES	183	206	217	194	164	129	148	144	135	174	156	710
	INV ADM	37.8%	25.9%	28.5%	27.5%	23.6%	31.1%	31.0%	40.0%	37.7%	39.0%	45.4%	39.6%
DHA 5	SEPS												
	CASES												
	INV ADM												
DHA 6	SEPS	247	294	237	284	348	312	211	221	254	242	283	1143
	CASES	195	214	195	218	250	232	159	160	183	190	211	841
	INV ADM							2.4%	0.9%	0.8%	1.2%	3.2%	1.8%
DHA 7	SEPS	177	154	185	152	202	185	197	192	213	178	195	933
	CASES	138	127	139	121	160	143	158	146	172	142	159	737
	INV ADM	19.8%	23.4%	19.5%	16.4%	18.8%	13.0%	18.8%	22.4%	19.7%	22.5%	20.0%	20.8%
DHA 8	SEPS	898	913	934	933	776	753	665	639	618	615	684	3044
	CASES	593	608	636	631	536	530	475	476	464	472	525	2260
	INV ADM	15.3%	15.0%	15.2%	16.8%	20.4%	26.7%	30.1%	32.7%	32.0%	28.1%	29.5%	30.9%
DHA 9	SEPS	1470	1231	1144	1153	1170	1183	1369	1269	1190	1111	1181	5832
	CASES	1059	947	892	897	860	840	927	1025	994	929	976	4711
	INV ADM	24.9%	28.6%	34.3%	28.9%	34.6%	36.6%	38.9%	44.3%	50.4%	49.7%	50.1%	46.9%
IWK	SEPS	179	221	206	146	155	219	220	223	207	240	388	1221
	CASES	149	174	166	115	136	166	163	158	160	188	258	875
	INV ADM	16.2%	19.5%	18.4%	19.9%	24.5%	18.3%	25.0%	26.9%	24.6%	30.8%	28.9%	27.8%
Total SEPS For Year		3812	3658	3579	3529	3429	3390	3365	3202	3195	3163	3481	15579
Total CASES For Year		2809	2766	2727	2667	2569	2506	2444	2488	2531	2549	2719	12113
Total INV ADM For Year		20.5%	20.8%	23.3%	20.5%	23.6%	26.1%	30.6%	33.6%	34.1%	33.5%	35.2%	33.8%

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007.
Figures prior to this date represent cases certified prior to undergoing observations
Figures for 2007 represent both these certified cases and involuntary admissions .

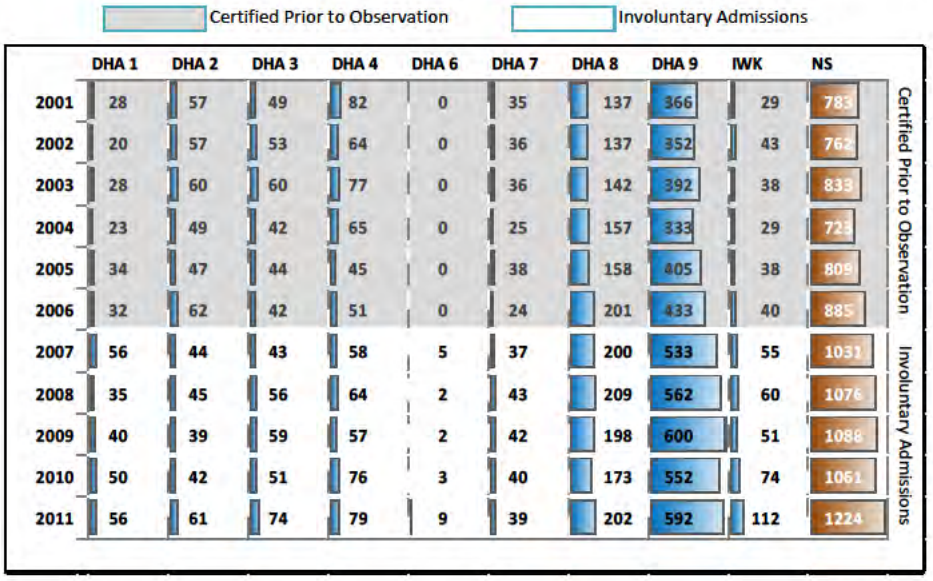
Note:

-Post July 3, 2007 'Involuntary admissions' are not necessarily similar to 'Certified prior to undergoing admission cases'.
Conclusions based on comparison of these two different methodologies may not be accurate .
-Count of cases is based on unique HCN's. On an average about 1% of cases have wrong or missing HCN's

For privacy reasons values less than 5 have been suppressed

Nova Scotia Department of Health and Wellness
IPTA REVIEW REPORT

Certified and Involuntary Admissions from 2001-2011 *



	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS	
2001	28	57	49	82	0	35	137	366	29	783	Certified Prior to Observation
2002	20	57	53	64	0	36	137	352	43	762	
2003	28	60	60	77	0	36	142	392	38	833	
2004	23	49	42	65	0	25	157	333	29	723	
2005	34	47	44	45	0	38	158	405	38	809	
2006	32	62	42	51	0	24	201	433	40	885	
2007	56	44	43	58	5	37	200	533	55	1031	Involuntary Admissions
2008	35	45	56	64	2	43	209	562	60	1076	
2009	40	39	59	57	2	42	198	600	51	1088	
2010	50	42	51	76	3	40	173	552	74	1061	
2011	56	61	74	79	9	39	202	592	112	1224	

Legend: **Source: CIHI DAD**

*Involuntary Admissions have been recorded only since July 3, 2007.
Figures prior to this date represent cases certified prior to undergoing observations
Figures for 2007 represent both these certified cases and involuntary admissions .

Note:

-Post July 3, 2007 'involuntary admissions' are not necessarily similar to 'certified prior to undergoing admission' cases. Conclusions based on comparison of these two different methodologies may not be accurate .

Total Seperations from 2001-2011

	DHA 1	DHA 2	DHA 3	DHA 4	DHA 6	DHA 7	DHA 8	DHA 9	IWK	NS
2001	128	299	197	217	247	177	898	1470	179	3812
2002	137	236	225	247	294	154	913	1231	221	3658
2003	102	277	224	270	237	185	934	1144	206	3579
2004	119	314	192	236	284	152	933	1153	146	3529
2005	150	256	181	191	348	202	776	1170	155	3429
2006	151	222	201	164	312	185	753	1183	219	3390
2007	141	225	150	187	211	197	665	1369	220	3365
2008	113	203	182	160	221	192	639	1269	223	3202
2009	147	226	189	151	254	213	618	1190	207	3195
2010	121	256	205	195	242	178	615	1111	240	3163
2011	116	220	240	174	283	195	684	1181	388	3481

Source: CIHI DAD

For privacy reasons values
less than 5 have been suppressed

Prepared by:
Junaid Kapra

7/5/2013

CIHI DISCHARGE ABSTRACT DATABASE

Information for IPTA Review

Where applicable, this information will be needed before 2007 compared to after 2007 (except for CTOs). Where possible/useful, maybe 5 years before and then 5 years after Act implemented.

Information to be broken down by DHA and also given for Nova Scotia total across all sectors.

Answers to the following question relate only to the information contained in the CIHI Inpatient Discharge Abstract Database held in Business Intelligence & Analytics. We do not have any outpatient information.

Involuntary Admissions	
Demographics	
Gender	Available all years
Age	Available all years
Race	Not available – is not collected
Employment status	Available from April 1, 2011 forward in CIHI's Group 15 in the Discharge Abstract Database – mandatory to collect for mental health patients
Education level	Available from April 1, 2011 forward in CIHI's Group 15 in the Discharge Abstract Database – mandatory to collect for mental health patients
Financial support	Available from April 1, 2011 forward in CIHI's Group 15 in the Discharge Abstract Database – mandatory to collect for mental health patients
Marital status	Not available – is not collected
Country of origin	Not available – is not collected

Timing of person being flagged for an involuntary assessment vs. how long it takes for the assessment to be done? (e.g. is the 72 hour time limit maximized frequently?)	Not available – is not collected
Number of repeat admissions/ rate of readmissions (broken down by gender and age)	Available all years
Number of re-admissions within 30 days of discharge [28 days]	Available all years – within 28 days
Number of admissions through the Emergency Department	Available all years
Compare duration of admission for those who spent all or part of their admission as involuntary vs. those who were voluntary for the entire admission.	Available all years – after July 3, 2007 when IPTA was proclaimed
Referral Source – who is making the request for Medical Examination	
Court – judicial orders for examination	Not available
Peace officer	Available from April 1, 2011 forward in CIHI's Group 15 Mental Health Indicators in the Discharge Abstract Database – mandatory to collect for mental health patients
Diagnosis	
Primary psychiatric diagnosis for those admitted	Available all years – most responsible diagnosis
Average length of stay and total length of stay for each diagnosis.	Available all years

Reason for Admission	
Patient meets which criterion for admission (how many of each): • harm to self or others OR • impairment/deterioration on assessment	Not available – only diagnosis is collected. Criteria not captured.
Duration	
Average duration of the hospital admissions in total.	Available all years – called average length of stay (ALOS)
Total days of care.	Available all years – called total length of stay (total LOS)
Average length of time since last discharge.	Available if using readmission code but that is to the same hospital. Could track the health card number through the database if necessary to determine if patient has gone to different hospitals. (reviewers did not think this was necessary)
For what ratio of the patients' stay was their status involuntary	Available all years – after July 3, 2007 when IPTA was proclaimed
Number of renewals of involuntary admission and for which criterion: • harm to self or others OR • impairment/deterioration on assessment	Not available – not collected
Status Change	
Change from involuntary to voluntary: • How often does this occur per year?	Not available – not collected From April 1, 2012 can determine if the patient had more than one involuntary component of his/her

• What is the timing of this change (i.e. just before the Review Board hearing?)	stay but no times collected
Ratio of average length of patients' voluntary status stay to their involuntary status stay.	Available from July 3, 2007 forward
Change from voluntary to involuntary: • How often does this occur per year? • What is the timing of this change?	Not available – not collected From April 1, 2011 can determine if he patient had more than one involuntary component of his/her stay but no times collected
Transfers	
Number of transfers between facilities and reasons given.	Available but only after the patient has been admitted.
Certificates of Leave	
Number of certificates of leave issued.	Available on inpatient only
Number of cancellations (and reason for cancellation): • breached a condition • patient's condition may present a danger to self or others • failed to report	Not available – not collected. We can also not follow outpatients
Discharge	
Reason for discharge	Available all years – called most responsible diagnosis. Outcomes of treatment not captured.

Number of absences without leave for one month or less (by number of unique patients and in total).	Available all years
Length of time since last discharge.	Available but would have to track the health card number through the database to find admissions to other facilities (reviewers did not think this was necessary)
Community Treatment Orders	
Demographics of patients with CTOs	
Gender	Available on patients admitted after July 3, 2007
Age	Available on patients admitted after July 3, 2007
Race	Not available – not collected
Employment Status	Available from April 1, 2011 forward in CIHI's Group 15 Mental Health Indicators in the Discharge Abstract Database – mandatory to collect for mental health patients
Education Level	Available from April 1, 2011 forward in CIHI's Group 15 Mental Health Indicators in the Discharge Abstract Database – mandatory to collect for mental health patients
Marital Status	Not available – not collected
Country of origin	Not available – not collected
Primary psychiatric diagnosis for patients on CTOs.	Available on patients admitted after July 3, 2007 – Most responsible

	diagnosis
The number of CTOs issued and number of unique patients on CTOs	Available on patients admitted after July 3, 2007 – inpatients only
Number of renewal of CTOs.	Not available – not collected
Number of revocations of CTOs: • Patient no longer meets criteria (Form 11A) • Non-compliance with CTO (Form 11B) • Services unavailable (Form 11C)	Not available – not collected
Criteria for being placed on CTO: • harm to self or others OR • impairment/deterioration on assessment	Not available – not collected
Number of requests made of peace officers to apprehend patient for breach of CTO.	Not available – not collected
Average times between issue of CTO and readmission to hospital.	Not available – not collected
Subsequent Questions / Input	
Disposition of individuals brought in for *involuntary assessment*; i.e. the proportion that had their status changed to involuntary admission, to voluntary within the 72-hour time frame, or had their status lapse with no formal status change.	Disposition for patients brought in with *involuntary assessment* is available for patients discharged April 1,2011 forward but there are no times available. Cannot find out if changes to involuntary occurred within 72 hours
'Referral source' - of all those individuals brought in for an	Referral source for patients is available in CIHI Group 15 Mental

assessment, what proportion were brought in by family/significant other/self, and what proportion by the other two (court/peace officer).	Health Indicators as of April 1, 2011.
Regarding diagnosis, ambiguity exists as to whether it refers only to involuntary admissions, or to involuntary assessments or both. Suggest we should be looking at how we are using our option of detaining for assessment purposes as well as the option of full involuntary admission for treatment.	Cannot answer this question
This ambiguity also seems to exist in relation to the question on status changes. Are you only interested in those changes as they relate to involuntarily admitted patients?	Cannot answer this question
There is concern that five years pre and post is so long that variations pre and post IPTA will be difficult to interpret. So many changes have happened in that time frame that variations could be attributable to them rather than the Act itself. It's all correlational of course, but you want as much clarity as possible. An alternative would be to break down all trends into five one-year periods pre and the same post.	Data collected pre IPTA is completely different from that collected post IPTA except for demographics. Comparisons are not available pre IPTA

Suggest collecting information about use of voluntary/incapable and also reference to concurrent disorders. Reference to 'primary psychiatric diagnosis' only would miss critical information about substance use in this population.	The comparable conditions in the CIHI inpatient database are pre-admit comorbidities which are conditions which exist prior to the patient's admission but which also require resources. Substance abuse should show up here if it is a major problem. We do not use the term concurrent disorders.
Compliance with the Act in terms of Review Board hearings. One indicator might be the number of hearings cancelled because of lack of availability of a Review Board member.	Not available through BIA – we do not collect
Exploration of the impact of the Patient Rights Advisor and our compliance with that part of IPTA.	Not available through BIA – we do not collect

Appendix J

Letter to Police Chiefs and Commanding Officer, RCMP, and Responses to Requests for Data

March 14, 2013

Dear Chiefs of Police and Commanding Officer RCMP,

I am following up on the meeting that was held with Justice La Forest, Professor Lahey and members of your organizations on February 21, 2013 regarding the Independent Review of the Involuntary Psychiatric Treatment Act (IPTA). I am supporting the work of the Review and in that capacity had the privilege of attending the meeting.

At the meeting, we discussed the issue of data and information generally. Participants suggested that we write to each of you regarding the availability of relevant information for the Review. It would be helpful to the Review if you are able to share aggregate data or information that you currently collect about the IPTA. As you will recall, the IPTA came into force in July 2007.

The participants at the meeting suggested that it would be helpful to provide a few examples of the types of information that may be relevant. Please do not feel restricted by the examples; we would be appreciative of receiving any information that you feel is relevant to the Review. Examples include:

- How often police exercise authorities under the IPTA? What are the issues that arise in relation to the exercise of these authorities and with what frequency do these issues arise? Has the frequency with which police authority under the IPTA is exercised increased, decreased or otherwise changed over time? Has the nature or frequency of the issues that arise in the exercise of police authorities under the IPTA changed over time? The relevant sections of the Act include:
    - Section 10 (relates to taking person into custody for involuntary psychiatric assessment)
    - Section 14 (relates to taking person into custody for medical examination)
        - It would be helpful to identify the criteria under s.14(d)that was engaged (harm, deterioration, criminal offence)
        - How many people brought to hospital under this section are admitted?
    - Section 16 (relates to remaining with person during medical examination and returning person to place where taken into custody or other appropriate place)
    - Section 44 (relates to returning person to facility where certificate of leave cancelled)
    - Section 46 (relates to returning person to facility where person absent without leave)
    - Section 56 (relates to taking person for examination where person fails to comply with community treatment order)

    - Section 57 (related to taking person for assessment where services become unavailable for a community treatment order)

- How many mental health related complaints does your organization receive each year? How many result in the use of police authority under the IPTA? Have the volume of mental health complaints and the frequency of use of police authority under mental health legislation (i.e. under IPTA or its predecessor, the Hospitals Act) changed since the coming into force of the IPTA?

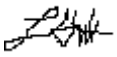
- What non-police resources (e.g. some hire jail staff) are utilized to assist in dealing with matters that arise for police under the IPTA? What agencies do police work with in dealing with matters that arise under the IPTA?

- What role do the police play in relation to the transportation of persons being evaluated or treated under the IPTA? What issues arise in relation to the role that the police play in transportation of these persons?

I also wanted to let you know about the Review's webpage. The link is http://www.nshrf.ca/initiatives/initiatives/independent-review-ipta. It provides information about the various ways stakeholders and the public can provide input to the Review. A discussion document and online survey will be posted to the webpage soon.

Thank you for your interest in and contribution to the work of the Independent Review of the Involuntary Psychiatric Treatment Act.

Sincerely,



Leah Hutt

Leah.hutt@dal.ca
902-424-5815

April 15th, 2013

Halifax Regional Police
1975 Gottingen Street
Halifax, Nova Scotia
Canada B3J 2H1

Chief of Police
Jean-Michel (JM) Blais
Halifax Regional Police
Directeur de police

Ms. Leah Hutt
IPTA Review Team
Dalhousie University
Halifax. N.S.

Dear Ms. Hutt;

The following is submitted in regards to your letter dated March 14th, 2013 requesting additional information regarding the IPTA;

How many mental health related complaints does your organization receive each year? How many result in the use of police authority under the IPTA? Have the volume of mental health complaints and the frequency of use of police authority under mental health legislation (i.e. under IPTA or its predecessor, the Hospitals Act) changed since the coming into force of the IPTA?

For 2012, Halifax Regional Police responded to 1193 calls for service that were coded as Mental Health related. These calls resulted in 223 persons taken into custody under the IPTA and transported to the hospital for assessment. Wait times ranged from 1/2 hour to 17 hours, with a mean of 4.86 hours, mode of 5 hours and a median of 4.5 hours. Of note is the fact that in 22% of these incidents, police wait times were seven hours or longer in duration. For the year, HRP personnel spent 1084 hours at the hospital waiting for assessments to be completed.

Locally we have seen significant increases in mental health related calls for service as noted in the following chart;

YEAR	Mental Health Calls for service
2007	638
2008	762
2009	834
2010	897
2011	1278
2012	1193

How often police exercise authorities under the IPTA? What are the issues that arise in relation to the exercise of these authorities and with what frequency do these issues arise? Has the frequency with which police authority under the IPTA is exercised increased, decreased or otherwise changed over time? Has the nature or frequency of the issues that arise in the exercise of police authorities under the IPTA changed over time?

From a police perspective, there are three main issues that we submit for consideration;

There is currently no requirement in the Act for hospital staff to notify police of the release of a person committed for assessment after arrest and transport by Police. Many times, these individuals have charges pending but are brought in for assessment prior to charges being laid. These persons are then released without the police being

notified. When enquiries are made, hospital staff will only confirm the person is no longer a patient at the hospital, resulting in significant police resources being expended to locate and arrest these individual. The Act should be amended to include a duty for Hospital staff to notify police. This requirement should include a stipulation that the notification is required to be given some amount of time (2-3 hours) prior to release to allow police to attend the area of the hospital to affect that arrest.

Section 16 (1) requires police to convey the person by the least intrusive means possible without compromising the safety of the person. In many cases persons taken into custody under the Act are not violent and do not require an armed police officer to maintain watch until assessed. For many, police represent authority and the officer's presence there serves to escalate the general atmosphere, much to the detriment of the person in custody. Currently section 16 (2) of the Act requires the peace officer to remain with the detained person until the medical examination is completed. Given the least intrusive provisions of section 16(1), there should be a provision within the Act to allow police to turn over non-violent persons detained under the Act to designated hospital staff members. Within HRM for example, the emergency room is staffed on a 24/7 basis by security officers. Police would turn over detained persons to these officers when appropriate. In those instances where the person was not admitted, police would re-attend to return the detained person to their place of residence.

Given escalating mental health related calls for service, lengthy police wait times should be addressed within the Act. For example, in 2012 police experienced wait times of seven hours or longer 22% of the time, with some wait times lasting as long 17 hours. While appreciating some of these instances relate to the ingestion of drugs or alcohol that delays the initial medical assessment, there remain numerous instances without complicating factors that result in significant wait times resulting in police resources being unavailable.

What non-police resources (e.g. some hire jail staff) are utilized to assist in dealing with matters that arise for police under the IPTA? What agencies do police work with in dealing with matters that arise under the IPTA?

Currently, Halifax Regional Police do not employ non police personnel to take over detention at the hospitals, rather the officer who forms the grounds for the detention attends the hospital and waits until the person is released, committed or he is relieved by another officer.

What role do the police play in relation to the transportation of persons being evaluated or treated under the IPTA? What issues arise in relation to the role that the police play in transportation of these persons?

As a rule, HRP does not undertake transportation of persons after they have been committed under the Act, though there are exceptions where due to extenuating circumstances we will provide this service, or provide an officer in the ambulance for transport.

Respectfully Submitted;

Supt. Sean Auld, Halifax Regional Police
Sgt. Scott MacDonald, Halifax Regional Police

APPENDIX "A"

HRP Hospital Wait times resulting from IPTA detentions in 2012

DATE	GO #	ARRIVAL TIME	TIME SEEN BY MD	CLEAREDBY MED	SEEN BY PSYCH	CLEARED/ COMIMITTED	TOTAL TIME	COMMENTS
01-Jan-12	577	1030				1800	5	
03-Jan-12	1113	1455			1950	2105	6	Suicidal
03-Jan-12	1248	1630				0	6.5	
05-Jan-12	2071	1400				1454	1	Agitated
05-Jan-12		330				800	4.5	
05-Jan-12		1900				100	6	
09-Jan-12	4629	2130				15	4	Paranoid, comparative
11-Jan-12	5395	1357			1830	1830	4.3	Paranoid, confused
13-Jan-12	6759	2040		2115	2345	211	6	Unpredictable female
14-Jan-12	7274	1900				2300	4	
14-Jan-12	7350	2130				630	9	
15-Jan-12	7779	2000		2114		2120	1	DUI/threats to harm himself
20-Jan-12	10452	2139			4	4.33	6.5	Harming himself- safety
21-Jan-12	10954	1940	2100	2130	2215	2245	4	Admitted- aggressive - medicated

22-Jan-12	11390	1615			1930	2300	7.5	Took ecstasy
23-Jan-12	11501	2306	2345	5	43	125	2	Unstable
28-Jan-12	14461	1115	1337	1530		1530	4	anxiety
28-Jan-12	14343	2028	2311	2311		200	6	Unstable
30-Jan-12	15555	1520	1535		1535	1635	1	
30-Jan-12	15746	2120	2125	2310		2311	2	Behaviour issues
06-Feb-12	19366	1400				2100	7	
08-Feb-12	20412	1400				2200	8	drugs/alcohol/aggression
09-Feb-12	20703	2200	120	311		311	6	Intoxicated taken home
11-Feb-12	22235	2030				2048	1	Admitted to N.S
13-Feb-12	22841	1043			1856	2150	12	Admitted to N.S
16-Feb-12	24514	1138			2128	2128	10	Depressed-
29-Feb-12	31327	1501			100	100	10	Behaviour Issues
02-Mar-12	32251	142			316	320	2	Risk of freezing
02-Mar-12	32516	1850				2100	3	Erratic Behaviour - HRP - Booking
06-Mar-12	34592	1450				1655	2	Unstable
06-Mar-12	34596	1749			2230	2340	8	Arrested for assault
08-Mar-12	35448	1215	1620			1620	5	admitted off medicated
09-Mar-12	36285	0				400	4	
12-Mar-12	37273	2330				430	5	
14-Mar-12	38708	1700			1930	2252	7	72 hr observation
15-Mar-12	39004	1900				2200	3	
18-Mar-12	40708	1530				2200	7.5	drugs
23-Mar-12	43634	2050		48		100	5.5	MI - unstable

23-Mar-12	43294	1030				1700	6.5	
24-Mar-12	44024	1400				1800	5	
26-Mar-12	45151	2200				300	5	
27-Mar-12	45426	1423	2030			105	12	intoxicated held till sober
28-Mar-12	46202	24	50		222	320	3	depressed
04-Apr-12	49360	245				525	2.5	
06-Apr-12	50603	1930				0	4.5	
07-Apr-12	50939	2250	2300	839		839	10.5	Aggressive - Cleared by DR.
10-Apr-12	52360	1253	1400	1452		1500	2	Emotional - unstable
10-Apr-12	52447	1800	2030		2135	2135	3	Unstable/ Abby Lane
12-Apr-12	53221	120	715			750	6	mentally stable
12-Apr-12	53578	1940	32		140	150	7	depressed stressed
16-Apr-12	55586	1621				2141	5	Arrested under IPTAct -
17-Apr-12	56153	1900				2200	3	
19-Apr-12	56899	853				1656	8	Arrested under IPTAct - Abbey Lane
21-Apr-12	57935	100				500	4	
24-Apr-12	59471	1220				1440	2.5	
24-Apr-12	59613	2127				17	3	Arrested under IPTAct -
24-Apr-12	48521	1330				1400	11.5	aggressive
25-Apr-12	60128	2130				15	2	
25-Apr-12	59710	800	905	940	1100	1300	5	Safety - Aggressive
25-Apr-12	60174	2340				528	5	Arrested under IPTAct -
28-Apr-12	61383	852				1021	1.5	

02-May-12	63302	1155	1300	1410		1420	2	Upset/Violent/in pain
02-May-12	63240	1058	1130			1953	9	Arrested under IPTAct -
03-May-12	64095	2200				740	7.5	alcohol
May-12	64973	1500	1545	1630		1640	1.4	Suic- Intoxicated
08-May-12	66472	1930				2300	3.5	
09-May-12	66973	2115	2140	2255	2321	2355	2	MI -
09-May-12	66657	538	815			1220	6.5	Arrested under IPTAct -
10-May-12	67075	830	910		942	1630	8	MI- talking to himself
12-May-12	68406	1638				2100	5	Paranoia/Schizophrenia
15-May-12	70067	2120	225	235		235	5	Mental Breakdown
15-May-12	70789	1030				1630	6	
16-May-12	70270	910	950		1100	1110	2	MI
16-May-12	70655	1910			1945	2159	3	Arrested under IPTAct
18-May-12	71329	1010	1055	1426	1453	1453	4	Delusional
22-May-12	73481	1415	1500		1530	1530	1	MI
22-May-12	73451	1400	1710		1725	1725	3	MI
23-May-12	74192	1954			135	237	6.5	Arrested under IPTAct -
30-May-12	77374	340				440	1	
31-May-12	77740	1840	1900	132	142	150	7	Suicidal
01-Jun-12	78460	440				930	5	Arrested under IPTAct
04-Jun-12	80341	1755	1915		2119	2125	4	Hear Voices/MH
07-Jun-12	81803	1330	1400		1410	1420	1	To be re-assessed
09-Jun-12	83189	2340	100		200	200	3	Suicidal
10-Jun-12	83247	600	820	1050		1050	4	Suicidal

11-Jun-12	83980	1740				2040	3	
11-Jun-12	83971	1520	1645	1700	2107	2200	7	MH- Issues
12-Jun-12	84651	2030				2339	3	MH- weapons complaint
13-Jun-12	84761	104			440	500	4	MH-dispute-verbal
14-Jun-12	85545	1330				2300	9	
15-Jun-12	85976	945	1045			1100	2	Behavioural Issues
16-Jun-12	86505	216	230	330	330	330	1	Thinking of Suicidal
16-Jun-12	86824	1730				2100	3.5	
16-Jun-12	86549	245	245	304	933	1105	9	Depressed
17-Jun-12	87318	1522	1530	1635		1635	1	Behavioural/assessment
17-Jun-12	87502	0			550	550	5.5	Safety - Issues
19-Jun-12	87951	2245				500	6	drugs/alcohol
20-Jun-12	88923	1749				2030	2.5	
21-Jun-12	89137	200				700	5	
23-Jun-12	90404	244	540		540	600	4	Suicidal
23-Jun-12	90713	2000	2200	2300	100	220	6	MH-Certified - agitated
23-Jun-12	90744	2100			345	630	9.3	Suicide
25-Jun-12	91682	1900				2300	4	
26-Jun-12	91849	245				535	3	
30-Jun-12	94318	1630	1725	1940		1945	3	Agitated
02-Jul-12	95509	1800				2100	3	
05-Jul-12	97294	2215	900		900	920	11	Intoxicated/agitated/
09-Jul-12	99003	240	600		610	615	4	Paranoid/bi-polar
09-Jul-12	99262	1600			2040	2050	4.5	depressed- Suicide teen

09-Jul-12	99425	1800				300	9	aggressive
09-Jul-12	99253	1450	720		720	735	17	Withdrawn/Un-cooperative
10-Jul-12	99505	2205	2315			2320	1	Abby Lane Admittance
10-Jul-12	99600	530	842	936	1055	1055	5	Distraught/ADHD
14-Jul-12	101936	300				622	3.5	
15-Jul-12	102819	219	500		500	520	3	Cutter
17-Jul-12	103712	1801	1915		1925	1935	1	Psych Referral
17-Jul-12	103839	2230				2450	2	admitted- safety issue
18-Jul-12	103838	2245		2400		2420	2	Mentally Challenged
24-Jul-12	107347	835	1415		1415	1425	6	Admitted to short stay
24-Jul-12	107414	1045				1700	6	
25-Jul-12	107541	1200				1700	5	
26-Jul-12	108686	2200				600	8	
27-Jul-12	109361	2330	123		226	240	3	Agitated- returned to Sullivan HSE
30-Jul-12	110579	1140	1715	1715		1730	6	MH issues
31-Jul-12	111448	2256				245	4	Suicidal male with knife
31-Jul-12	111221	1521	1620	2245		2250	7	Aggressive
01-Aug-12	112020	1845				2356	5	
04-Aug-12	113599	1827			2000	129	7	Arrested under IPTAct - Admitted
04-Aug-12	113344	420			840	1335	9	Admitted to hospital
07-Aug-12	114958	1521				230	11	alcohol
08-Aug-12	115668	1844				2247	4	Arrested under IPTAct - Released

09-Aug-12	115880	430				530	1	
10-Aug-12	116921	1441				2130	7	Arrested under IPTAct - Released
10-Aug-12	116778	1417				2130	7.1	Arrested under IPTAct -
18-Aug-12	121237	2133			2242 - 640	745	10	Arrested under IPTAct - Released
19-Aug-12	121801	2111				143	4.5	Arrested under IPTAct - Admitted
19-Aug-12	121563	1108				1835	7.5	Arrested under IPTAct -
20-Aug-12	121911	620				1007	3.75	Arrested under IPTAct - Released
21-Aug-12	122846	2300				100	2	
21-Aug-12	122918	2246				236	3	
23-Aug-12	123608	830	925	925	1135	1330	5	Abnormal behaviour
24-Aug-12	124313	1630			32	40	8	Agitated Behaviour
Aug-12	125046	1750				2200	5	
28-Aug-12	126311	643	715		1240	1245	6	Agitated
29-Aug-12	127191	2246				205	4	
31-Aug-12	128205	2000				2100	1	
31-Aug-12	128378	0				600	6	
01-Sep-12	128771	1930				2230	3	
04-Sep-12	130039	915	1017	1040	1100	1140	2	Agitated
Sep-12	131195	1515				2300	8	
10-Sep-12	133453	1630				230	10	aggressive
Sep-12	134680	1830				2306	4.3	
15-Sep-12	136178	1200				1800	6	aggressive
18-Sep-12	137806	1900				2300	3.5	

20-Sep-12	138882	200				2330	1.5	
22-Sep-12	139681	1800				2200	4	
Sep-12	139273	1937			2142	48	5.1	
30-Sep-12	143622	17	210		650	804	7	
01-Oct-12	144261	1800				2100	3	
Oct-12	144850	1841				250	8	
02-Oct-12	144812	1725		245		250	9	MH/Certified
04-Oct-12	145672	1126	1135	1135	1522	1553	4	Suicidal
05-Oct-12	146551	2200				300	5	
06-Oct-12	146764	1400				700	17	aggressive/drugs/alcohol
07-Oct-12	147201	258	325	348		356	1	Unstable
12-Oct-12	149335	1830	2130		230	235	8	Unstable issues
13-Oct-12	150269	1545	1635	1700		1710	4	MH
16-Oct-12	151677	1900				0	5	
17-Oct-12	152059	1350				1700	4	MH
19-Oct-12	152661	1600				300	11	IWK
Oct-12	154802	2331				1411	12	Arrested/released
23-Oct-12	155347	2300	425	430		435	5	Well Being- Safety
Oct-12	157336	1859				1939	0.4	Arrested under IPTAct - Admitted
27-Oct-12	157365	2100				300	6	aggressive/drugs
31-Oct-12	158998	2219				626	8	Arrested under IPTAct - Released
01-Nov-12	160034	2020		2334		120	5	Safety
01-Nov-12	159965	2100				245	6	

02-Nov-12	160454	1450			1636	1700	3	Post Part. Depression/Anxiety
03-Nov-12	161193	20		140		150	2	Postal Suicide - teenager
05-Nov-12	162119	2145	2200	2340		2350	2	Safety- Intoxicated
06-Nov-12	162633	2000				220	6	Agitated
10-Nov-12	164482	1300				1400	1	
Nov-12	164673	2002				233	6	Arrested under IPTAct - Released
12-Nov-12	165624	2030				2100	0.5	
12-Nov-12	165355	1000	1100	1604	1604	1731	7	Psychiatrically - on-going issues
13-Nov-12	165695	530				630	1	Arrested under IPTAct -
13-Nov-12	165885	1230	1400		1500	1555	4	Suicidal
13-Nov-12	166142	2025	140			210	6	Suicidal
14-Nov-12	166378	1250		1645		1700	5	Unstable
14-Nov-12	166242	200				830	6.5	
16-Nov-12	167482	1700				1800	1	
16-Nov-12	167429	1345	1515	1600		1850	5	Agitated
17-Nov-12	167886	1000				1600	6	
19-Nov-12	168652	330	437	447		450	1.1	Upset- intoxicated
Nov-12	168636	136			410	425	2.5	Arrested under IPTAct -
19-Nov-12	168993	1900				0	5	
20-Nov-12	169532	1720		1910		1920	2	MI - Upset
Nov-12	169988	1628				1843	2	Arrested under IPTAct -
22-Nov-12	170327	640	800	900	945	1003	4	Upset -
22-Nov-12	170647	1830				2330	5	
25-Nov-12	171959	800				1300	5	

26-Nov-12	172466	940		1921	2100	2130	12	MHA - Issues
28-Nov-12	173430	641				1149	5	Arrested under IPTAct - Released
30-Nov-12	174693	1417				1745	3.5	Arrested under IPTAct -
01-Dec-12	175269	1630				1930	3	
02-Dec-12	175494	30	52	128	149	239	3	Depressed
03-Dec-12	175928	416				618	2	Arrested under IPTAct -
04-Dec-12	176654	1447				2010	5	Arrested under IPTAct -
05-Dec-12	177261	1700				1900	2	
05-Dec-12	177344	2155				57	2	Arrested under IPTAct -
06-Dec-12	177857	55				456	4.1	Arrested under IPTAct -
09-Dec-12	178972	530				1000	4.5	
12-Dec-12	187327	1357				1526	1.3	Arrested under IPTAct -
15-Dec-12	181884	820		1010		1010	2	treated and released quickly
17-Dec-12	182643	130				530	4	
21-Dec-12	184965	2300	36		36	36	2	Upset
21-Dec-12	184653	1236	1512		1530	1530	3	Suicidal
23-Dec-12	185774	2200	2335		2350	2350	1.5	Upset/MI
23-Dec-12	185470	320	1145		1305	1305	10	Suicidal
24-Dec-12	186076	1720	1830		1900	1900	2	Suicidal/Aggressive bi-polar
30-Dec-12	188144	1200	1700		1715	1745	5	Mental Illness
30-Dec-12	188210	1838				46	6	Arrested under IPTAct -
31-Dec-12	188465	1500	1700		1715	171735	4	Erratic Behaviour
Mean							4.86	
Median							4.5	

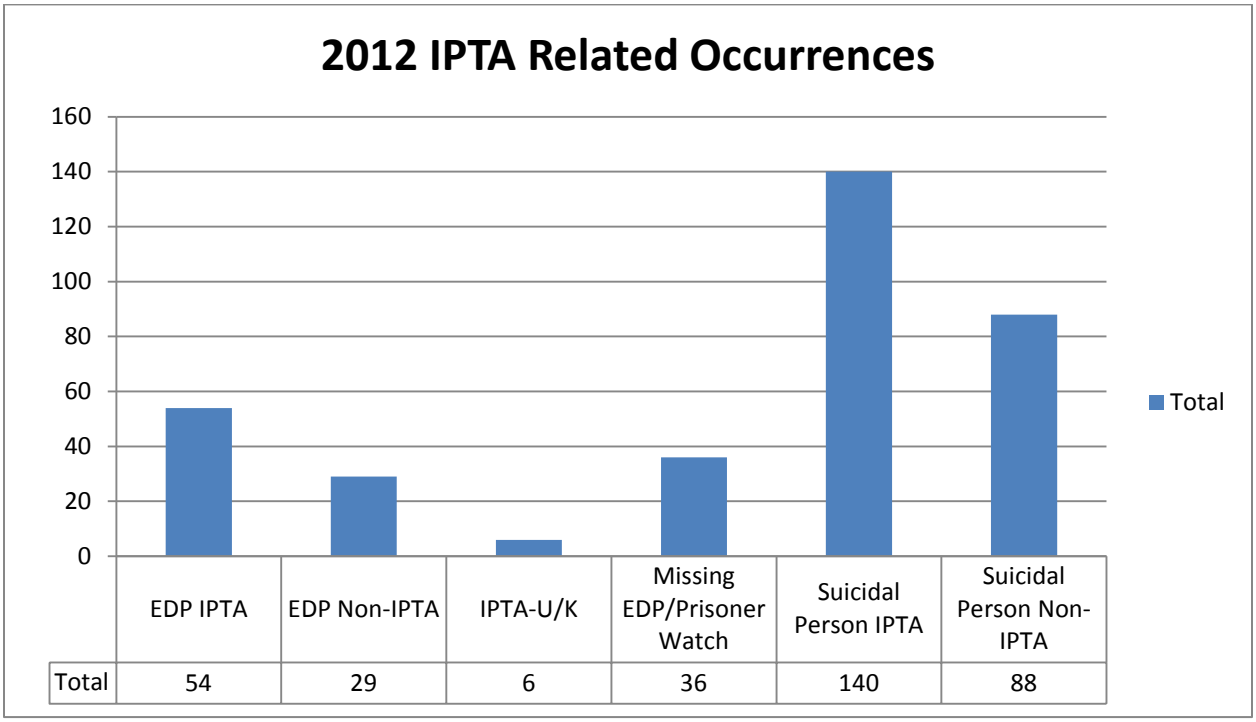
Mode							5	
Range							.4 hours -17 hours	
TOTAL							1084.15	

.

Project: Involuntary Psychiatric Treatment Act (IPTA) related calls for service received by the Cape Breton Regional Police Service for January 1, 2012 to December 31, 2012

Method - All Watch Commander Reports for the 2012 calendar year were first analyzed to calls related to Suicidal persons, Emotionally Disturbed Persons, Arrests under IPTA, persons missing from the Mental Health Unit and occurrences where a jailer or Police Officer was required to watch a subject of complaint at a hospital facility. To cross check all data uncovered, a search of the NICHE RMS system was conducted for the calendar year 2012 to uncover all calls for service given an occurrence type of Request for Assistance-Mentally Ill Person, Attempted Suicide and all other Suicide. A final tally of all data found is listed below

Results



*Non-IPTA = Subject of Complaint attend Hospital voluntarily

Detailed information for each Month

**** details removed by Reviewers for publication purposes****

Aggregate data for your information as it relates operational files that would fall under the Involuntary Psychiatric Treatment Act.

In the RCMP operational records management system, **Police Reporting Occurrence System (PROS) t**his type of occurrence is captured under Mental Health Act - Other. This is a generic term as the system is used across the country by many provinces and so does not specifically refer to Provincial legislation. This occurrence type has a file retention period of five years so we are at a point where they have begun to purge from our system.

Operational Files RCMP Nova Scotia		
Year	# of Mental Health Occurrences	Total # of Occurrences
2009	2144	41,734
2010	2190	45,414
2011	2212	83,340
2012	2374	100,537

Source: Police Reporting Occurrence System (PROS)

Context:
* Occurrence numbers relate only to PROS occurrences which encompass RCMP units outside of the Halifax Regional Municipality.
**Halifax District RCMP uses the Versadex system which is integrated with Halifax Regional Police.
*** For the years of 2009, 2010 and up to May 2nd of 2011 the occurrence numbers do not reflect the actual number of total occurrence. They do not show the files that have purged from the records management system.

Appendix K

Statistics from Empowerment Connection, the Patient Advisor Service

Patient Rights Advisor Service of Nova Scotia

April 1, 2012 – March 31, 2013

	DHA1	DHA2	DHA3	DHA4	DHA7	DHA8	DHA9	IWK	PICU	TOTAL
Request										
Rts: Involuntary Admissions	20	29	28	29	29	110	249	28	8	530
Rts:CTO	0	10	3	8	1	15	45	0	1	83
Rts: Certificate of Leave		1	1				1			3
Rts:Declaration of Renewal		9	4	11	2	35	91	3		155
Assistance for Review Board		1		11		5	26			43
Assistance for Legal Aid	1	4	2	15		9	45	2		79
Notices of Hearings	2	2	4	11	1	27	65	3		115

The delivery of rights for Involuntary Admissions, Community Treatment Orders (CTOs), Certificates of Leave (COLs), and Declarations of Renewal represent 771 required patient contacts by Patient Rights Advisors (PRAs), plus 771 contacts with Substitute Decision Makers. In addition, approximately 50% of patients require two or more visits, plus contacts by phone with the central office, totaling about 1,900 to 2,000 patient contacts per year to deliver rights information.

You will note that PRAs assisted with more Legal Aid applications than Review Board Hearing applications. The difference reflects the fact that automatic hearings do not require the patient to apply.

Our hearing statistics are based on 115 Notices of Hearing generated by the Psychiatric Review Board. There are more Notices of Hearing than actual hearings held because cancellations, postponements, adjournments, etc. require additional Notices of Hearing. Of the hearings held, PRAs attended about 95%, at the request of patients.

The HRM (District 9) represents approximately half of our province-wide activity. Hearing activities in HRM for the year ending March 31, 2013 were:

Hearings initiated	65
Cancelled	20
Postponed	8
Held & completed	31
Held & adjourned	6

Appendix L

Annual Review Board Reports

2007-2011

DRAFT

ANNUAL REPORT

REVIEW BOARD UNDER THE INVOLUNTARY PSYCHIATRIC TREATMENT ACT (JULY 3, 2007-MARCH 31, 2008)

INTRODUCTION

In 2002 the Law Reform Commission of Nova Scotia released its Final Report on the mental health provisions of the *Hospitals Act*. In this Report it recommended that new legislation be implemented in Nova Scotia, which would allow, among other things, community treatment orders and leave certificates.

On May 11, 2005 the *Involuntary Psychiatric Treatment Act* (IPTA) received first reading. There were numerous Committee amendments to the Bill and on December 8, 2005 it received Royal Assent. It was proclaimed into force on July 3, 2007.

The Review Board is established under s. 65 of the *IPTA* to hear and consider applications under the *Act* .It is presently comprised of nine lawyers, four psychiatrists and three lay members.

This annual report is presented in three parts. Since this is the first Report under the new legislation, Part I provides a detailed look at the types of reviews which the Review Board may be asked to perform. Part II presents the statistics and trends of the Board's operation during the period from July 3, 2007 – March 31, 2008. In Part III we bring to the attention of the Legislature issues of present concern.

Part I - Types of Review

(i) Review of Status

The main responsibility of the new Review Board is to review the decision of the treating psychiatrist that a person in a psychiatric facility should be held as an involuntary patient. "Involuntary" is the new language to describe what had

previously been referred to as “formal” status. By legislation, a person may be held under involuntary status if they meet the criteria under s, 17.

The criteria for involuntary status (s. 17) are:

(a) has a mental disorder
(b) is in need of psychiatric treatment in facility
(c) as a result of mental disorder
    (i) is threatening or attempting to cause serious harm to self or has recently done so, has recently caused serious harm to self, is seriously harming or is threatening serious harm towards another or has recently done so, or
    (ii) is likely to suffer serious physical impairment or serious mental deterioration, or both;
(d) not suitable for inpatient admission as a voluntary patient; and
(e) as a result of the mental disorder, does not have capacity to make admission and treatment decisions.

With respect to criteria 17(e) – capacity, the test is whether the patient fully appreciates:

(a) the nature of the condition for which treatment is proposed;
(b) the nature and purpose of the specific treatment;
(c) the risks and benefits involved in undergoing specific treatment; and
(d) the risks and benefits in not undergoing the specific treatment.

Also, whether the patient’s mental disorder affects ability to fully appreciate the consequences of making the treatment decision.

A review of this type is most often triggered by a request from the patient but a review may also be requested by the substitute decision maker, the hospital or the Review Board itself.

(ii) Has the substitute decision maker rendered a capable informed consent?

Under s. 42(1) Review Board can review the decision of a substitute decision maker if asked by a psychiatrist or patient.

The test for whether or not the SDM made a capable, informed consent or refusal is that the decision must be made in accordance with the patient’s “prior capable informed expressed wishes” or in the absence of this (or if this would endanger the patient or another person) the patient’s “best interests”.

DRAFT

(iii) Review of Community Treatment Orders (CTO)

Community Treatment orders are a new aspect of the legislation and it is uncertain how often they will be used. In the period from July 3, 2007-March 31, 2008 there have been ? CTOs filed with the Review Board

The patient or the substitute decision maker may apply under s. 58(1) for review of whether or not the criteria for granting or renewing a CTO have been met. Automatic review also occurs on 1st and 2nd renewals.

Criteria for CTOs (s.47)

Psychiatrist must have examined in last 72 hours and is of the view that

(i) the person has a mental disorder for which the person is in need of treatment or care and supervision in the community (and it can be provided),

(ii) the person as a result of the mental disorder,

a) is threatening or attempting to cause serious harm to self or has recently done so, is seriously harming or is threatening serious harm towards another or has recently done so, or

b) is likely to suffer serious physical impairment or serious mental deterioration, or both,

(iii) as a result of the mental disorder, the person does not have full capacity to make treatment decisions,

With respect to capacity, the Board must consider whether patient fully appreciates:

(a) the nature of the condition for which treatment is proposed;
(b) the nature and purpose of the specific treatment;
(c) the risks and benefits involved in undergoing specific treatment; and
(d) the risks and benefits in not undergoing the specific treatment.

Also, whether the patient's mental disorder affects ability to fully appreciate the consequences of making the treatment decision. (s.18).]

(iv) during the immediately preceding 2 year period, the person

a) has been detained in a psychiatric facility for a total of 60 days or longer,

b) has been detained in a psychiatric facility on two or more separate occasions, or

c) has previously been the subject of a community treatment order, and

(v) the services that the person requires in order to reside in the community

a) exist in the community,

b) are available to the person, and

c) will be provided to the person.

At the conclusion of this type of review, the Review Board may either revoke the CTO and allow the person to live in the community without being subject to the CTO or it may refuse to do so.

(iv) Review of Leave Certificate

Leave Certificates are also a new concept and may be used more often than CTOs since they are time limited (six months) and non-renewable.

Under s. 68 of the Act there is only reference to the Board's authority to review a cancellation of a Leave Certificate. Under s. 76(2)(e), however, it states that "where the application is to review a certificate of leave…" Thus, it is clear that the Review Board may be asked to review a certificate of leave. After a hearing, the Review Board may revoke the certificate of leave and allow the patient to live in the community without being subject to the certificate, or may refuse to do so.

Additionally, if a psychiatrist has canceled a leave certificate the Board may be asked to review. Board needs to see the specifics to determine a breach of written conditions. Psychiatrist may also have cancelled it if:

(a) patient's condition presents danger to patient or others; or
(b) patient failed to report as required. (s.44(1)).

The outcome of a hearing to review a cancellation of a leave certificate is that the Review Board may confirm the cancellation or it may refuse to do so.

DRAFT

(v) Review of competency to administer estate under Hospitals Act

The *Involuntary Psychiatric Treatment Act* replaces and repeals most portions of the *Hospitals Act* relevant to the Review Board. The Board does, however, retain its review powers under s.58 (1) which authorizes the Board to review a declaration of competency for involuntary patients who have been found incompetent to manage their own estate.

It appears that the Review Board has never been asked to conduct this type of review under the *Hospitals Act*.

Part II Statistics and Trends

a) Introduction

During the period of operation from July 3, 2007- March 31, 2008 the Board received 60 requests for review of involuntary status under the Involuntary Psychiatric Treatment Act. This includes ten "automatic" requests under s.37 of the Act. The total number of reviews held in the period July 3, 2007- March 31, 2008, including both requested and automatic reviews, was 21 representing a follow-through percentage of 30.9 percent.

b) Automatic Reviews

Under the Section 37 of the Act, the Board is required to review the file of each person detained under a Declaration of Involuntary Admission 60 days after the initial declaration and at the end of the 6th, 12th, 18th and 24 month stage and every twenty-four months thereafter. This must be done regardless of whether the patient wants the review or not. In fact, the patient is "deemed" to have made a request for review.
In the period of July 3, 2007 - March 2008, ten (10) automatic reviews were triggered. Of those ten reviews, four patients retained their involuntary status, two hearings were postponed and four patients were made voluntary prior to the hearing.

c) Requested Reviews

Requested reviews are initiated primarily by requests from patients although on occasion requests come from hospitals as well or the Review Board or substitute decision maker may initiate a hearing. The number of patient requests between July 3, 2007 and March 31, 2008 this was 45. It is anticipated that this number

will rise as patients become more familiar with their rights through the patient rights advisors.
Of the 45 requests for review, 15 were made voluntary by their attending psychiatrist prior to the hearing being held and 13 withdrew their requests. Thus the Board conducted 17 hearings for patients who requested reviews. Of these 17 reviews, the status of 14 patients was upheld (i.e. they remained as involuntary patients) and two (2) had their status changed to voluntary patients. Of the remaining hearings, one (1) resulted in adjournments.

d) Community Treatment Orders and Leave Certificates

Psychiatric Facilities are required to file community treatment orders and leave certificates with the Review Board. During the period July 3, 2007- March 31, 2008 ??? community treatment orders and ???leave certificates were filed with the Review Board.

Part III Comments

With only nine months to assess the impact of the new legislation the Review Board is limiting its comments to three main areas of concern: appointments to the Review Board; the need for further training and education; and community supports.

(i) Appointments to the Board

It had been hoped that with the implementation of the new legislation that the problem of appointments to the Board would have been addressed by now. Unfortunately this has not been the case. The last several reports have asked that additional psychiatrists be appointed to the Board to facilitate more timely hearings. The limited availability of psychiatrists is increasing the time it takes to set down a hearing and is stretching the present psychiatrist members of the Board to beyond reasonable expectations. It is expected that if this matter is not addressed soon that there will be some patients in the province who have to wait beyond 21 days to have a hearing scheduled.

(ii) Need for Further Training and Education

The training and education needed to facilitate a smooth transition from the *Hospitals Act* to the *Involuntary Psychiatric Treatment Act* was not sufficient to meet those needs. The Review Board has heard complaints from nurses, psychiatrists, patient rights advisors and legal aid lawyers about the amount of misinformation about the new legislation. It is clear that on-going education is

needed to make all people who are dealing with the new legislation more aware of the changes and the implications for the individuals affected.

(iii) Community Supports

The requirement for increased community supports such as appropriate housing, and outreach continues to be an urgent issue. Some areas of the province do not have the community mental health programs and staffing to fully utilize the tools available in the new legislation. The Review Board has been told that psychiatrists in some facilities are not authorized to use community treatment orders or leave certificates because there is not enough support in the community to ensure compliance. This is not an acceptable situation. If the Legislature has deemed it appropriate to include these options they should be available to involuntary patients throughout the province who satisfy the legislative criteria. The Review Board recommends that this be examined more fully and that funding be provided to allow treatment in the communities in which people live.

Conclusion

Annual Report

Review Board under the *Involuntary Psychiatric Treatment Act*
April 1, 2008- March 31, 2009

Introduction

The *Involuntary Psychiatric Treatment Act*, (S.N.S. 2005, c.42) (IPTA) was proclaimed into force on July 3, 2007. It replaced the *Hospitals Act* and established the Review Board under s. 65 of *IPTA*. The Review Board hears and considers applications under the *IPTA* for various types of review. A panel of three Review Board members (a lawyer member, a psychiatrist member and a lay member) hears the application and provides written decisions. At the commencement of this fiscal year (April 1, 2009) the Review Board was non-operational due to the fact that members had not been re-appointed. This was rectified on April 14, 2009 and the Review Board is now comprised of eight lawyers, six psychiatrists and five lay members.

This Annual Report is presented in three parts. Part I provides a detailed look at the types of reviews which the Review Board may be asked to perform. Part II presents the statistics and trends of the Board's operation during the period from April 1, 2008 – March 31, 2009. In Part III issues of present concern to the Review Board are discussed.

Part I Types of Review

(i) Review of Status

The main responsibility of the Review Board is to review the decision of the treating psychiatrist that a person in a psychiatric facility should be held as an involuntary patient. A person may be held under involuntary status if they meet the criteria under s.17 of the *Act*.

The criteria for involuntary status (s. 17) are:

(a) has a mental disorder
(b) is in need of psychiatric treatment in the facility
(c) as a result of mental disorder
    (i) is threatening or attempting to cause serious harm to self or has recently done so, has recently caused serious harm to self, is seriously harming or is threatening serious harm towards another or has recently done so, or
    (ii) is likely to suffer serious physical impairment or serious mental deterioration, or both;
(d) is not suitable for inpatient admission as a voluntary patient; and
(e) as a result of the mental disorder, does not have capacity to make admission and treatment decisions.

With respect to criteria 17(e) – capacity, the test is whether the patient fully appreciates:

(a) the nature of the condition for which treatment is proposed;
(b) the nature and purpose of the specific treatment;
(c) the risks and benefits involved in undergoing specific treatment; and
(d) the risks and benefits in not undergoing the specific treatment.

Also, whether the patient's mental disorder affects his or her ability to fully appreciate the consequences of making the treatment decision.

A review of this type is most often triggered by a request from the patient but a review may also be requested by the substitute decision maker, the hospital or the Review Board itself.

Additionally, under the Section 37 of the *Act*, the Review Board is required to review the file of each person detained under a Declaration of Involuntary Admission 60 days after the initial declaration and at the end of the 6th, 12th, 18th and 24 month stage and every twelve months thereafter. This must be done regardless of whether the patient wants the review or not. In fact, the patient is deemed to have made a request for review. These are often referred to as "automatic" reviews.

In the period April 1, 2008 to March 31, 2009 the Review Board received one hundred and fifteen (115) requests for review of status. The details of these requests are discussed below in Part II.

(ii) *Has the substitute decision maker rendered a capable informed consent?*

Under s. 42(1), the Review Board can review the decision of a substitute decision maker (SDM) if asked by a psychiatrist or a patient to do so.

The test for whether or not the SDM made a capable, informed consent or refusal is that the decision must be made in accordance with the patient's "prior capable informed expressed wishes" or in the absence of this (or if this would endanger the patient or another person) that the decision be in the patient's "best interests".

In the period April 1, 2008 – March 31, 2009 the Review Board received one (1) application for a review of a SDM decision. In that case, the patient was made voluntary and the hearing was not scheduled.

(iii) Review of Community Treatment Orders (CTO)

In the period from April 1, 2008 to March 31, 2009 there were ten (10) Community Treatment Orders (CTOs) filed with the Review Board.

A patient or the SDM may apply under s. 58(1) for a review of whether or not the criteria for granting or renewing a CTO have been met. Automatic reviews also occur on the 1st renewal and every 2nd renewal thereafter.

Criteria for CTOs (s.47)

A Psychiatrist must have examined the patient in the last 72 hours and be of the view that:

(i) the person has a mental disorder for which the person is in need of treatment or care and supervision in the community (and it can be provided),

(ii) the person as a result of the mental disorder,

(A) is threatening or attempting to cause serious harm to self or has recently done so, is seriously harming or is threatening serious harm towards another or has recently done so, or

(B) is likely to suffer serious physical impairment or serious mental deterioration, or both,

(iii) as a result of the mental disorder, the person does not have full capacity to make treatment decisions.

With respect to capacity, the Review Board must consider whether patient fully appreciates: the nature of the condition for which treatment is proposed; the nature and purpose of the specific treatment; the risks and benefits involved in undergoing specific treatment; and the risks and benefits in not undergoing the specific treatment. Also, whether the patient's mental disorder affects ability to fully appreciate the consequences of making the treatment decision. (s.18).]

(iv) during the immediately preceding 2 year period, the person

(A) has been detained in a psychiatric facility for a total of 60 days or longer,

(B) has been detained in a psychiatric facility on two or more separate occasions, or

(C) has previously been the subject of a community treatment order, and

(V) the services that the person requires in order to reside in the community

(A) exist in the community,

(B) are available to the person, and

(C) will be provided to the person.

At the conclusion of this type of review, the Review Board may either revoke the CTO and allow the person to live in the community without being subject to the CTO or it may refuse to do so.

In the period April 1, 2008 – March 31, 2009 the Review Board received two (2) requests for a review of a CTO renewal. In both instances the requests were "automatic" and the decision in both cases was to uphold the terms of the CTO.

(iv) Review of Leave Certificate

Leave Certificates are similar to CTOs but are time limited (six months only) and they are non-renewable. They also do not require any prior involuntary hospitalizations. During the period April 1, 2008 - March 31, 2009 four (4) Leave Certificates were filed with the Review Board.

The Review Board may be asked to review the status of a patient who is on a Certificate of Leave. Since a person on a Certificate of Leave is still an

involuntary patient, the automatic review provisions of the *Act* still apply. A stated above, if a patient has been involuntary for sixty (60) days they are deemed to have requested a review. This is true even of they have left the hospital under a Certificate of Leave. After a hearing, the Review Board may revoke the Certificate of Leave and allow the patient to live in the community without being subject to the Certificate, or may refuse to do so.

Additionally, if a psychiatrist has canceled a Certificate of Leave, the Review Board may be asked to review it. A psychiatrist may cancel the Certificate of Leave if:

> (a) the patient's condition presents a danger to the patient or others; or
> (b) the patient failed to report as required. (s.44(1)).

The outcome of a hearing to review a cancellation of a Certificate of Leave is that the Review Board may confirm the cancellation or it may refuse to do so.

To date the Review Board has not been asked to review the cancellation of a Certificate of Leave.

(v) Review of competency to administer estate under Hospitals Act

The *Involuntary Psychiatric Treatment Act* replaces and repeals most portions of the *Hospitals Act* relevant to the Review Board. The Board does, however, retain its review powers under s.58 (1) which authorizes the Review Board to review a declaration of competency for involuntary patients who have been found incompetent to manage their own estate.

It appears that the Review Board has never been asked to conduct this type of review under the *Hospitals Act*.

Part II Statistics and Trends

a) Introduction

During the period of operation from April 1, 2008 to March 31, 2009 the Review Board received one hundred and fifteen (115) requests for review under the *Act*. This includes twenty-five (25) "automatic" requests under s.37 of the *Act*. Under the Section 37 of the *Act*, the Review Board is required to review the file of each person detained under a Declaration of Involuntary Admission 60 days after the initial declaration and at the end of the 6th, 12th, 18th and 24 month stage and every twenty-four months thereafter. This must be done regardless of whether the patient wants the review or not. In fact, the patient is "deemed" to have made a request for review. Past Annual Reports have treated requested reviews and automatic reviews separately. This has lead to confusion and given that an automatic review is deemed to be a request, for the purposes of this Report all requests will be analyzed together.

The total number of hearings held between April 1, 2008 and March 31, 2009 was thirty-eight (38) representing a follow-through percentage of thirty-three (33) percent.

b) Outcomes of Requests

One hundred and fifteen requests (115) for review were made from April 1, 2008 to March 31, 2009. Fifty-five (55) patients had their status changed to voluntary before the hearing. Thirteen (13) patients cancelled their request and three (3) hearings were postponed. One patient was transferred to another hospital prior to the hearing and five (5) requests for a review were denied.

Of the thirty-eight (38) hearings which were held between April 1, 2008 and March 31, 2009, thirty-four (34) patients had their status as involuntary patients upheld by the Review Board. One (1) patient had his status changed to voluntary and three (3) hearings were adjourned.

The follow through rate for requests has remained stable this year. Roughly one third of the requests result in a hearing. This is not the same as saying that one third of patients have a hearing. The Review Board tracks the information by requests not patient. The same patient may ask for a request for a review a number of times. The Review Board, however, has discretion under the *Act* to not hold a hearing if one has already been held in the previous three (3) months. This is why the statistics show five (5) denied requests.

c) Community Treatment Orders and Leave Certificates

Psychiatric facilities are required to file Community Treatment Orders and leave certificates with the Review Board. During the period April 1, 2008- March 31,

2009 ten (10) community treatment orders and four (4) leave certificates were filed with the Review Board. In terms of district, five (5) of the CTOs were from Capital District Health, three (3) were from Cape Breton and two (2) were from the South Shore. For the Certificates of Leave, two (2) were from Yarmouth, one (1) was from Valley Regional and one (1) was from Capital District Health.

d) Legal Representation

As discussed above one hundred and fifteen requests (115) for review were made from April 1, 2008 to March 31, 2009. Legal representation occurred in fifty-two (52) of the requests. This accounts for forty-five (45) percent of the cases. When it comes to the hearings themselves, the percentage of patients with legal representation increases slightly. Thirty–eight (38) hearings were held and patients were represented in nineteen (19) of the cases. This means that fifty (50) percent of patients who appear before the Review Board have legal representation.

e) Length of Time to Schedule a Hearing

The Review Board is required to hold a hearing within twenty-one (21) days of receiving a request pursuant to s. 68 of IPTA. For this fiscal year the average wait time between a request and a hearing was 20.76 days. This is higher than previous years for two reasons. First of all, more patients are requesting legal representation. The patient rights advisors complete the forms for legal aid and forward them to the appropriate offices. Lawyers then are assigned to the patient and arrangements have to be made to visit the patient and review the charts. The Review Board will automatically re-schedule a hearing if it is at the request of the patient's lawyer. Secondly, there were a few hearings which took an exceptionally long time to schedule this year due to legal representation and these raise the average significantly.

Part III Comments

The Review Board has now completed its first full fiscal year under the new legislation. In last year's Annual Report three areas of concern were raised which related to appointments, training and community supports. These items continue to be of interest and are worth repeating. Additionally, the Review Board has three other areas of concern: obligations of the district health authorities to provide timely information to involuntary patients; clarification around conflict of interest for panel members; and the appropriate response for patients who choose not to attend hearings.

Appointments to the Board

It had been hoped that with the implementation of the new legislation that the problem of timely appointments to the Board would have been addressed. Unfortunately, until recently this has not been the case. As mentioned earlier, the Review Board was unable to conduct any hearings from the latter part of March 2009 until mid-April 2009 because it only had one Board member. Fortunately, this did not affect any patients who were waiting for a hearing but the potential existed for this to cause unreasonable delay. It is hoped that more attention will be given to the issue of appointments in the future.

Continuing Need for Further Training and Education

The need continues for ongoing education and training about the new legislation. This is particularly so for new psychiatrists who are unfamiliar with the tests for involuntary status or the appropriate use of Community Treatment Orders and Certificates of Leave. It is clear that on-going education and training is needed to make people aware of the changes and the implications the new legislation has for the individuals whose rights are affected by it.

Increased Community Supports

It bears repeating that the requirement for increased community supports such as appropriate housing and outreach continues to be an urgent issue in light of the new tools for treatment in the community in the new legislation. If the Legislature has deemed it appropriate to include community treatment options they should be available to involuntary patients throughout the province who satisfy the legislative criteria. The Review Board recommends that this be examined more fully and that funding be provided to allow treatment in the communities in which people live. Furthermore, more co-ordination and co-operation is needed between the departments of Health and Community Services in order to better address the housing needs of involuntary patients seeking placement in the community.

Timely Information to Involuntary Patients

This may appropriately be linked to the education/training issue but the Review Board is of the view that there is a great deal of disparity among the district health authorities in terms of the information which is being provided to involuntary patients. Section 26 of IPTA requires that the hospital tell involuntary patients and their substitute decision makers (in writing) that, among other things, they have the right to apply to the Review Board for a review of the patient's status and the right to retain and instruct counsel without delay.

Some district health authorities are not making patients aware of these rights and the Department of Health needs to ensure compliance with the *Act.*

Clarification around Conflict of Interest

The *Act* says that efforts should be made to ensure that one of the psychiatrists appointed to the Review Board has a specialization in adolescent psychiatry. Section 67(1), however, states that a Review Board member is not eligible to sit on a panel if he or she is an "officer, employee or staff member of the psychiatric facility" where the patient is being treated. The difficulty this creates is that most (if not all) adolescent psychiatrists in Nova Scotia will be employees of the IWK. They will not, however, necessarily work on the in-patient unit in the IWK. If the desire is to have an adolescent psychiatrist on the panels at the IWK, the legislation should be amended to allow an adolescent psychiatrist who is not working on the same unit (and who has not treated the patient) hear such reviews.

Patients Who Choose Not to Attend Hearings

Under section section 71(2) of *IPTA* where the patient is unable or unwilling to attend a hearing and has not appointed someone to act on the patient's behalf, the Review Board shall appoint a representative to attend the hearing and act on behalf of the patient. The question which has arisen for the Review Board is who should be appointed? The substitute decision maker is a party to the hearing and is often not necessarily the person to best represent the patient. Lawyers will only represent clients if they are able to receive instructions and will not represent a patient if the patient does not wish to participate. This leaves the patient rights advisors who do not, at present, have the mandate to perform such duties.

The Review Board is of the view that in the absence of advocates who can represent involuntary patients that the patient rights advisors be alerted to this responsibility and trained to represent these patients.

Conclusion

With the first full year of operation under the *Involuntary Psychiatric Treatment Act* the Review Board has been busy attempting to set matters down for review as expeditiously as possible and ensure that involuntary patients receive hearings and decisions in a timely manner. The number of requests for review has risen significantly over previous years and it is anticipated that this will continue as patients and families become more aware of the provisions of the *Act.*

Approximately fifty (50) percent of involuntary patients were represented by legal counsel at their hearings this year and it is expected that this will also increase over the next year. It is hoped that this will not slow down the process of scheduling but rather will ensure that involuntary patients receive the assistance and advocacy they need to better represent their views before the Review Board.

Annual Report

Review Board under the *Involuntary Psychiatric Treatment Act*
April 1, 2009- March 31, 2010

Introduction

The *Involuntary Psychiatric Treatment Act*, (S.N.S. 2005, c.42) (IPTA) was proclaimed into force on July 3, 2007. It replaced the *Hospitals Act* and established the Review Board under s. 65 of *IPTA*. The Review Board hears and considers applications under the *IPTA* for various types of review. A panel of three Review Board members (a lawyer member, a psychiatrist member and a lay member) hears the application and provides written decisions. The Review Board is presently comprised of eight lawyers, six psychiatrists and nine lay members.

This Annual Report is presented in three parts. Part I provides a detailed look at the types of reviews which the Review Board may be asked to perform. Part II presents the statistics and trends of the Board's operation during the period from April 1, 2009 – March 31, 2010. In Part III issues of present concern to the Review Board are discussed.

Part I Types of Review

(i) Review of Status

The main responsibility of the Review Board is to review the decision of the treating psychiatrist that a person in a psychiatric facility should be held as an involuntary patient. A person may be held under involuntary status if they meet the criteria under s.17 of the *Act*.

The criteria for involuntary status (s. 17) are:

(a) has a mental disorder
(b) is in need of psychiatric treatment in the facility
(c) as a result of mental disorder
    (i) is threatening or attempting to cause serious harm to self or has recently done so, has recently caused serious harm to self, is seriously harming or is threatening serious harm towards another or has recently done so, or
    (ii) is likely to suffer serious physical impairment or serious mental deterioration, or both;
(d) is not suitable for inpatient admission as a voluntary patient; and
(e) as a result of the mental disorder, does not have capacity to make admission and treatment decisions.

With respect to criteria 17(e) – capacity, the test is whether the patient fully appreciates:

(a) the nature of the condition for which treatment is proposed;
(b) the nature and purpose of the specific treatment;
(c) the risks and benefits involved in undergoing specific treatment; and
(d) the risks and benefits in not undergoing the specific treatment.

Also, whether the patient's mental disorder affects his or her ability to fully appreciate the consequences of making the treatment decision.

A review of this type is most often triggered by a request from the patient but a review may also be requested by the substitute decision maker, the hospital or the Review Board itself.

Additionally, under the Section 37 of the *Act*, the Review Board is required to review the file of each person detained under a Declaration of Involuntary Admission 60 days after the initial declaration and at the end of the 6th, 12th, 18th and 24 month stage and every twelve months thereafter. This must be done regardless of whether the patient wants the review or not. In fact, the patient is deemed to have made a request for review. These are often referred to as "automatic" reviews.

In the period April 1, 2009 to March 31, 2010 the Review Board received one hundred and twenty-one (121) requests for review. The details of these requests are discussed below in Part II.

(ii) *Has the substitute decision maker rendered a capable informed consent?*

Under s. 42(1), the Review Board can review the decision of a substitute decision maker (SDM) if asked by a psychiatrist or a patient to do so.

The test for whether or not the SDM made a capable, informed consent or refusal is that the decision must be made in accordance with the patient's "prior capable informed expressed wishes" or in the absence of this (or if this would endanger the patient or another person) that the decision be in the patient's "best interests".

In the period April 1, 2009 – March 31, 2010 the Review Board received one (1) application for a review of a SDM decision. In that case, the hearing was adjourned and the patient was later made voluntary and thus the hearing was not re-scheduled.

(iii) Review of Community Treatment Orders (CTO)

In the period from April 1, 2009 to March 31, 2010 there were twenty-four (24) Community Treatment Orders (CTOs) filed with the Review Board.

A patient or the SDM may apply under s. 58(1) for a review of whether or not the criteria for granting or renewing a CTO have been met. Automatic reviews also occur on the 1st renewal and every 2nd renewal thereafter.

Criteria for CTOs (s.47)

A Psychiatrist must have examined the patient in the last 72 hours and be of the view that:

(i) the person has a mental disorder for which the person is in need of treatment or care and supervision in the community (and it can be provided),

(ii) the person as a result of the mental disorder,

(A) is threatening or attempting to cause serious harm to self or has recently done so, is seriously harming or is threatening serious harm towards another or has recently done so, or

(B) is likely to suffer serious physical impairment or serious mental deterioration, or both,

(iii) as a result of the mental disorder, the person does not have full capacity to make treatment decisions.

With respect to capacity, the Review Board must consider whether patient fully appreciates: the nature of the condition for which treatment is proposed; the nature and purpose of the specific treatment; the risks and benefits involved in undergoing specific treatment; and the risks and benefits in not undergoing the specific treatment. Also, whether the patient's mental disorder affects ability to fully appreciate the consequences of making the treatment decision. (s.18).]

(iv) during the immediately preceding 2 year period, the person

(A) has been detained in a psychiatric facility for a total of 60 days or longer,

(B) has been detained in a psychiatric facility on two or more separate occasions, or

(C) has previously been the subject of a community treatment order, and

(V) the services that the person requires in order to reside in the community

(A) exist in the community,

(B) are available to the person, and

(C) will be provided to the person.

At the conclusion of this type of review, the Review Board may either revoke the CTO and allow the person to live in the community without being subject to the CTO or it may refuse to do so.

In the period April 1, 2009 – March 31, 2010 the Review Board received four (4) requests for a review of a CTO renewal. In all instances the requests were "automatic" and the decision in all cases was that the CTO would not be revoked.

(iv) Review of Leave Certificate

Leave Certificates are similar to CTOs but are time limited (six months only) and they are non-renewable. They also do not require any prior involuntary hospitalizations. During the period April 1, 2009 - March 31, 2010 five (5) Leave Certificates were filed with the Review Board.

The Review Board may be asked to review the status of a patient who is on a Certificate of Leave. Since a person on a Certificate of Leave is still an involuntary patient, the automatic review provisions of the *Act* still apply. A stated

above, if a patient has been involuntary for sixty (60) days they are deemed to have requested a review. This is true even of they have left the hospital under a Certificate of Leave. After a hearing, the Review Board may revoke the Certificate of Leave and allow the patient to live in the community without being subject to the Certificate, or may refuse to do so.

Additionally, if a psychiatrist has canceled a Certificate of Leave, the Review Board may be asked to review it. A psychiatrist may cancel the Certificate of Leave if:

(a) the patient's condition presents a danger to the patient or others; or
(b) the patient failed to report as required. (s.44(1)).

The outcome of a hearing to review a cancellation of a Certificate of Leave is that the Review Board may confirm the cancellation or it may refuse to do so.

To date the Review Board has not been asked to review the cancellation of a Certificate of Leave.

(v) Review of competency to administer estate under Hospitals Act

The *Involuntary Psychiatric Treatment Act* replaces and repeals most portions of the *Hospitals Act* relevant to the Review Board. The Board does, however, retain its review powers under s.58 (1) which authorizes the Review Board to review a declaration of competency for involuntary patients who have been found incompetent to manage their own estate.

The Review Board has never been asked to conduct this type of review under the *Hospitals Act*.

Part II Statistics and Trends

a) Introduction

During the period of operation from April 1, 2009 to March 31, 2010 the Review Board received one hundred and twenty-one (121) requests for review under the *Act*. This includes twenty-seven (27) "automatic" requests under s.37 of the *Act*. Under the Section 37 of the *Act*, the Review Board is required to review the file of each person detained under a Declaration of Involuntary Admission 60 days after the initial declaration and at the end of the 6th, 12th, 18th and 24 month stage and every twenty-four months thereafter. This must be done regardless of whether the patient wants the review or not. In fact, the patient is "deemed" to have made a request for review. Past Annual Reports have treated requested reviews and automatic reviews separately. This has lead to confusion and given that an automatic review is deemed to be a request, for the purposes of this Report all requests will be analyzed together.

The total number of hearings held between April 1, 2009 and March 31, 2010 was fifty-five (55) representing a follow-through percentage of forty-five (45) percent. This is higher than last year's follow-through rate which was thirty-three (33) percent.

b) Outcomes of Requests

One hundred and twenty-one requests (121) for review were made from April 1, 2009 to March 31, 2010. Fifty-three (53) patients had their status changed to voluntary before the hearing. Nine (9) patients cancelled their request, two (2) patients were placed on a community treatment order, one (1) patient was released on a certificate of leave, and one (1) request for review was denied.

Of the fifty-five (55) hearings which were held between April 1, 2009 and March 31, 2010, thirty-three (33) patients had their status as involuntary patients upheld by the Review Board. Eleven (11) patients had their status changed to voluntary and seven (7) hearings were adjourned. Four of the hearings pertained to reviews of community treatment orders.

c) Community Treatment Orders and Leave Certificates

Psychiatric facilities are required to file Community Treatment Orders and Leave Certificates with the Review Board. During the period April 1, 2009- March 31, 2010, twenty- four (24) community treatment orders and five (5) leave certificates were filed with the Review Board. In terms of district, ten (10) of the CTOs were from Capital District Health, seven (7) were from Cape Breton, three (3) were from the South Shore Regional Hospital and four (4) were from Yarmouth Regional Hospital. For the Certificates of Leave, one (1) was from Yarmouth, one

(1) was from the IWK, one (1) was from Capital District Health and two (2) were from South Shore Regional Hospital.

d) Legal Representation

As discussed above one hundred and twenty-one requests (121) for review were made from April 1, 2009 to March 31, 2010. Legal representation occurred in fifty-eight (58) of the requests. This accounts for forty-eight (48) percent of the cases. When it comes to the hearings themselves, the percentage of patients with legal representation increases. Fifty-five (55) hearings were held and patients were represented in thirty-three (33) of the cases. This means that sixty (60) percent of patients who appear before the Review Board have legal representation. This is an increase of 10% over the number of people appearing before the Board with legal representation last year.

e) Length of Time to Schedule a Hearing

The Review Board is required to hold a hearing within twenty-one (21) days of receiving a request pursuant to s. 68 of IPTA. For this fiscal year the average wait time between a request and a hearing was twenty-two (22) days. There were some exceptionally long delays this year in setting down a number of automatic hearings. The Review Board receives notification from hospitals that patients are an involuntary patients and in need of a hearings. In one case, it was more than four months before the Review Board knew that a patient was an involuntary patient. This is not an acceptable situation and steps are being taken to ensure that adequate information is presented to the Review Board in a timely manner.

Part III Comments

The Review Board has now completed its second year under IPTA. In previous Annual Report areas of concern to the Board included: training; community supports; obligations of the district health authorities to provide timely information to involuntary patients; conflict of interest for panel members; and the appropriate response for patients who choose not to attend hearings. These are re-iterated below as are additional issue which have arisen during the past year.

Continuing Need for Further Training and Education

The need continues for ongoing education and training about the Act. This is particularly so for new psychiatrists who are unfamiliar with the tests for involuntary status or the appropriate use of Community Treatment Orders and Certificates of Leave. It is clear that on-going education and training is needed to make people aware of the changes and the implications the new legislation has for the individuals whose rights are affected by it.

Increased Community Supports

It bears repeating that the requirement for increased community supports such as appropriate housing and outreach continues to be an urgent issue in light of the new tools for treatment in the community in the new legislation. If the Legislature has deemed it appropriate to include community treatment options they should be available to involuntary patients throughout the province who satisfy the legislative criteria. The Review Board recommends that this be examined more fully and that funding be provided to allow treatment in the communities in which people live. Furthermore, more co-ordination and co-operation is needed between the departments of Health and Community Services in order to better address the housing needs of involuntary patients seeking placement in the community.

The Review Board is aware of situations where involuntary patients are being housed in psychiatric facilities because supportive housing is unavailable to them. Often, to the dismay of family members, the patients have their status changed to voluntary during the wait for placement and consequently no longer meet the criteria for community treatment orders.

Timely Information to Involuntary Patients

There is a great deal of disparity among the district health authorities in terms of the information which is being provided to involuntary patients. Section 26 of IPTA requires that the hospital tell involuntary patients and their substitute decision makers (in writing) that, among other things, they have the right to apply to the Review Board for a review of the patient's status and the right to retain and

instruct counsel without delay. This information is to be provided whenever there is a change in a patient's status. Similarly, the facility is obliged to notify the Patient's Rights Service of changes in status so that a patient rights advisor can visit the patient and advise them of their rights under the Act. When this does not happen, people are unaware of their rights and the strict legislative timelines for automatic hearings are jeopardized and unnecessary adjournments are required. This is discussed further below.

Some district health authorities are not making patients aware of these rights and the Department of Health needs to ensure compliance with the *Act.*

Clarification around Conflict of Interest

This issue was canvassed in last year's Annual Report but, to date, has not been addressed. The *Act* says that efforts should be made to ensure that one of the psychiatrists appointed to the Review Board has a specialization in adolescent psychiatry. Section 67(1), however, states that a Review Board member is not eligible to sit on a panel if he or she is an "officer, employee or staff member of the psychiatric facility" where the patient is being treated. The difficulty this creates is that most (if not all) adolescent psychiatrists in Nova Scotia will be employees of the IWK. They will not, however, necessarily work on the in-patient unit in the IWK. If the desire is to have an adolescent psychiatrist on the panels at the IWK, the legislation should be amended to allow an adolescent psychiatrist who is not working on the same unit (and who has not treated the patient) hear such reviews.

Patients Who Choose Not to Attend Hearings

Again, this issue bears repeating from last year's Annual Report. Under section 71(2) of *IPTA* where the patient is unable or unwilling to attend a hearing and has not appointed someone to act on the patient's behalf, the Review Board shall appoint a representative to attend the hearing and act on behalf of the patient. The question which has arisen for the Review Board is who should be appointed? The substitute decision maker is a party to the hearing and is often not necessarily the person to best represent the patient. Lawyers will only represent clients if they are able to receive instructions and will not represent a patient if the patient does not wish to participate. This leaves the patient rights advisors who do not, at present, have the mandate to perform such duties.

The Review Board is of the view that in the absence of advocates who can represent involuntary patients that the patient rights advisors be alerted to this responsibility and trained to represent these patients.

Timeliness of Hospital Reports

Treating psychiatrists provide Hospital Reports to the Review Board and legal counsel prior to the commencement of a Review Board hearing. It has become increasingly common for these reports to be available only a day or two before a hearing and, in some cases, on the day of a hearing. The Review Board is of the view that If individuals are being deprived of their liberty they are entitled to timely disclosure of the details of their detention.

"Voluntary but Incapable" Patients

The Review Board has serious concerns about the rights of voluntary patient who have been deemed incapable of consenting to treatment. Assessments of the capability of a voluntary patient to consent to treatment or the appointment of a substitute decision-maker are carried out pursuant to the relevant provisions of the Hospitals Ac but the Hospitals Act lacks the same procedural safeguards for rights advice which is contained in the Involuntary Psychiatric Treatment Act.

The Review Board is aware of situations where patients who were scheduled for Review Board hearings as involuntary patients have had their status changed to voluntary but incapable immediately prior to the hearing date. The patient's only recourse for review in this situation would be an application pursuant to s. 58(2) of the Hospitals Act:

> (2) A declaration of capacity for a patient in a hospital or a psychiatric facility or a declaration of competency for a patient in a hospital or a voluntary patient may be reviewed by the Supreme Court of Nova Scotia (Family Division) or by the Family Court where there is no Supreme Court (Family Division).

The Review Board believes that it is the most appropriate body to be responsible for this type of review. Review Board hearings can be set down more quickly than a Court application and the Board has the expertise and experience to review capacity issues. The Review Board is always comprised of three members, one of whom is a psychiatrist and these types of reviews were routinely conducted by the Board under the Hospitals Act prior to the passage of the Involuntary Psychiatric Treatment Act. Furthermore, the Review Board has jurisdiction to review declarations of competency for involuntary patients pursuant to subsection 58(1) of the *Hospitals Act* and it should also be able to review declarations of incapacity pursuant to s. 58(2).

Conclusion

With the second full year of operation under the *Involuntary Psychiatric Treatment Act* the Review Board has been busy attempting to set matters down for review as expeditiously as possible and ensure that involuntary patients receive hearings and decisions in a timely manner. This has occasionally been challenging due to issues around the timely release of information about patients' status from hospitals. The number of requests for review has risen significantly again this year and this may continue as patients and families become more aware of the provisions of the *Act.*

Approximately sixty (60) percent of involuntary patients were represented by legal counsel at their hearings this year and it is expected that this will also increase over the next year. It is hoped that this will not slow down the process of scheduling but rather will ensure that involuntary patients receive the assistance and advocacy they need to better represent their views before the Review Board.

Annual Report

Review Board under the *Involuntary Psychiatric Treatment Act*
April 1, 2010- March 31, 2011

Introduction

The *Involuntary Psychiatric Treatment Act*, (S.N.S. 2005, c.42) (IPTA) was proclaimed into force on July 3, 2007. It replaced the *Hospitals Act* and established the Review Board under s. 65 of *IPTA*. The Review Board hears and considers applications under *IPTA* for various types of review. A panel of three Review Board members (a lawyer member, a psychiatrist member and a lay member) hears the application and provides written decisions. The Review Board is presently comprised of ten lawyers, seven psychiatrists and eight lay members.

This Annual Report is presented in three parts. Part I provides a detailed look at the types of reviews which the Review Board may be asked to perform. Part II presents the statistics and trends of the Board's operation during the period from April 1, 2010 – March 31, 2011. In Part III, issues of ongoing concern to the Review Board are discussed.

Part I Types of Review

(i) Review of Status

The most common type of review is a review of a patient's status as an involuntary patient. The Review Board reviews the decision of the treating psychiatrist that the person in the psychiatric facility should be held as an involuntary patient. A person may be held under involuntary status if they meet the criteria under s.17 of the *Act*.

The criteria for involuntary status are:

(a) has a mental disorder
(b) is in need of psychiatric treatment in the facility
(c) as a result of mental disorder
    (i) is threatening or attempting to cause serious harm to self or has recently done so, has recently caused serious harm to self, is seriously harming or is threatening serious harm towards another or has recently done so, or
    (ii) is likely to suffer serious physical impairment or serious mental deterioration, or both;
(d) is not suitable for inpatient admission as a voluntary patient; and
(e) as a result of the mental disorder, does not have capacity to make admission and treatment decisions.

With respect to capacity, the test is whether the patient fully appreciates:

(a) the nature of the condition for which treatment is proposed;
(b) the nature and purpose of the specific treatment;
(c) the risks and benefits involved in undergoing specific treatment; and
(d) the risks and benefits in not undergoing the specific treatment.
Also, whether the patient's mental disorder affects his or her ability to fully appreciate the consequences of making the treatment decision.

A review of a patient's status is most often triggered by a request from the patient but a review may also be requested by the substitute decision maker (SDM), the hospital or the Review Board itself.

Additionally, under the Section 37 of the *Act*, the Review Board is required to review the file of each person detained under a Declaration of Involuntary Admission 60 days after the initial declaration and at the end of the 6th, 12th, 18th and 24 month stage and every twelve months thereafter. This must be done regardless of whether the patient wants the review or not. In fact, the patient is deemed to have made a request for review. These are referred to as "automatic" reviews.

In the period April 1, 2010 to March 31, 2011 the Review Board received one hundred and thirty-three (133) requests for review. Requests, for these purposes, include automatic requests. The details of these requests are discussed below in Part II.

(ii) *Has the substitute decision maker rendered a capable informed consent?*

Under s. 42(1), the Review Board can also review the decision of a substitute decision maker (SDM) if asked by a psychiatrist or a patient to do so.

The test for whether or not the SDM made a capable, informed consent or refusal is that the decision must be made in accordance with the patient's "prior capable informed expressed wishes" or in the absence of this (or if this would endanger the patient or another person) that the decision be in the patient's "best interests".

In the period April 1, 2010 – March 31, 2011 the Review Board received two (2) applications for a review of a SDM decision. In both these cases, the hearings were adjourned and the patients were later made voluntary.

(iii) Review of Community Treatment Orders (CTO)

In the period from April 1, 2010 to March 31, 2011 there were thirty-six (36) Community Treatment Orders (CTOs) filed with the Review Board.

A patient or the SDM may apply under s. 58(1) for a review of whether or not the criteria for granting or renewing a CTO have been met. Automatic reviews of CTOs also occur on the 1st renewal and every 2nd renewal thereafter. Again, patients are deemed to have requested a review under the *Act*.

Criteria for CTOs (s.47)

Prior to issuing a CTO, a psychiatrist must have examined the patient in the last 72 hours and be of the view that:

> (i) the person has a mental disorder for which the person is in need of treatment or care and supervision in the community (and it can be provided),
>
> (ii) the person as a result of the mental disorder,
>
> (A) is threatening or attempting to cause serious harm to self or has recently done so, is seriously harming or is threatening serious harm towards another or has recently done so, or

(B) is likely to suffer serious physical impairment or serious mental deterioration, or both,

(iii) as a result of the mental disorder, the person does not have full capacity to make treatment decisions.

With respect to capacity, the psychiatrist must consider whether patient fully appreciates: the nature of the condition for which treatment is proposed; the nature and purpose of the specific treatment; the risks and benefits involved in undergoing specific treatment; and the risks and benefits in not undergoing the specific treatment. Also, whether the patient's mental disorder affects ability to fully appreciate the consequences of making the treatment decision. (s.18).]

(iv) during the immediately preceding 2 year period, the person

(A) has been detained in a psychiatric facility for a total of 60 days or longer,

(B) has been detained in a psychiatric facility on two or more separate occasions, or

(C) has previously been the subject of a community treatment order, and

(v) the services that the person requires in order to reside in the community

(A) exist in the community,

(B) are available to the person, and

(C) will be provided to the person.

At the conclusion of a CTO review, the Review Board may either revoke the CTO and allow the person to live in the community without being subject to the CTO or it may refuse to do so.

In the period April 1, 2010 – March 31, 2011 the Review Board received twenty (20) requests for a review of a CTO renewal. In sixteen (16) of these instances the requests were "automatic". Of the twenty (20) cases, three (3) patients were made voluntary before a hearing, sixteen (16) community treatment orders were upheld and one hearing was canceled. It is important to note that in numerous cases, the patient did not object to being on the community treatment order.

(iv) Review of Leave Certificates

Leave Certificates or Certificates of Leave are similar to CTOs but are time limited (six months only) and they are non-renewable. They also do not require any prior involuntary hospitalizations. During the period April 1, 2010 - March 31, 2011 only two (2) Leave Certificates were filed with the Review Board.

The Review Board may be asked to review the status of a patient who is on a Certificate of Leave. Since a person on a Certificate of Leave is still an involuntary patient, the automatic review provisions of the *Act* still apply. As stated above, if a patient has been involuntary for sixty (60) days they are deemed to have requested a review. This is true even of they have left the hospital under a Certificate of Leave. After a hearing, the Review Board may revoke the Certificate of Leave and allow the patient to live in the community without being subject to the Certificate, or may refuse to do so.

Additionally, if a psychiatrist has canceled a Certificate of Leave, the Review Board may be asked to review it. A psychiatrist may cancel the Certificate of Leave if:

(a) the patient's condition presents a danger to the patient or others; or
(b) the patient failed to report as required. (s.44(1)).

The outcome of a hearing to review a cancellation of a Certificate of Leave is that the Review Board may confirm the cancellation or it may refuse to do so.

To date the Review Board has not been asked to review the cancellation of a Certificate of Leave.

(v) Review of competency to administer estate under Hospitals Act

The *Involuntary Psychiatric Treatment Act* replaces and repeals most portions of the *Hospitals Act* relevant to the Review Board. The Board does, however, retain its review powers under s.58 (1) which authorizes the Review Board to review a declaration of competency for involuntary patients who have been found incompetent to manage their own estate.

The Review Board has never been asked to conduct this type of review under the *Hospitals Act*.

Part II Statistics and Trends

a) Introduction

During the period of operation from April 1, 2010 to March 31, 2011 the Review Board received one hundred and thirty-three (133) requests for review under the *Act*. This includes thirty (30) "automatic" requests under s.37 of the *Act*. The total number of hearings held between April 1, 2010 and March 31, 2011 was fifty-three (53).

b) Outcomes of Requests

One hundred and thirty-three (133) requests for review were made from April 1, 2010 to March 31, 2011. Sixty-two (62) patients had their status changed to voluntary before the hearing. Ten (10) patients cancelled their request, two (2) patients were placed on community treatment orders, one (1) request for review was denied and five (5) hearings were adjourned.

Of the fifty-three (53) hearings which were held between April 1, 2010 and March 31, 2011, thirty (30) patients had their status as involuntary patients upheld by the Review Board. Ten (10) patients had their status changed to voluntary and seven (7) hearings were adjourned. Thirteen of the hearings pertained to reviews of community treatment orders.

c) Community Treatment Orders and Leave Certificates

Psychiatric facilities are required to file Community Treatment Orders and Leave Certificates with the Review Board. During the period April 1, 2010- March 31, 2011, thirty-six (36) community treatment orders and two (2) leave certificates were filed with the Review Board. In terms of district, twenty-eight (28) of the CTOs were from Capital District Health, six (6) were from Cape Breton, one (1) was from the IWK and one (1) was from Yarmouth Regional Hospital. For the Leave Certificates, both were from South Shore Health.

d) Legal Representation

As discussed above, one hundred and thirty-three requests (133) for review were made from April 1, 2010 to March 31, 2011. Legal representation occurred in seventy-seven (77) of the requests. This accounts for fifty-eight (58) percent of the cases. When it comes to the hearings themselves, the percentage of patients with legal representation increases. Fifty-three (53) hearings were held and patients were represented in thirty-four (34) of the cases. This means that sixty-two (62) percent of patients who appear before the Review Board have legal representation.

e) Length of Time to Schedule a Hearing

The Review Board is required to hold a hearing within twenty-one (21) days of receiving a request pursuant to s. 68 of IPTA. For this fiscal year the average wait time between a request and a hearing was eighteen (18) days.

Part III Comments

The Review Board has now completed its third full year under IPTA. In previous Annual Reports, areas of concern to the Board included: training; community supports; obligations of the district health authorities to provide timely information to involuntary patients; conflict of interest for panel members; and the appropriate response for patients who choose not to attend hearings. These matters continue to be of concern and they are worth re-iterating:

Continuing Need for Further Training and Education

Even though the Act has been in effect since July 2007 there continues to be a need for ongoing education and training about the *Act.* This is particularly so for new psychiatrists who are unfamiliar with the tests for involuntary status or the appropriate use of Community Treatment Orders and Certificates of Leave. It is clear that on-going education and training is needed to make people aware of the changes and the implications the new legislation has for the individuals whose rights are affected by it. Again, the Review Board would be willing to facilitate this learning and participate in the process.

Increased Community Supports

It bears repeating that the requirement for increased community supports such as appropriate housing and outreach continues to be an urgent issue in light of the new tools which allow for treatment in the community under the new legislation. If the Legislature has deemed it appropriate to include community treatment options they should be available to involuntary patients throughout the province who satisfy the legislative criteria. The Review Board recommends that this be examined more fully and that funding be provided to allow treatment in the communities in which people live. Furthermore, more co-ordination and co-operation is needed between the departments of Health and Community Services in order to better address the housing needs of involuntary patients seeking placement in the community.

The Review Board is aware of situations where involuntary patients are being housed in psychiatric facilities because supportive housing is unavailable to them. Often, to the dismay of family members, the patients have their status changed to voluntary during the wait for placement and consequently no longer meet the criteria for community treatment orders.

Timely Information to Involuntary Patients

There is a great deal of disparity among the district health authorities in terms of the information which is being provided to involuntary patients. Section 26 of the *Act* requires that the hospital tell involuntary patients and their substitute decision

makers (in writing) that, among other things, they have the right to apply to the Review Board for a review of the patient's status and the right to retain and instruct counsel without delay. This information is to be provided whenever there is a change in a patient's status. Similarly, the facility is obliged to notify the Patient's Rights Service of changes in status so that a patient rights advisor can visit the patient and advise them of their rights under the *Act*. Some district health authorities are not making patients aware of these rights and the Department of Health needs to ensure compliance with the *Act.*

Clarification around Conflict of Interest

This issue was canvassed in previous Annual Reports but, to date, has not been addressed. The *Act* says that efforts should be made to ensure that one of the psychiatrists appointed to the Review Board has a specialization in adolescent psychiatry. Section 67(1), however, states that a Review Board member is not eligible to sit on a panel if he or she is an "officer, employee or staff member of the psychiatric facility" where the patient is being treated. The difficulty this creates is that most (if not all) adolescent psychiatrists in Nova Scotia will be employees of the IWK. They will not, however, necessarily work on the in-patient unit in the IWK. If the desire is to have an adolescent psychiatrist on the panels at the IWK, the legislation should be amended to allow an adolescent psychiatrist who is not working on the same unit (and who has not treated the patient) hear such reviews.

Patients Who Choose Not to Attend Hearings

Again, this issue was addressed in previous reports. Under section 71(2) of *IPTA* where the patient is unable or unwilling to attend a hearing and has not appointed someone to act on the patient's behalf, the Review Board shall appoint a representative to attend the hearing and act on behalf of the patient. The question which has arisen for the Review Board is who should be appointed? The substitute decision maker is a party to the hearing and is often not necessarily the person to best represent the patient. Lawyers will only represent clients if they are able to receive instructions and will not represent a patient if the patient does not wish to participate. This leaves the patient rights advisors who do not, at present, have the mandate to perform such duties.

The Review Board is of the view that in the absence of advocates who can represent involuntary patients that the patient rights advisors be alerted to this responsibility and trained to represent these patients.

"Voluntary but Incapable" Patients

The Review Board has serious concerns about the rights of voluntary patient who have been deemed incapable of consenting to treatment. Assessments of the

capability of a voluntary patient to consent to treatment or the appointment of a substitute decision-maker are carried out pursuant to the relevant provisions of the *Hospitals Act*. The *Hospitals Act* lacks the same procedural safeguards for rights advice which is contained in the *Involuntary Psychiatric Treatment Act*.

The Review Board is aware of situations where patients who were scheduled for Review Board hearings as involuntary patients have had their status changed to voluntary but incapable immediately prior to the hearing date. The patient's only recourse for review in this situation would be an application to the Supreme Court pursuant to s. 58(2) of the *Hospitals Act*:

> (2) A declaration of capacity for a patient in a hospital or a psychiatric facility or a declaration of competency for a patient in a hospital or a voluntary patient may be reviewed by the Supreme Court of Nova Scotia (Family Division) or by the Family Court where there is no Supreme Court (Family Division).

The Review Board believes that it is the most appropriate body to be responsible for this type of review. Review Board hearings can be set down more quickly than a Court application and the Board has the expertise and experience to review capacity issues. The Review Board is always comprised of three members, one of whom is a psychiatrist and these types of reviews were routinely conducted by the Board under the Hospitals Act prior to the passage of the Involuntary Psychiatric Treatment Act. Furthermore, the Review Board has jurisdiction to review declarations of competency for involuntary patients pursuant to subsection 58(1) of the *Hospitals Act* and it should also be able to review declarations of incapacity pursuant to s. 58(2).

Conclusion

With the third full year of operation under the *Involuntary Psychiatric Treatment Act* the Review Board has addressing concerns around setting matters down for review as expeditiously as possible and ensures that involuntary patients receive hearings and decisions in a timely manner. This has occasionally been challenging due to issues around the timely release of information about patients' status from hospitals. The number of requests for review has remained similar to the previous year but the number of hearings pertaining to community treatment orders has increased significantly.

Approximately sixty-two (62) percent of involuntary patients were represented by legal counsel at their hearings this year and it is expected that this will also increase over the next year through the ongoing efforts of Nova Scotia Legal Aid.