Appendix E:

External Review of East Coast Forensic Hospital Community Access Policies

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Dear Dr. Slayter and Ms. Ricker:

Re: External Review of East Coast Forensic Hospital Community Access Policies

At your request, I have reviewed the policies, procedures and practices regarding community access for patients in the East Coast Forensic Hospital who are under the jurisdiction of the Nova Scotia Criminal Code Review Board (CCRB).

I wish to express my appreciation for being invited to provide assistance and advice to the Committee. The East Coast Forensic Hospital's commitment to person centred care and assisting its patients towards the rehabilitative pathway is evident throughout the policies, protocols and procedures reviewed and examined. While clear strengths are present, this review also identified opportunities for further improvements in the hospital's forensic mental health services. I hope that my comments and recommendations will be regarded in the sense intended: to assist where possible and as appropriate, in improving further what evidently already is an organization committed to clinical excellence.

The East Coast Forensic Hospital is not unique in its challenges; the task of maintaining the appropriate balance between individual patient liberties as enshrined in the *Charter*, and the need to protect the safety of society as articulated in the *Criminal Code of Canada*, is a difficult one and common to all forensic psychiatric hospitals and services. I hope that my comments and recommendations will be of assistance to the Committee.

This report is based on the following:

1. A review of "Management of Restrictions on Patient Liberties in a Forensic Psychiatric Hospital Setting," August 2006, prepared by J. Livingston and J. Balmer from the Research and Quality Department of BC Mental Health and Addiction Services.
2. Review of the "Management of Patient Privileges in Forensic Psychiatric Hospital Settings — An Update," June 2012, prepared by J. Livingston, PhD, and K. Chu, BA.
3. Review of relevant policies and protocols made available for this review by twelve forensic organizations in Canada.
4. A review of the results of a survey completed in 2012 regarding the processes for granting community access in forensic organizations nationally and internationally.
5. With the other members of the Review Committee, interviews with:
   a. Senior management at the East Coast Forensic Hospital
   b. Members of the clinical teams
   c. Dr. Andrew Starzomski
   d. Selected patients
6. Review of selected clinical charts.

Literature Review and Case Law

The survey conducted by researchers Livingston and Balmer from the Forensic Psychiatric Hospital in British Columbia in 2006, entitled "Management of Restrictions on Patient Liberties in a Forensic Psychiatric Hospital Setting," comprised a review of the academic literature and synthesized the research evidence regarding the granting and restrictions imposed on patient liberties, a review of relevant Canadian case law and legislation, and lastly a nation-wide survey of Canadian forensic psychiatric organizations regarding how organizations balance the liberty needs of patients with public safety.

Forensic psychiatric organizations and hospitals are mandated by the Canadian Criminal Code and relevant case law to provide treatment and care to persons found Not Criminally Responsible on account of Mental Disorder (NCRMD) or Unfit to Stand Trial (UST) and to reintegrate them safely into the community. Despite the important and central role of this mandate, there is a dearth of research in the academic literature regarding this issue. In the 2006 systematic review of the research literature, three recent and relevant studies were identified. A study by Stübner, Gross, & Nedopil (2006) surveyed forensic practice in Germany and reported that of the twelve forensic hospitals canvassed, less than half used a pre-defined checklist of a fixed set of criteria to make reintegration-based decisions. More than 80 per cent of the informal criteria utilized were patient focussed, with less than 10 per cent referring to the therapeutic alliance or the patients' social environment, thus identifying wide variation across forensic hospitals.

A study by Collins and Davies in 2005 described the development of the Security Needs Assessment Profile (SNAP) for the identification of patient security needs. The article concluded that personal as well as institutional security could be improved and that rehabilitation efforts could be enhanced by the implementation of empirically based instruments such as the SNAP. An additional, and important, benefit was identified as the resultant increased transparency of the decision making processes.

A third study by Beer et al. (2005) focussed on forensic units in England and identified that a significant number of patients were housed at security levels inappropriate to their identified risk, hence impacting negatively on rehabilitation and liberty issues while adding to institutional operational costs.

An article by Petrila and Douglas (2002) focussed on legal aspects regarding care in secure hospitals. The need for comprehensive and thorough clinical documentation on patient charts was identified and the authors recommended that some form of review mechanism such as a Review Committee be implemented to make decisions regarding patient liberties. With respect to relevant legislation and case law, Livingston and Balmer appropriately noted that restrictions imposed on forensic psychiatric patient liberties are guided by the *Canadian Charter of Rights and Freedoms* and the *Criminal Code of Canada* and Canadian case law.

It is essential that the restriction of civil liberties on patients adjudicated under the mental disorder provisions of the *Criminal Code* are managed in accordance with section 7 of the Charter, which stipulates that everyone has the right to life, liberty and security and the right not to be deprived thereof except in accordance with the principles of fundamental justice. Section 9 of the Charter articulates the prohibition against arbitrary restriction of liberties.

Section 672.54 of the *Criminal Code of Canada* contains the mental disorder provisions that apply to NCRMD and UST accused persons and direct that the risk that they pose to the safety of the public and the treatment that they require be provided and managed in the "least onerous and least restrictive" manner.

Relevant case law in this regard includes *Winko v. British Columbia (Forensic Psychiatric Institute) (1999)*, where Madam Justice McLachlin provided the tests to be applied by the review boards and forensic clinicians when evaluating significant risk to the safety of the public.

In *Penetanguishene Mental Health Centre v. Ontario (2004)* the Supreme Court of Canada ruled that the "least restrictive regimen" principle applies not only to whether a patient shall be detained in hospital but also to the level of security within that institution where the accused is managed.

In *Orru v. Administrator, Mental Health Centre, Penetanguishene (2004)* the Ontario Supreme Court of Justice held that the continued detention in a maximum secure setting of a person who may be safely managed in a lower security setting violated their civil liberty rights protected in the Charter.

In *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services) (2006)* the Supreme Court of Canada held that the provision of medical care and therapeutic interventions is provided only in advance of public safety and to maximize the accused person's liberty interests. The Court emphasized that the primary purpose of the *Criminal Code* provisions is to protect the safety of the public while minimizing the restrictions on personal liberty. The manner in which forensic hospitals arrange for the application for, and review and granting of, community liberties has come under significant scrutiny.

In 2005 the BC Review Board in *Gielzecki* concluded that the manner in which the Programs and Privilege Committee of the BC Forensic Psychiatric Hospital operated likely transgressed the *Criminal Code* and *Charter of Rights and Freedoms*. The BC Forensic Psychiatric Hospital subsequently revised its policies and procedures governing the Programs and Privilege Committee and the Committee now operates in what is believed to be a fair and transparent manner. This issue, as well as the role and responsibilities of the person in charge of hospital as articulated in the *Criminal Code*, will be discussed further in subsequent sections of this report.

The 2006 review by Livingston and Balmer also included a survey of Canadian forensic hospitals, with eleven providing a response. In summary, there was considerable variation across forensic sites regarding the criteria for, and decision making regarding, community access. Of note is that some organizations criticized the use of the term "privilege" rather than as "rights" or "liberties," likely indicative of the sensitivity around this issue.

Earlier in 2012 an updated review of the management in which patient privileges and liberties are managed in forensic psychiatric settings in Canada was commissioned and completed by researchers in the BC Forensic Psychiatric Hospital. This was done as part of a comprehensive re-examination of the policies, practices and procedures employed at the BC Forensic Psychiatric Hospital regarding patient liberties, and serves in part to inform the current review. The review included an updated evaluation of the academic literature which identified a few recent articles but none addressing the issues of specific interest to this review.

As part of the 2012 review, a fifteen item questionnaire was developed to canvas the policies and procedures on a range of issues related to the management of patient privileges and liberties. The survey was sent by email to all known Canadian forensic hospital Directors. Nine organizations completed the survey, for a response rate of approximately 45 per cent.

Of the nine forensic hospitals that completed the survey, all but one indicated that they had a system in place for managing patient privileges. Five hospitals indicated that their liberty levels ranged from five to ten, with the remaining four indicating that they have not established formalized levels, with patient liberties loosely structured and based on informal guidelines.

Most of the survey respondents indicated that the responsibility for making liberty related decisions resided with the treatment teams, Administrative Directors, or multi-professional committees. Six of the nine forensic hospitals responding have established a system whereby the patient's clinical team makes recommendations to the Administrative or Clinical Director regarding patient liberties. For the remaining three hospitals responding, the responsibility for granting liberties rests with the individual clinical staff members or with multi-professional committees such as Privilege or Security Committees. In all responding hospitals a clinical staff member has the authority to revoke liberties. In all participating hospitals, patients have the ability to request a review of their liberty level, with four hospitals indicating that patients have the ability to appeal privilege-related decisions.

With respect to the criteria for determining liberty or security levels, there was considerable consistency across the nine participating hospitals. In almost all of the facilities, decisions are made on the basis of clinical and risk information that is routinely gathered by teams. There is significant disparity, however, in the manner in which the clinical and risk information is garnered. Six of the nine responding hospitals indicated that they use standardized assessments, including the HCR-20 or a variant thereof (n=2), the Short-Term Assessment of Risk and Treatability — START (n=1), some other format for brief structured clinical-based risk assessment (n=2), OAS (n=1), and the Bröset Assessment Scale (n=1).

The survey included twenty-six criteria, and respondents were asked to indicate which were important in decision making. Twenty-four out of the twenty-six criteria were deemed to be important by respondents when making liberty-related decisions.

All participating hospitals indicated that they had a policy or procedure in place for notifying external stakeholders about unauthorized absences.

2012 Review of Forensic Policies

In preparation for this report I conducted a review of available policies and procedures from twelve Canadian forensic hospitals. For ten of the twelve organizations the policies were revised within the last three years. Ten of the twelve hospitals report between three and six security levels, with two having more than six levels. For one organization the policies do not indicate the number of levels.

Similar to the findings of 2006, the majority of organizations have a mechanism in place whereby an Administrative Director or Security Committee reviews and approves liberties based on the recommendation of clinical teams. For one organization it was not possible to discern the process; in one hospital the interdisciplinary team has the decision-making powers and in one hospital it is the psychiatrist in consultation with the clinical team who carries that responsibility. In nine out of the twelve organizations, a staff member has the authority to revoke liberties, while in seven of the twelve hospitals there is no process established in policy regarding the reinstatement of privileges.

With respect to the use of risk assessment measures in the decision-making process, practice varied widely. In four organizations a structured risk assessment measure, or suite of measures, is identified (e.g., HCR-20, START, Risk Checklist, Camberwell Assessment of Need). In three of the twelve forensic organizations, reference is made only to some structured review of risk relevant information.

With respect to the East Coast Forensic Hospital (ECFH) specifically, the policy makes reference to the Camberwell Assessment of Need. In the course of this review it became evident that a comprehensive risk assessment is indeed completed soon after admission and that a brief structured measure, the Imminent Risk Rating Scale (IRRS), is also used. The ECFH policies make no specific reference, however, to this instrument or direct that it shall be used, but it would appear that the ECFH is in broad agreement with the majority of other forensic hospitals in the manner in which risk is assessed.

It would thus appear that in seven of the twelve hospitals, including the ECFH, policy directs that specific attention be focussed on risk relevant information, either in the use of structured, validated risk assessment measures or on a review of risk relevant factors. In all but one other forensic hospital, it was not possible to review the extent to which these

policies find adherence. It is evident, therefore, that in seven of the twelve hospitals there is recognition of the necessity of a structured review of risk related factors. This is in keeping with empirically informed and leading practice in forensic mental health.

It is nevertheless desirable, and it is recommended, that the East Coast Forensic Hospital revise its policies to identify and describe clearly the process and measures used when decisions regarding patient liberties are made. As for all organizations, compliance with policies needs to be verified through audit and regular quality review.

In all but one, forensic hospitals have clear policies regarding AWOLs and escapes. The East Coast Forensic Hospital is particularly strong in this regard and has a very clear protocol for staff to follow in the event of such an untoward outcome. The East Coast Forensic Hospital is also particularly strong in the quality review forms that are used.

Interviews with Senior Management, Staff and Patients

The East Coast Forensic Hospital commitment to patient-centred care was strongly evident throughout the interviews with senior leadership, members of the clinical teams and with patients. While maintaining the delicate balance between ensuring the safety of the public and protecting patient liberties is a daunting challenge, and may readily default to a correctional model, I did not at any time gather the impression that the hospital was draconian, punitive or overly restrictive in its approach to the engagement of patients in the rehabilitative pathway.

Following a tour of the hospital the committee and I met with members of the senior management team. We were informed that policies were revised in 2011 and that the rates at which patients complete community access successfully were in excess of 90 per cent.

The pathway towards community access for some patients commences in the ECFH even before the first CCRB hearing, with some patients receiving unescorted community access privileges within forty-five days of being found NCRMD, even before their first formal CCRB hearing. It is my understanding that in certain cases a request for unescorted community access privileges is made to the CCRB and that a preliminary hearing is then held prior to the first formal CCRB hearing. In my experience, and from my review of the polices, practices and the surveys of forensic hospitals, this practice is unique to the ECFH and the CCRB and the practice probably is the result of a combination of the expectations of the Nova Scotia CCRB regarding patient liberties and the strong rehabilitation focus that the hospital embraces. It is my further understanding that the CCRB has more recently expressed its discomfort with this process and prefers that all privileges be discussed and decided upon at a formal hearing of the Board. The issue of whether such a "preliminary"

hearing constitutes a formal hearing pursuant to the direction of the CCC, is an interesting one, and should be clarified by the respective legal parties, should the practice continue.

I could not escape the impression that repeated and insistent requests from patients to be granted privileges outside the hospital in order to smoke may result in rapid progression towards community access. It is therefore not unusual for patients to be granted unescorted leave to the bus stop just outside the hospital perimeter in order to smoke. There were also what was described as "individualized" views among certain clinical teams regarding privileges and the response following unauthorized absences. Indeed, comments by staff included that "AWOL has become a culture in the hospital".

The process map for the review of liberties starts with the clinical team making an application to the Senior Administrative Manager who reviews the application and, if approved, returns it to the unit where the attending physician enters the order into the clinical chart. Patients are requested to provide and adhere to an itinerary and keep a log of their whereabouts while in the community.

I am informed that the Nova Scotia CCRB, when a custodial disposition is made at its first hearing, typically grants up to six overnight leaves at the discretion of the clinical team. Privileges range from Level 1 to Level 5, which includes Conditional Discharge but with the patient still required to reside in the hospital. These arrangements may be in effect for months to years while a suitable community placement is finalised.

The committee and I had the opportunity to hear a presentation by Dr. Andrew Starzomski, PhD, a psychologist in the hospital. Dr. Starzomski described the rationale for, as well as the design and development of, the IRRS, a brief structured measure for the assessment of violence risk in the short term. The IRRS was developed following a realization that ECFH staff were at a 10 per cent per year likelihood of being the victim of patient on staff assault. Dr. Starzomski reported favourable short-term predictive validity correlations for the IRRS and that it is intended for use on all admissions and at regular intervals as well as on an as-needed basis following an untoward event or unexpected change in clinical status. In practice the IRRS is coded at a frequency of between one week and one month, and all Registered Nurses have been trained in the measure. It is intended to inform all risk management strategies and to facilitate enhanced communication of risk relevant information during shift handovers.

From a review of randomly selected clinical charts and interviews with the clinical team members, it is evident that the IRRS is completed at the beginning of the patient's stay but at irregular intervals thereafter and does not appear to inform risk related decisions in any structured or consistent manner. This is unfortunate, as clinical teams are advised in policy to utilize all available risk related information in making these important decisions. Risk assessment measures can assist not only in ensuring that patients receive and avail

themselves of appropriate liberties within the hospital and into the community, but also bring greater transparency to the process whereby public safety concerns are considered when deciding in patient liberties into the community

Dr. Cohen, another psychologist on staff, described the standardized process whereby formal risk assessments are completed upon admission. These include a measure of psychopathy (PCL-R), an actuarial risk measure (VRAG), and a structured professional guide for the assessment of risk in the medium term (HCR-20). This process is to be commended and represents a leading practice in Canada for risk assessment in forensic psychiatric hospitals.

The results of these assessments however, do not appear to inform the decision-making process regarding privilege levels. Clinical team members report that in the course of team meetings the patient's mental state, substance abuse history, program requirements and history of unlawful absences are considered as well as the IRRS and other risk assessment information from file. Such a process, while exemplary, was not evident from a review of clinical charts and completed Community Access Forms. The process by which teams apply for a change in liberties will be addressed later in this report.

There appears to be consensus among the members of the clinical teams interviewed that the more recent practice of one hour unescorted community access, introduced since the hospital wide smoking ban, has been problematic. The teams acknowledge that there has been a decreased threshold for granting one hour passes as opposed to three hour passes despite equal risk of AWOL. The committee was informed that smokers were likely to press for one hour passes and are more likely to have these granted when compared to non-smoking patients, even if a risk assessment indicates them to be at a higher risk than non-smokers for untoward outcomes. The teams also felt that unescorted community liberties, combined with confusion regarding search policy and practices, have resulted in an increase in the illicit drug trade in the hospital.

The committee members and I interviewed seven patients. They were uniformly complimentary about the care that they receive and appreciative of the attention to their desire for community reintegration. They would welcome greater opportunity for personal contact with the nursing staff and reported inconsistent practices across individual nurses and shifts regarding opportunity for interviews and responses to requests. While the patients were appreciative of opportunities for community access, they were clearly also acutely aware of the need to protect the safety of the public and volunteered that on some occasions they were surprised to see patients being granted community leave despite obvious and evident risk markers. It is therefore recommended that the hospital find mechanisms to increase the frequency for individual interviews and contact with staff, as this would enhance the likelihood of signs of a destabilised mental and/or emotional state being recognized at

an earlier stage. Clearly, the patients would welcome more contact with professional staff and, should this be facilitated, would likely result in improved therapeutic alliance. Some patients reported frustration with the need to call the hospital while on community passes, and suggested that the use of hospital issue cell phones be considered.

Selected Chart Review

Seven clinical charts were selected randomly for review. By and large, the charts were found to be in compliance with the policies; in all cases the CCRB liberty ceiling was on file, Community Access Forms completed, privilege levels identified and ordered, and the approval of the Administrative Manager recorded. A copy of at least one IRRS was available on all files but not addressed or included, or evidently considered, when access to the community was applied for. Evidence that the formal risk assessment suite had been completed was included on all the files, but as noted above, the process whereby teams consider the results of risk assessment during community access related decision making was unclear.

Evidence that staff largely complied with relevant policy was apparent from the files reviewed. However, a significant gap appears to exist between the proceedings of Service Implementation Plan (SIP) meetings, where recommendations are finalised regarding privilege changes, and the completion of the Community Access Forms (CAF). With one exception, there was no dissenting vote recorded on file regarding the agreed upon privilege level on the CAF. Identified challenges with this process present opportunity for enhanced practice; for example, the team members not infrequently canvass opinion regarding what recommendation to make to the Senior Administrative Manager via email and do not always meet in person to discuss the issues. Furthermore, the person completing the CAF may not have been present at the SIP and the signatures of consenting staff members are canvassed and the opinion of dissenting members reportedly discarded. This is problematic practice. Power imbalances within the team may result in one member having undue influence while the voice of others is ignored or dismissed; the lack of consistent opportunity to meet in person may result in important information not being communicated or recorded, and the requirement that only nurses may complete the CAF has resulted in frustration for other members of the team who were present at the meetings and who feel capable of completing a detailed application form. It is therefore recommended that SIP meetings be formalized and structured so as to ensure, as far as is practicable, the attendance of all available team members and that the CAF be completed by a team member who was present during the SIP meeting. All members present at the meeting should be asked to indicate by means of signature their agreement with, or dissent from, the recommendation. All relevant clinical and risk related information should

be recorded on the Community Access Form and should constitute the only document upon which the Senior Administrative Manager bases their decision. The use of informal communication, such as by email to provide additional information not included on the CAF, should be avoided.

Risk Assessment Process

The East Coast Forensic Hospital uses an exemplary range of risk assessment instruments, including an assessment of psychopathy for long-term risk of violence, the Violence Risk Appraisal Guide (VRAG), which is an actuarial measure for long-term violence risk appraisal, and the HCR-20, a clinical structured judgment measure for violence risk in the medium term. In addition, the Imminent Risk Rating Scale (IRRS) is a brief checklist for assessing risk for inpatient violence over the next ten days. The IRRS was developed by psychologists at the East Coast Forensic Hospital and is designed to be administered upon admission, at regular intervals, and whenever there has been a significant change in behaviour or mental status.

This suite of risk assessment measures is comprehensive and impressive and likely represents leading practice in Canada. Unfortunately, at least as far as is evident from interviews with staff and review of randomly selected clinical charts, there may be a need for greater structure to assist clinicians in connecting the results of assessments with risk related decision-making processes. While staff members reported that the results of risk assessment are discussed during team meetings, it is not clear how risk ratings inform recommendations for increased liberties. The approach by the Nova Scotia CCRB, with reported expectations to initiate rehabilitation, including unescorted community access as soon as possible, even perhaps prior to the initial CCRB hearing, may place the hospital in a difficult position. The results of formal risk assessment thus may identify a patient as posing a significant risk for violence and that a cautious approach to community reintegration would be appropriate, but agitated demands by patients for community access in order to smoke, combined with the risk of being perceived as punitive or overly restrictive, represent a scenario whereby patients may be granted unescorted community access at an inappropriately early stage of their rehabilitation.

The availability of unescorted community access to ECFH patients who are yet to appear for their first CCRB hearing is unusual and as far as I am aware, unique in Canada. It is unlikely that Parliament intended in the mental disorder provisions of the *Criminal Code* that persons who have been found NCRMD could have unescorted access to the community before the CCRB has had opportunity for a formal and detailed review of clinical and risk related information. As stated earlier in this report, I am informed that the Nova Scotia CCRB has expressed their discomfort with preliminary reviews and prefers a formal hearing before making the appropriate disposition.

Risk Decision

Finding the right balance between patient liberties and public safety is of course a daunting task. Identifying and developing measures to ensure that the results of risk assessment inform clinical risk management decisions as well as recommendations for changes in liberties decrease the likelihood of harm to the public and staff while ensuring that the rehabilitation pathway proceeds at an appropriate pace.

Madam Justice McLachlin, writing for the majority in *Winko v. British Columbia (Forensic Psychiatric Institute) (1999)*, states that the Review Board should attend to the expert opinion available to it when making decisions regarding the risk the accused person poses to the safety of the public. If the risk is not significant the Board must grant an Absolute Discharge. If the accused person is deemed still to pose a significant threat to the safety of the public the Review Board must retain jurisdiction. The level of care and management of risk must be in a manner that is "least restrictive and least onerous."

ECFH Policies

The current ECFH policies require that recommendations for a change in privilege levels be made by the clinical team to the Senior Administrative Manager. From interviews with staff, the information is provided to the decision maker in various forms, including the Community Access Form, email communications and personal communication. The quantity and quality of information provided appears diverse. The East Coast Forensic Hospital may wish to consider a minimum data set of information to be provided to the decision maker in a consistent format. This would enhance consistency and a standardized approach to decision making with enhanced transparency of the decision making process.

The primary foundation upon which risk relevant policies rest, is described in the *Criminal Code*. In section 672.54, regarding the terms of dispositions and the responsibilities of the Review Boards, the Code states: "Taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is the least onerous and least restrictive to the accused . . ."

In this short statement, the key ethical principles upon which assessments about dispositions, and by implication, passes and privileges, are made are clearly outlined. As such, an integrated approach is required to meet these principles; namely, to ensure public safety, to balance with due consideration the mental health needs and to reintegrate accused persons into society while utilizing the least restrictive means available for the management of the patient at any point in time. This approach grounds and should inform all policies and practices related to passes and privileges for forensic patients.

As discussed under various headings in this report, a comprehensive suite of ECFH policies related to patient privileges and community access was reviewed. It is evident that the ECFH policies are in broad alignment with other forensic hospitals in Canada.

In addition, given that the East Coast Forensic Hospital is part of Capital Health, its policies and procedures should meet the expectations and requirements of the District as appropriate for this facility. This means that, at a minimum, the values and principles of person centred care, transparency, consistency, and accountability are relevant for any and all policies related to passes and privileges.

These considerations as set out in the *Criminal Code* need to be the focus of the granting of community access privileges and therefore should be noted in policy as guiding principles. To do so in a separate policy section would help distinguish the opening policy statement in the current policy from the statement of values and principles that support what the policy establishes and facilitate understanding, integration and connection between the various policies.

Training and Roles

It is essential in complex organizations such as forensic mental health facilities that the roles and responsibilities of team members be clearly defined, articulated and communicated. This is especially important in risk assessment and the risk related decisions that are required at each level of privilege, as well as first unescorted community access. Registered psychologists and psychiatrists are the appropriate team members to conduct formal risk assessments such as the PCL-R, VRAG, and HCR-20. Psychiatrists, psychologists and Registered Nurses, if suitability trained, are appropriate to complete IRRS assessments. Members of the nursing staff are best positioned to monitor their patients for day-to-day changes and to conduct daily assessments.

Recommendations

Given my impressions, findings, and opinions regarding the issues discussed, the following recommendations are made:

A. General Policy

Recommendation 1

- Include a "guiding principles and values" section within the relevant policies to reflect and highlight the above-noted values and principles as well as any others that may be deemed appropriate.

Recommendation 2

- Consider whether there should be one overarching policy or framework that has different sections that cross the range of passes and privileges (e.g., from getting the first pass to gaining more privileges, to revoking and reinstating privileges) to help unify and support consistency and practice.

B. Risk Assessment and Privilege Levels — Process and Oversight

Recommendation 3

- That the consideration of identified risk for violence and/or AWOL be clearly linked and documented in relation to the granting of community access privilege levels.

Recommendation 4

- That ECFH give further consideration to the processes for granting first access to the community and first unescorted access to the community. This would include a consideration of the level of detail provided to the person in charge of the hospital for review before granting such privilege, particularly prior to the first CCRB hearing.

Recommendation 5

- That the East Coast Forensic Hospital revise its policies to identify and describe clearly the process and risk assessment measures used, and how they inform decisions regarding patient liberties, including clarity around documentation expectations.
- That mechanisms be explored to ensure that the opinions and recommendations of all staff members, including those who have most frequent contact with the patient, be included as an essential part of risk assessment, and are incorporated into team decision making. Dissenting opinions should be clearly documented.
- That risk of AWOL be assessed and documented separately from violence risk assessment, but also considered in the granting of community access privileges.

Recommendation 6

- That the Community Access Form be revised to ensure that it is signed by a team member who attended the SIP meeting; provides for a summary of the pros and cons of the recommended level; includes the risk relevant data and documentation; identifies the level of risk; i.e., low, medium or

high risk for violence presently, should the recommended level be approved. The information and documentation in support of a recommended change in privilege levels should be contained in this single document and submitted to the Senior Administrative Manager for review and decision.

Recommendation 7

- That a protocol be developed for the assessment of the patient's daily suitability for proceeding with accessing the community. This assessment should be done by nursing staff who have contact with the patient. It should include an assessment by an appropriate RN in the morning, and a briefer assessment by staff at the time of authorizing the particular pass, and should take into consideration risk level as per documented risk assessments.
- As part of the protocol, the daily assessment should be documented. In addition to the current practice of documenting the clothing worn by the patient at the time of the pass, nurses should also:
- Assess the patient's mental status for suitability to go on a pass.
- Review the chart to ensure that the patient has the appropriate level of privilege.
- That nurses be supported in their decision to withhold a pass based on the patient's presentation and mental status.
- That should a pass be held, the reasons and support for the hold be clearly documented.
- That the ability of any staff member to hold privileges be continued as currently is the case. Privileges should be suspended when a client has received additional medications or interventions due to unusual or unstable behaviour.

Recommendation 8

- That the monitoring and review of patient behaviour while on pass by the clinical team as described in the ECFH pass monitoring policy be supported and continued.

Recommendation 9

- That the monitoring and review of patient behaviour while on pass by the clinical team as described in the ECFH pass monitoring policy be supported and continued. ECFH should explore the possibility of using cell phones and pagers to offer additional monitoring options.

Recommendation 10

- That ECFH consider the establishment of a hospital committee consisting of senior clinical and non-clinical members, external to the clinical team, to advise the person in charge of the hospital whether to approve the change in privilege level.

Recommendation 11

- In order that the role and responsibility of the person in charge of the hospital regarding community access privileges be emphasized in policy, consideration be given to including in the community access privilege policy a statement about the role of the "person in charge of the hospital." For example, "The East Coast Forensic Hospital has been designated by the Minister of Health as a 'hospital' under section 672.1 of the Criminal Code. The Capital Health Authority has appointed XXX as the 'person in charge of the hospital' for the purpose of part XX.1 'mental disorder' of the Criminal Code. If the Nova Scotia Criminal Code Review Board delegates authority to the person in charge of the hospital to direct that the liberty of an accused person be increased or decreased under section 672.56(1) of the Criminal Code, this authority must be exercised by the person in charge of the hospital and cannot be Delegated."

C. Training

Recommendation 12

- That everyone involved in risk assessment be trained to a level appropriate to their level of involvement. This should include that all psychiatrists and psychologists be given the opportunity for formal risk assessment training including, for example, the PCL-R, HCR-20, VRAG, SORAG, SVR-20, RSVP, IRRS and others as required. LPNs should be trained and be able to monitor patients for changes in mental status and behaviour. All staff involved in protocols established under Recommendation #7 should be trained on their roles and expectations.

Recommendation 13

- That ECFH explore training opportunities to enhance a culture of team cohesion and collaboration, particularly in relation to risk assessment.

D. Quality Review

Recommendation 14

- That compliance with policies, protocols and procedures be reviewed through regular audits and quality processes.

Recommendation 15

- That after each AWOL the patient's privileges be held until the appropriateness of continued community access can be reviewed by the patient's clinical team.

Recommendation 16

- That ECFH have a Capital District Health Authority (CDHA) quality review process for every AWOL lasting more than one hour.

Recommendation 17

- That the CDHA and the ECFH consider a meeting with the CCRB to discuss and clarify the Board's view of, and expectations regarding, the balance between public safety and patient liberty rights.

Summary

The East Coast Forensic Hospital has significant strengths in several areas including a broad suite of policies, comprehensive formal risk assessment protocols, clearly identified privilege levels, as well as physicians and staff who are truly committed to patient centred care and rehabilitation.

Opportunities for policy revision, standardized practice, improved documentation and team functioning as well as enhanced transparency of risk relevant decision-making processes have been identified, and recommendations offered for consideration.

I thank you for the opportunity to assist the Review Committee. I trust you will find my observations, opinions and recommendations helpful.

Sincerely,

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