Annual Report

Review Board under the Involuntary Psychiatric Treatment Act

April 1, 2012- March 31, 2013
and
April 1, 2013- March 31, 2014

NOVA SCOTIA

Involuntary Psychiatric Treatment Act (IPTA)

Annual Report

2012-2013
and
2013-2014

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Review Board
Involuntary Psychiatric Treatment Act (IPTA)
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April 30, 2014

Honourable Minister Glavine
Minister, Department of Health and Wellness
Halifax, Nova Scotia

RE: IPTA Annual Report – 2012-13 and 2013-2014

Dear Minister Glavine:

I am pleased to submit this combined Annual Report of the Review Board under the *Involuntary Psychiatric Treatment Act* for the years April 1, 2012- March 31, 2013, and April 1, 2013 – March 31, 2014.

The filing of the 2012-13 portion of this Report has been delayed due to issues pertaining to the administrative functioning of the Review Board. There is still no database being used for data collection for the Review Board's work and reporting requirements. In light of this, a paper review of all documentation related to requests for review for fiscal years 2012-13 and 2013-14 was undertaken and the results were provided to me earlier this month. The provision of adequate administrative support to the Review Board was one of the main recommendations of the independent, legislated review of the *Involuntary Psychiatric Treatment Ac*t which was tabled in the House in December, 2013. The LaForest Report highlighted the need for quantitative data tracking in order to understand the functioning of the *Act*. The Review Board is hopeful that the LaForest Report recommendations will be implemented in a timely manner and that next year's Annual Report will contain the comprehensive data needed to support the Review Board's recommendations.

Sincerely,

Anne Jackman
Chair, Review Board under IPTA

C: Ken Scott
Lynn Cheek
Review Board Members

Annual Report

Review Board under the *Involuntary Psychiatric Treatment Act*

April 1, 2012 – March 31, 2013
and
April 1, 2013 – March 31, 2014

Introduction

This Report comprises statistics for two fiscal years: April 1, 2012 - March 31, 2013; and April 1, 2013 - March 31, 2014.[1]

The Review Board established under s. 65 of the *Involuntary Psychiatric Treatment Act*, (S.N.S. 2005, c.42) (IPTA) hears and considers applications for various types of review. Most often the review is to consider whether or not a person continues to meet the criteria for admission as an involuntary patient either in a psychiatric facility or in the community on a community treatment order. A panel of at least three Review Board members (a lawyer member, a psychiatrist member and a lay member) hears the application and provides written decisions.

The Review Board at March 31, 2013 was comprised of seven lawyers, six psychiatrists and four lay members. At March 31, 2014 it was comprised of ten 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 two periods from April 1, 2012 – March 31, 2013 and April 1, 2013 – March 31, 2014.

Part III outlines issues of ongoing concern to the Review Board.

[1] The statistics for this Report were compiled after a review of all paper documentation from the administrative office of the Review Board. As with any review of this kind there are inherent limitations in terms of the reliability and accuracy of the data.

Part I Types of Review

(i) ***Review of Status***

The most frequent type of review is a review of a patient's status as an involuntary patient in a psychiatric facility. The Review Board reviews the decision of the treating psychiatrist who has determined that the person in the psychiatric facility should be held as an involuntary patient. A person may be held as an involuntary patient only if they meet all of 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. (s. 18)

A review of a patient's status as an involuntary patient is most often triggered by a request from the patient but a review may also be requested by the substitute decision maker (SDM) or guardian, 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 sixty (60) days after the initial declaration and at the end of the 6th, 12th, 18th and 24 month stage and every twelve months thereafter. At each of these intervals, an involuntary patient is deemed to have made a request for review. These are often referred to as "automatic" reviews. How the Review Board receives notification from the psychiatric facilities about the status of these involuntary patients is a challenge which is discussed in Part III below.

(ii) ***Has the substitute decision maker rendered a capable informed consent?***

Under s. 42(1) of the *Act*, the Review Board may also review the decision of a substitute decision maker (SDM) if asked by a psychiatrist or a patient to do so.

It is not entirely clear from the legislation if this section provides sufficient authority to review an SDM's decision in relation to the decision-making criteria which are set out in the *Act*. The Review Board interprets it to mean that the test for whether or not the SDM has 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". The LaForest Report concluded that this interpretation is a "defensible approach" (p.100) but that the language in the *Act* should be clearer.

If the Review Board was to determine that the SDM did not make a capable, informed consent, the next person in the hierarchical list under s. 38(1) would become the SDM.

To date, the Review Board has not been required to make such a determination. In the limited number of requests which have been received to review an SDM's decision the patients have had their status changed to voluntary prior to the scheduled hearing.

(iii) ***Review of Community Treatment Orders (CTO)***

A patient or the SDM may apply under s. 58(1) of the *Act* for a review of whether or not the criteria for granting or renewing a Community Treatment Order (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

In order to decide whether or not a CTO should be upheld or revoked the Review Board considers whether or not all of the criteria have been met.

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 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. (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. (s. 47)

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.

(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.

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 if 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 the Hospitals Act***

IPTA 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) of the *Hospitals Act* which authorizes it 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

2012-2013

a) **Introduction**

During the period of operation from April 1, 2012 to March 31, 2013 the Review Board received one hundred and five (105) requests for review under the *Act*. This includes thirty-two (32) "automatic" requests under s.37 of the *Act*.

The total number of hearings held between April 1, 2012 and March 31, 2013 was forty-four (44). (See Annex A for an overview of the IPTA Review Board Statistics for 2012-2013).

b) **Outcomes of Requests**

One hundred and five (105) requests for review were made from April 1, 2012 to March 31, 2013.
Thirty-three (33) patients had their status changed to voluntary before the hearing. Four (4) patients withdrew their request, thirteen (13) patients were placed on community treatment orders, one (1) patient was placed on a certificate of leave, three (3) patients had their community treatment orders revoked, and six (6) were cancelled for unknown reasons.[2]

Of the forty-four (44) hearings which were held between April 1, 2012 and March 31, 2013, thirty-four (34) patients had their status as involuntary patients upheld by the Review Board. Ten (10) patients had their status changed to voluntary. Nine (9) of the hearings pertained to reviews of community treatment orders.

In the period April 1, 2012 – March 31, 2013 the Review Board did not receive any applications for a review of a SDM decision.

c) **Community Treatment Orders and Leave Certificates**

Psychiatric facilities are required to file Community Treatment Orders (CTOs) and Leave Certificates with the Review Board.

During the period April 1, 2012- March 31, 2013, twenty-five (25) CTOs were filed with the Review Board. The geographical breakdown for these was as follows: Capital Health - fifteen (15); Cape Breton - four (4); Yarmouth – three (3); South Shore – one (1); and Colchester – two (2).

[2] This highlights the insufficiency of information available to the Review Board. Six (6) hearings were cancelled at the administrative level (i.e. without convening a panel) for "unknown reasons".

In this same time period the Review Board received fourteen (14) requests for a review of a CTO renewal. Of the fourteen (14) cases, three (3) were revoked prior to the hearing. Of the nine (9) CTOs hearings which were held, six (6) CTOs were upheld and three (3) were revoked.

During the period April 1, 2012 - March 31, 2013 only one (1) Leave Certificate was filed with the Review Board and it was from South Shore Health.

d) **Legal Representation**

As discussed above, one hundred and five requests (105) for review were made from April 1, 2012 to March 31, 2013. Legal representation occurred in sixty-six (66) of the requests. This accounts for sixty-two (62) percent of the cases. When it comes to the hearings themselves, the percentage of patients with legal representation increases. Forty-four (44) hearings were held and patients were represented in thirty-one (31) of the cases. This means that seventy (70) 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 time between a request and a hearing was twenty-nine (29) days.

2013-2014

a) **Introduction**

During the period of operation from April 1, 2013 to March 31, 2014 the Review Board received one hundred and thirty (137) requests for review under the *Act*. This includes sixty-eight (68) "automatic" requests under s.37 of the *Act*.

The total number of hearings held between April 1, 2013 and March 31, 2014 was seventy-two (72). (See Annex B for an overview of the IPTA Review Board Statistics for 2013-2014).

b) **Outcomes of Requests**

One hundred and thirty-seven (137) requests for review were made from April 1, 2013 to March 31, 2014. Twenty-seven (27) patients had their status changed to voluntary before the hearing. Three (3) patients withdrew their request, twenty-one (21) patients were placed on community treatment orders, five (5) patients were placed on certificates of leave, seven (7) patients had their community treatment orders revoked, and two (2) were cancelled for administrative errors.

Of the seventy-two (72) hearings which were held between April 1, 2013 and March 31, 2014, fifty-nine (59) patients had their status as involuntary patients upheld by the Review Board. Thirteen (13) patients had their status changed to voluntary. Twenty-seven (27) of the hearings pertained to reviews of community treatment orders.

In the period April 1, 2013 – March 31, 2014 the Review Board did not receive any applications for a review of a SDM decision.

c) **Community Treatment Orders and Leave Certificates**

Psychiatric facilities are required to file Community Treatment Orders (CTOs) and Leave Certificates with the Review Board.

During the period April 1, 2013- March 31, 2014, forty-four (44) CTOs were filed with the Review Board. The geographical breakdown for these was as follows: Capital Health - nineteen (19); Cape Breton - sixteen (16); Yarmouth – two (2); Colchester – four (4); Valley – one (1); and GASHA – two (2).

In this same time period the Review Board received thirty-five (35) requests for a review of a CTO renewal. Of the thirty-five (35) cases, eight (8) were revoked prior to the hearing. Of the twenty-seven (27) hearings which were held, twenty-four (24) CTOs were upheld and three (3) were revoked.

During the period April 1, 2013 - March 31, 2014 five (5) Leave Certificates were filed with the Review Board: one (1) was from Capital; one (1) was from Yarmouth; two (2) were from Valley; and one (1) was from South Shore Health.

d) **Legal Representation**

As discussed above, one hundred and thirty-seven (137) requests for review were made from April 1, 2013 to March 31, 2014. Legal representation occurred in sixty-two (62) 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 increased. Seventy-two (72) hearings were held and patients were represented in forty-two (42) of the cases. This means that fifty-eight (58) percent of patients who appear before the Review Board had legal representation.

The statistics for 2013-14 suggest that a decrease was seen in the number of patients who were represented by legal counsel at Review Board hearings (58% in 2013-14 as compared to 70% in 2012-13). It is impossible to determine the reason for this without a re-examination of the original data. Anecdotal evidence, however, suggests that it may be in light of the fact that there was a significant increase in the number of hearings to review community treatment orders (9 hearings in 2012-13 and 27 hearings in 2013-14). The experience of the Review Board members suggests that people who are living in the community on a community treatment order are sometimes less inclined to seek legal representation when appearing before the Review Board.

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 time between a request and a hearing was twenty (20) days.

Part III Comments

As has been the practice with previous Annual Reports, in this part of the Report the Review Board raises concerns about the ongoing administration of the *Act* and makes recommendations for change. Once again, the biggest challenge to the Review Board during the fiscal years represented in this Report has been the administrative functioning of the Review Board.

Independent Review (LaForest Report)

December 2013 saw the public release of the *Report of the Independent Panel to Review the Involuntary Psychiatric Treatment Act and Community Treatment Orders* (the "LaForest Report"). The *LaForest Report* detailed many of the same concerns which have been raised by the Review Board in its Annual Reports since the *Act* first came into effect. It used particularly strong language in describing the administrative functioning of the Board:

> *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. (p. 70)*

The Review Board in its Annual Reports has consistently raised similar apprehensions with respect to adjournments and delays in scheduling, appointments to the Board and a lack of statistical data collection. While the LaForest Report highlights the administrative challenges facing the Review Board, there were no concerns raised about the Review Board's decisions or its interpretation of the *Act*.

Some of the following topics have been explored in previous Annual Reports as well as the LaForest Report but they continue to be matters which the Review Board feels require immediate attention from the Department of Health and Wellness.

Appointments to the Review Board

Review Board membership is comprised of representatives from three competency areas: lawyers, psychiatrists (at least one of whom must be an adolescent psychiatrist) and members of the public who have an interest in mental health issues. People interested in being appointed to the Review Board apply through the Executive Council application process for adjudicative Agencies, Boards and Commissions. Advertisements typically run in the fall and in the spring and appointments to the Review Board are through Orders

in Council. Unfortunately, there is no mechanism in the *Act* to allow Review Board members to continue serving until they are re-appointed or replaced and if there are vacancies this places additional scheduling pressures on the Review Board which is required to hold hearings within twenty-one days of receipt of a request for review.
In the past number of years there have been problems of members' terms expiring at the same time. A particularly critical lapse, from an administrative functioning perspective, occurred at the end of March 2012 when the Chair's term ended and there was no-one acting in the Chair's role. As a result, there was a period of almost two months when the Board was unable to conduct hearings. This meant that patients who were entitled to have a review of their status as involuntary patients did not have the hearings which they were entitled to have. The statistics for 2012-13 appear to reflect this as the total number of hearings for the year was forty-four (44), the lowest number since the *Act* came into effect.

The other appointment challenge has continued to be the appointment of psychiatric members of the Review Board. As the LaForest Report states: "Essentially the pool comes down to retired psychiatrists since practicing 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" (p.71). The Review Board recognizes that this is an ongoing concern but suggests that consideration should also be given to amending the *Act* to allow former members of the psychiatric profession to sit on the Review Board. At present, retired psychiatrists must have a licence to practice and not all of them wish to undergo the continuing medical education required for active licensure.

On a positive note, as at the end of March, 2014, there are now six active and fully engaged psychiatrists on the Board and this will certainly continue to assist with scheduling challenges for the Review Board. In fact, the statistics for 2013-14 seem to reflect this more robust membership of psychiatrists on the Board. In 2012-13 the average time to schedule a hearing was 29 days while in 2013-14 the average time had decreased to 20 days. This was in spite of the fact that the total number of hearings held in 2013-14 was seventy-two (72), the highest number of hearings since the *Act* was introduced.

Adjournments

This matter was also raised in the Review Board's previous Annual Report. It was noted that the Review Board had begun the process of scheduling hearings for the purposes of adjournment. This allows the Board to maintain jurisdiction if the initial convening for the Board occurred within the twenty-one day legislative requirement. The need for an adjournment occurs most frequently when a person decides to retain legal counsel and needs to wait for an available lawyer. There may also be delays for the lawyers in accessing charts and finding time to meet with clients. It should be noted that this more frequently occurs in areas of the province where there are no legal aid lawyers specifically designated for mental health clients.

Adjournments within the twenty-one day period may satisfy a jurisdictional question but it is a costly remedy as it requires a three member panel to be convened for a process

which may take minutes to conclude. The Review Board favours a more flexible approach which would allow the Chair of the Review Board to adjourn a hearing with the patient's consent. Alternatively, if the Review Board moves to regularly scheduled hearing days adjournments could easily be accommodated on the regularly scheduled hearing days.

Regularly Scheduled Hearing Days

For several years the Review Board has internally debated the merits of having regularly scheduled days for its hearings. At present, the Board's scheduling works on as "as needs" basis and hearings are scheduled whenever a request for review is received or whenever there is an automatic review under the *Act*. Historically, the Review Board has tried to accommodate the preferences of patients and their families and has travelled to psychiatric facilities throughout the province to hold "in person" hearings. In the past few years, however, more hearings have been conducted by telehealth, a high speed, secure video link which connects people at a number of distant sites. It is expected that the trend towards using more telehealth services will continue as more members of the Review Board are appointed from different parts of the province. Regularly scheduled hearing days would require that hearings be held in one specific location and would necessitate travel to the site for some people and telehealth for other participants. This would inconvenience some people but the benefits may outweigh the disadvantages.

The LaForest Report had this to say about the matter:

> *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.* (p. 72)

In 2013-14 the Review Board conducted seventy-two (72) hearings. If this trend towards more hearings continues it appears that the Board's volume may justify regularly scheduled days for hearings.

Role of Psychiatric Facilities

The concern with respect to the information flow from the psychiatric facilities to the Review Board is twofold: (a) the information provided in the Hospital Report by the attending psychiatrist for a specific hearing; and (b) the information provided by the

facility with respect to the number of involuntary patients and whether or not they require a statutory review of their status as involuntary patients.

(a) Hospital Reports - The quality and quantity of information provided to the Review Board prior to a hearing continues to vary tremendously from one facility to another and sometimes from one practitioner to another. The Review Board has provided a Hospital Report template to assist the psychiatric facilities but this is not always used or it is sometimes completed in almost illegible cursive writing. This results in hearings which take much longer than necessary as the Board is required to ask many questions and seek clarification on numerous issues. While the length of time for a hearing is a variable which is difficult to control and in itself is not a problem, the Board is mindful of the fact that the hearings are often emotional and difficult for the patients and families and anything which can be done to make them flow more smoothly and efficiently is ultimately in the best interest of the involuntary patient.

(b) Monthly Status Reports – The Act requires the Review Board to review the status of involuntary patients within certain time frames, for example sixty days after admission or after the initial renewal of a community treatment order. Since the Review Board does not maintain a database of involuntary patients the only way it knows when to conduct a statutory review is from the information provided by the psychiatric facilities themselves. The timeliness and comprehensiveness of these reports has also been a challenge to the Board. If the Board is not advised of the renewal of a community treatment order until weeks after it has been renewed it is impossible for the Board to meet the twenty-one day legislative requirement for a hearing. The Department needs to work more closely with the district health authorities to ensure that the data which is provided to the Board is both timely and accurate. It also highlights the need for continued training and education for those required to administer the Act.

Unrepresented Patients

The Review Board continues to have difficulties with hearings where a patient does not attend. This is most common when a community treatment order was renewed and there is an automatic review of the order. Section 71(2) of *IPTA* requires the Board to appoint a representative where the patient is unable or unwilling to attend a hearing and has not appointed someone. It states as follows:

> **71(2)** Where the patient is unable or unwilling to attend a hearing before the Review Board and the patient 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 Review Board has had some success with asking patient rights advisors to represent a patient who has not attended a hearing. However, not all patient rights advisors are

comfortable with this approach as it is not within their job description and nor are they trained to be advocates. The patient rights advisors are also providing information to substitute decision makers and some feel conflicted when asked to represent the patients themselves.

The Review Board is of the view that the Department of Health and Wellness should consider the appointment of guardians to represent people who do not wish to attend review board hearings. Alternatively, the *Act* should be amended to allow the Review Board to proceed in the person's absence as was permitted under the *Hospital Act*.

The LaForest Report also supported this latter approach:

> *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.* (p.73-74)

Conclusion

It appears from the statistical information available that the number of requests for review changed significantly between 2012-13 and 2013-14. Even taking into account that the Review Board was unable to hold hearings for two months at the beginning of 2012-13, there is still an increase in the number of hearings from forty-four (44) in 2012-13 to seventy-two (72) in 2013-14. There was also an increase in the overall number of community treatment orders in the province, from twenty-five (25) in 2012-13 to forty-four (44) in 2013-14.[3] The most notable increase in the use of community treatment orders was seen in Cape Breton where the number of orders filed with the Review Board rose from four (4) in 2012-13 to sixteen (16) in 2013-14.

The Review Board is mandated to make decisions which significantly affect the rights of involuntary patients. In light of this, it is critical that the Review Board offer a high degree of procedural protection to those affected by its decisions. In 2012-13, the legislated twenty-one (21) day requirement to hold a hearing was not met in numerous cases. The average length of time for a hearing to be scheduled in 2012-13 was twenty-nine (29) days. This improved in 2013-14 when the length of time to schedule a hearing was twenty (20) days which is within the legislated time frame. The Review Board is hopeful that this trend will continue now that the Review Board has a full complement of members.

The LaForest Report provides an opportunity to improve the working of IPTA and the administrative functioning of the Review Board. The Board looks forward to the opportunity to work with the Department as it seeks to implement the Report's recommendations as well as to improve the tracking and analysis of quantitative data relative to the Review Board's functioning.

[3] Psychiatric facilities are required to file all community treatment orders with the Review Board and these continued to be received during the two months in 2012 when the Review Board was unable to hold hearings.

Annex A
IPTA 2012-2013 Statistical Overview

Requests			Hearings				Hearing Outcome/Status				Legal Representation			
Total	Requested	Automatic	Held	Involuntary Inpatient	CTO Renewal	Adjourned	Patient Involuntary Status Upheld	Patient Status changed to Voluntary	CTO Upheld	CTO Revoked	At Request Stage		At Hearing Stage	
105	**73**	**32**	**44**	**34**	**9**	**1**	**28**	**7**	**6**	**3**	**66/105**	**62%**	**31/44**	**70%**

Annex B

IPTA 2013-2014 Statistical Overview

Requests			Hearings				Hearing Outcome/Status				Legal Representation			
Total	Requested	Automatic	Held	Involuntary Inpatient	CTO Renewal	Adjourned	Patient Involuntary Status Upheld	Patient Status changed to Voluntary	CTO Upheld	CTO Revoked	At Request Stage		At Hearing Stage	
137	**69**	**68**	**72**	**22**	**27**	**23**	**35**	**10**	**24**	**3**	**62/137**	**45%**	**42/72**	**58%**