Who Applies to Regional Review Boards and What Are the Outcomes?

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Objective: To determine the outcomes for patients following applications to regional review boards at an Ontario provincial psychiatric hospital for 1992 through 1994.

Method: A retrospective casenote study examined frequency of readmission, time to next admission, status upon readmission, and episodes of dangerous behaviour perpetrated in the community for patients applying to review boards.

Results: Over 3 years, 116 hearings took place to review various certificates. Only 57% of applications reached a hearing. Of those, 69% were confirmed and 31% rescinded. A small group of patients made multiple applications to the review board. Median time to next admission for patients who had certificates of involuntary admission rescinded by the review board was 14 days, compared with 53 days for those who remained in hospital until the time of planned discharge.

Conclusion: Review boards consume considerable resources, serve only a small proportion of patients, and contribute to the “revolving door” phenomenon.

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Key Words: review boards, dangerous behaviour, patient readmission, Mental Health Act

Within almost all jurisdictions in the civilized world, legal provisions exist to enable the treatment and protection of people who have mental disorders and to protect other citizens from dangerous behaviour by such individuals. These provisions are usually balanced by other legislation intended to protect the rights to liberty and self-determination for those judged to be mentally disordered and lacking insight. The criteria by which the mentally disordered are judged to fall into this category may vary somewhat among jurisdictions.

Within the provisions of the Ontario Mental Health Act (1), only those mentally disordered patients whose mental disorder is “of a nature of quality that likely will result in (i) serious bodily harm to the person, (ii) serious bodily harm to another person, or (iii) imminent and serious physical impairment of the person” may be detained in hospital against their wishes. Under the Act, patients have extensive rights of appeal to an independent regional review board (now the Consent and Capacity Review Board) for review of their involuntary status and other decisions made under the Act. The review board consists of 3 to 5 appointed members (usually 3) and must include a lawyer, a psychiatrist, and a lay person. The review board has the power to confirm or rescind certificates issued under the Mental Health Act and considers issues including involuntary status, financial competency, and ability to consent to treatment. Hearings are essentially adversarial, resembling a trial—with the doctor cast in the role of prosecutor and the patient defending—although they are less formal than a court, and the rules of evidence are less rigid. Both the attending physician and the patient may be represented at the hearing and may present evidence, as may other witnesses called by either party, but it is on the physician that the legal onus falls for proving his or her case (2). The decision of the review board is open to appeal in the Ontario Court (General Division) by any party to the hearing, but no new evidence may be considered on appeal.

In the past, it was acceptable for psychiatrists to adopt a paternalistic position in their relationships with patients: psychiatrists would plan treatment according to their view of the patients’ best interests. The swing toward individual rights

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and freedoms as a fundamental right in our society has changed this considerably (3). As a result, conflict may arise, and the trusting relationship between physician and patient may be adversely affected (4). As Hoffman and Bay (5) have pointed out, some patients who could benefit from treatment fall through cracks created by the legislation.

In Ontario there is no legal provision to ensure that people who are simply sick with a mental illness which affects their thinking in such a way as to impair their insight into the presence and severity of that illness receive treatment, hospital admission, or preventative medicine. The Mental Health Act deals only with those who are likely to cause or suffer serious bodily harm. The new Consent to Treatment Act (6) and Substitute Decisions Act (7) replaced some of the provisions for involuntary treatment of patients detained under the Mental Health Act. Following a change in the Provincial Government in Ontario, these Acts were considered flawed and were quickly replaced by the Health Care Consent Act (8). Nothing in these acts can be used to circumvent the Mental Health Act.

The gaps in health care created by current legislation are evident in the case of Butorac v Kletke and Butorac (9). The judge in the appeal upheld the decision of the board:

As sad as it may be, this woman has to be turned out into the cold of a Thunder Bay winter to make do for herself as she sees fit. As sad as it may be, those people who love her and those people who want only to help her must stand by on the sidelines and watch her as she suffers the experience of living in conditions that no one wants her to live in. Unhappily, while the evidence is clear that she suffers from a mental illness, while the evidence is clear that she herself does not truly appreciate that illness as it affects herself, the evidence is not clear that she is a danger to others. The evidence is not clear that she is a danger to herself in either of the manners suggested (9).

While it has been reported that regional review boards uphold the attending physician’s position in 80% to 85% of committal cases (2), informal discussion with psychiatrists working in the provincial psychiatric hospitals suggested there may be considerable variation from hospital to hospital. Predicting future dangerousness is a difficult and contentious issue and not one that psychiatrists undertake lightly. The dismissal of a carefully considered opinion undoubtedly leads to feelings of chagrin. Unwilling though the statistics may be, there is a considerable body of literature that suggests that people with a mental disorder are more likely to be violent than the general population (10). There is also evidence that experienced clinicians can predict future violence with better than chance accuracy, but with poor sensitivity and specificity (11). One of the functions of review boards is to provide involuntary patients with a mechanism for review of the clinician’s decision to detain them in hospital based on such predictions.

This study examined applications to and decisions by regional review boards over a 3-year period at North Bay Psychiatric Hospital (1 of 10 provincial psychiatric hospitals for the province of Ontario). Some measures of outcome were also determined for the year following decisions. The research was stimulated by a belief among attending physicians that review boards frequently ignore the opinion of the attending physician and rescind certificates for patients who subsequently become a threat to themselves or others and end up being readmitted to hospital within a short period of time.

Hypotheses

In comparison with involuntary patients who apply to a regional review board and whose certificates of involuntary status are upheld, those patients whose certificates of involuntary status are rescinded 1) will have a higher risk for readmission within the year following discharge, 2) if they leave hospital prematurely, will have more episodes of dangerous behaviour in the community in the year following discharge than the patients whose certificates are confirmed and who remain in hospital until the planned date of discharge, 3) will, if they are readmitted within one year, be readmitted within a significantly shorter period of time, and 4) will have a higher risk for readmission as involuntary patients.

Method

Hospital records of applications and outcomes for regional review board hearings were examined for the years 1992 through 1994 at North Bay Psychiatric Hospital, which serves the catchment area of Northeastern Ontario. Further information about individuals who made applications was obtained from the hospital’s AViiON mainframe computer system, which holds patient admission information, and from individual patient charts (Table 1). Initial data on all applications were collected regardless of the issue being contested, but follow-up data were collected only for those patients who had contested their involuntary status.

For those patients who had a hearing to review their involuntary status and who were subsequently readmitted to hospital, the charts were examined by the authors in greater detail for evidence of episodes of dangerous behaviour occurring in the community, as defined in Table 2. Because some patients made multiple applications, their first application for a review board hearing in the period sampled was used as a starting point for the purpose of examining subsequent incidents of dangerous behaviour and readmissions.

Data were entered into an Epi Info (12) database, and the hypotheses were tested using chi-square (hypotheses 1, 2, and 4) for categorical variables and analyses of variance (ANOVA) (hypothesis 3) for continuous variables. Numbers of episodes of dangerous behaviour for multiple and single applicants were compared using the Kruskal-Wallis test for 2 groups.
In the 3-year period of the study, 119 patients made 208 applications to the review board for review of their various certificates (Figure 1). Seven patients made 22% of all applications. One person accounted for 12 applications, comprising 6.8% of the total. Patients challenging their involuntary status were similar to the applicants as a whole, with 95 patients making 149 applications. Four patients made 20% of the applications in this category.

The mean age of patients applying to the review boards was 42 years (range 19 to 85 years), which is similar to the mean age of all admissions (41 years). Forty-two applicants were female and 77 were male, which is also similar to the hospital profile.

Diagnostic groupings were derived from clinical diagnosis assigned by the attending physician at discharge (using ICD-9 criteria) and are shown for patients making applications to the review board in Figure 2. The diagnostic groupings for the subgroup of patients applying to contest their involuntary status were similar to applicants as a whole. In comparison with all hospital admissions during the study period, the review board applicants are different in that patients with mania and schizophrenia are overrepresented. The “other” category, which includes less severe depressive illness, adjustment disorders, and personality disorders, is greatly underrepresented.

Only 116 of 208 applications for review reached a hearing. In 27 cases, applicants withdrew their applications and in 58 cases, physicians changed the applicants’ status prior to the hearing. In the remainder, some other event, such as the patient absconding, precluded a hearing. With respect to review of involuntary status (Figure 3), 74 of 149 applications were heard by the board; in 16 cases, applicants withdrew their applications and in 57 cases, physicians made the applicants voluntary prior to the hearing. Of those cases heard by the review board, 64% (n = 47) of certificates were confirmed by the board, while 36% (n = 27) were rescinded.

The distribution of review board decisions by diagnostic group is shown for those contesting involuntary status in Figure 4. Of note is the fact that only the subgroup of patients with manic disorders managed to have more certificates rescinded than confirmed. Patients with schizophrenia who contested their involuntary status had it rescinded as frequently as it was confirmed. Other diagnostic groups most frequently had their certificates confirmed.

Patients whose certificates of involuntary admission were confirmed were more likely to be readmitted within the year after discharge (22 patients versus 14 patients), but this finding was not statistically significant. On examining the time to next admission for those patients who had a review board hearing and were subsequently readmitted within one year, we found that the median time to next admission was less for those patients whose original certificate was rescinded (14 days versus 53 days). This difference was statistically significant (P < 0.05).

Following the review board hearings, 60 episodes of dangerous behaviour were recorded as being perpetrated in the community by 23 patients who were readmitted to the hospital. Those whose first application to the review board was rescinded had more subsequent episodes of dangerous behaviour overall (3.5 versus 2.2). In all categories of dangerous behaviour incidents, the rescinded group perpetrated more incidents than the confirmed group (Figure 5). Although
all trends in the data are in the direction of hypothesis 2, the results were not statistically significant.

On comparison of whether the subsequent admissions were voluntary or involuntary, there was no difference between the confirmed and rescinded groups.

The data did suggest an association between multiple applications to the review board and subsequent dangerous behaviour, in that the 26% of patients who made more than one application accounted for 55% of the dangerous behaviour episodes. On further examination of the data, we found that patients making more than one application to the review board in the study period perpetrated a median of 5.5 episodes of dangerous behaviours as opposed to 2 episodes for those making a single application. This finding was statistically significant ($P < 0.025$).

Age of the patient and number of previous admissions bore no relationship to the outcome of hearings. Board composition was examined, but the presence or absence of any individual board member (or group of board members) had no effect on the outcome of hearings. Individual attending physicians did not perform differently in terms of outcomes of hearings, but there was a fourteenfold variation in the number of applications that reached a hearing for the 6 physicians with similar responsibilities on the acute admission unit.

Discussion

Of the 4 hypotheses, only one, that patients whose certificates of involuntary status were rescinded would be readmitted more quickly (hypothesis 3), was confirmed. The trends in the data followed the expected direction in considering the likelihood of dangerous behaviour in the community (hypothesis 2), but the null hypothesis that there was no difference between the confirmed and rescinded group could not be rejected. There was no evidence that the patients who had their certificates of involuntary admission rescinded were more likely to be readmitted, and no evidence that those who were readmitted were more likely to be readmitted on an involuntary basis, so hypotheses 1 and 4 were not confirmed. The finding that patients who made more than one application to the review board in the 3-year period exhibited more episodes of dangerous behaviour was not predicted and will therefore require confirmation in future studies. This study clearly has a number of limitations; it was a retrospective study based on casenote information, and there are few other similar studies with which to compare it. Our method for ascertainment of dangerous behaviour almost certainly underestimated the true incidence, since only those episodes recorded in the casenotes, usually events leading to hospital admission, were recorded.

It is apparent that some diagnostic groups, for example those with schizophrenia or mania, are more likely to apply for regional review board hearings, and some individuals seem to wish to contest and recontest every finding under the Mental Health Act. There are several possible explanations for this. Lack of insight is more characteristic of some diagnoses and individuals, as is violent or self-destructive behaviour. Patients with psychoses such as schizophrenia or mania are clearly at greater risk of falling into this category. Over-representation of manic patients in our group may, in part, be due to the grandiose beliefs associated with mania, resulting in this group being more likely to challenge the opinion of the physician. The self-critical attitudes associated with depression may act in the opposite way, making an individual less
likely to challenge the doctor's decision. Certain diagnoses, such as personality disorder or substance abuse, may be perceived by physicians as producing behaviour that is more under the control of the patient, and as a result, these individuals may be less likely to be detained under the Mental Health Act.

Our findings are generally consistent with those of Chandrasena and Smith (13), who studied review board applications (under the Mental Health Act of 1967) at the Royal Ottawa Hospital from 1974 to 1983. Chandrasena and Smith commented that the frequency of applications increased throughout their study period. This trend has obviously continued: we had almost as many applicants in the 3 years of our study as they had in 10 years, which suggests increasing numbers even after one allows for the fact that North Bay Psychiatric Hospital has 300 beds compared with 180 at the Royal Ottawa.

Out of all 208 applications to the regional review board, only 56% reached the hearing stage. The majority of applicants were challenging their involuntary status, and of these, only 50% of applications reached a hearing. This finding is also similar to that of Chandrasena and Smith (13), who cite 53% of applications reaching the hearing stage.

It is not clear why patients withdraw their application prior to a hearing, but it may be because they anticipate an adverse outcome or they improve in the interim and gain insight. Surprisingly, the most frequent outcome following an application to the review board for a review of involuntary status was for the physician to change the patients status to voluntary. This occurred over the period studied in 39% of cases. It is difficult to understand why this occurred so frequently, since hearings are normally scheduled within a matter of days from the application. It is possible that in some cases there was a dramatic improvement in the patient’s mental state, but one could also speculate that psychiatrists are reluctant to expend the large amounts of time that are necessary to prepare and engage in review board hearings and then expose themselves and their decisions to scrutiny, criticism, and reversal. The fact that there was such wide variation in the number of hearings attended by different physicians with similar responsibilities supports the latter explanation, as it may be expected that physicians differ in their ability to tolerate the review process. Bay and Hoffman (2) comment that the regional review board has found that generally 20% to 40% of involuntary patients have their status made voluntary by their physician prior to the hearing, and they suggest that physicians who tend regularly, or never, to change their patients’ status prior to hearings should review their understanding of and attitudes toward the Mental Health Act. We would concur with this view.
although most hearings resulted in a finding in favour of the physician, it is perhaps surprising that the physician’s view was rejected in such a large proportion as 36% of hearings. This would suggest either that physicians are being too cautious or review boards are not exercising sufficient caution. It may be that both cases are true, since physicians have a potentially heavy liability burden if things go wrong, whereas responsibility for review board decisions are diffused among 3 or more individuals who are protected from liability. (It is debatable whether the physician continues to carry some liability when a patient, whom he or she has argued is dangerous, is released by the review board, in view of the possibility for an appeal from the decision of the board.)

Manic patients were not only more likely to apply to review boards, but they seemed to perform exceptionally well in hearings, obtaining more favourable findings than their attending physicians. The literature suggests that the risk for violence by patients with mania and schizophrenia is similar (10,14), so perhaps review boards are more influenced by the appearance and conduct of the patient during the hearing than the evidence presented.

The fact that patients whose certificates of involuntary status were confirmed were more frequently readmitted in the year following their eventual discharge was initially surprising, since it was the opposite of what we had hypothesized. On reflection, we think this finding is probably attributable to the fact that the most seriously ill individuals have their involuntary status confirmed, and those same individuals are at greater risk of subsequent relapse. Nevertheless, the patients whose involuntary status was rescinded and who were readmitted within a year were readmitted in a significantly shorter time. This suggests they were not well served by the premature discharge from hospital, and they were probably less well at the time of discharge than those patients whose certificates were confirmed and who remained in hospital until they were adequately recovered. Our examination of the records of subsequent dangerous behaviour episodes suggests that patients whose involuntary status is rescinded may also pose an increased risk for committing violence in the community.

It is interesting that those individuals who make multiple applications to the review board, who presumably have the least insight and are least willing to accept the judgements of others, pose an increased risk for dangerous behaviour. These individuals are probably at high risk of subsequent undesirable outcomes such as involvement with the forensic system. They also consume a disproportionate percentage of scarce resources. Clearly, since the number of patients making applications to review boards has been increasing steadily, and since the proportion of the applicants receiving favourable decisions has also been increasing, we might expect to require increased expenditure in order to maintain the current system. Not surprisingly, the present provincial government in Ontario is in the process of reexamining the current Mental Health Act and Consent to Treatment provisions with a view to reducing costs and removing barriers to rational care decisions.

Following this study of the outcomes of regional review board applications in Ontario, we suggest that patients and the general public would be best served by some revisions to the current legislation. We feel that some form of long-term community treatment order with a limited frequency of appeals, as has recently been provided in the Saskatchewan Mental Health Act (15), and some form of involuntary admission for the purpose of treatment such as exists in the Mental Health Act of England and Wales (16) would improve the current system.

**Clinical Implications**
- Patients who are released by review boards are readmitted more quickly.
- Frequent review board applications may predict dangerous behaviour.
- Manic patients, perhaps by virtue of their illness, are adept at presenting themselves favourably to review boards.

**Limitations**
- The data were collected retrospectively.
- The study was based on the use of casenote data.
- The frequency of dangerous behaviour was probably underestimated.

**References**
9. *Butorac v Kletke and Butorac*. Ontario Court General Division Thunder Bay, Ontario (December 1994)
Résumé


Méthode : Une étude rétrospective de dossiers a porté sur la fréquence de réadmission, l’intervalle jusqu’à l’admission suivante, l’état lors de la réadmission et des épisodes de comportement dangereux commis dans la collectivité chez des malades s’adressant à des commissions de révision.

Résultats : Sur une période de trois ans, il y eut 116 audiences passant en revue divers certificats. Seulement 57% des demandes sont parvenues à une audience. Dans ce groupe, 69% étaient confirmés et 31% étaient abrogés. Un groupe restreint de malades a saisi la commission de révision de demandes multiples. L’intervalle médian jusqu’à l’admission suivante chez les malades dont le certificat d’admission involontaire avait été abrogé par la commission de révision était de 14 jours, en comparaison de 53 jours chez ceux qui sont demeurés à l’hôpital jusqu’à la date prévue de leur sortie.

Conclusion : Les commissions de révision accaparent des ressources importantes, ne servent qu’une faible proportion de malades et contribuent au phénomène de « rotation ».