Appendix F:

Review of Policies and Procedures of the Capital District Health Authority in Relation to Policies and Procedures Relevant to the Care and Supervision of Forensic Patients

Report for the Department of Health and Wellness, Nova Scotia

August 2012

Dr. Alexander I.F. Simpson MBChB, BMedSci, FRANZCP
Centre for Addiction and Mental Health (CAMH), and University of Toronto
Unit 3, Centre for Addiction and Mental Health
1001 Queen St West
Toronto, Ontario M6J 1H4
email: Sandy.Simpson@camh.ca

Contents

Executive Summary

This Review followed an incident of alleged serious offending by a patient from the East Coast Forensic Hospital (ECFH). The Review focused on placing policies and procedures employed at ECFH into a national and international context, assessing the strengths of these policies in order to make suggestions about areas for policy enhancement.

The methodology employed was a review of policies and procedures in the area of granting leaves to forensic patients from across Canada, and informed by like policies in similar jurisdictions. This was followed by a review of relevant literature, with a focus on policies and practices employed in other locations and patterns or rates of absent without leave (AWOL) behaviour. Linked to this is the limited literature in relation to how to assist clinical decision-making with risk assessment or service procedures. Finally, a small amount of information was also available about novel approaches to the issue of electronic monitoring of forensic patients during leave.

Putting all these strands of evidence and opinion together, the Review found that the ECFH's policies and procedures are similar to those commonly employed across Canada, and in a number of key areas they are superior to many other forensic programs' policies. There are, however, some areas where the policies could be enhanced to a standard of international best practice, primarily:

- The institution of a process of senior clinical and administrative oversight of the granting of leave;
- The introduction of a structured professional judgment tool to assist clinical teams in making leave decisions;
- Tightening the definition of AWOL;
- Enhancing formal processes of clinical quality audit of incidents of AWOL; and
- Consideration of victim impact and wider public impact when making leave decisions, which is more common in other jurisdictions than Canada but which may be worthy of inclusion also.

Policies of some forensic programs across Canada provide examples of how to address of these issues. All forensic programs grapple with similar issues. It is important that this process is seen as one of joint learning and sharing of experience and expertise. Evidence from the scientific literature is only a partial guide to those making and developing policy in this area. We lack formal or rigorous studies into the causes of, and best response to, the problem of AWOL behaviour.

1. Background

On April 16, 2012, a patient of the East Coast Forensic Hospital (ECFH), who had been granted unsupervised community privileges, failed to return from a community leave pass. The patient was subsequently reported absent without leave (AWOL). Later that night, the patient was involved in a serious act of violence in which a member of the public died. Consequently, a coordinated series of reviews was commissioned jointly by the Nova Scotia Department of Justice, the Department of Health and Wellness, and Capital District Health Authority (CDHA). This review is one of three reviews.

2. Terms of Reference

The following terms of reference define the purpose and scope of this review:

The Department of Health and Wellness shall (inter alia):

- Engage an out-of-province expert in the area of forensic mental health to conduct a review of:
- Department of Health and Wellness's standards related to forensic services.
- CDHA's policies and procedures related to community access privileges, notification of the public in the event of a failure to return, and patient surveillance.
- Compare the standards, policies and procedures against best practices both nationally and internationally.

3. Outline

Forensic patients relevant to this review are those persons subject to orders pursuant to Part XX.1 of the *Criminal Code* under the jurisdiction of the Review Board system. Whilst forensic patients are a relatively small number of clients in the broader mental health system, they appear to be increasing in number in many parts of Canada (Latimer and Lawrence 2006). They are an important patient group. They have been found to have committed a criminal act, or have a prima facie case of having done so, but they have either been found not criminally responsible for that act because of mental disorder, or unfit to stand trial in relation to the index charge(s).

The *Criminal Code* requires that a plan of care is established for each person that attends to the rehabilitative needs of the accused person, and at all times considers the safety of the public. Such plans are made in a careful and progressive manner. They

include setting the level of security that the person is subject to, and the opportunity to have access to the community under certain conditions. The clinical service responsible for the person's care, through the Person in Charge, then implements that plan of care at a rate appropriate to the person's current progress. This care plan is reviewed at least annually by the Review Board. Issues such as control of symptoms of illness relevant to risk, control of substance misuse, improved impulse control and building therapeutic alliance with staff allow for a gradual and progressive increase in privileges. The rate at which this process occurs is patient-specific, and offence-specific. Relevant victim issues can be important factors to include in this decision making.

The patient's trajectory through care may have periods of progress, followed by periods of relapse or consolidation. Serious mental illness may follow a relapsing course. Forensic recovery is a broad-based enterprise. In addition to treating the person's illness, other problems in life (antisocial networks, drug and alcohol use, antisocial attitudes) are also issues that must be addressed therapeutically if they contribute to the risk of relapse or reoffending. Exposure to stressors or destabilizers such as drugs and alcohol are common issues that must be overcome, as are issues such as understanding the need for medication and compliance with imposed conditions.

The attending clinical team, the Person in Charge of the Facility and the Review Board must grapple with these issues to both encourage the person to succeed but at no time take undue risks in making these decisions of granting privileges and increasing community access. This is not an exact science, nor one that is very well defined in literature. But increasingly there are emergent principles for approaching these challenges to help guide clinicians, Boards and forensic systems to make such decisions in a careful, planned, transparent and consistent manner.

This report will, firstly, attempt to summarize the extant literature in this subject internationally. Secondly, it will review the practices across Canada as evident in the policies and procedures provided to Nova Scotia. On the basis of the literature and the scan of Canadian policies, it will describe a series of questions that can be asked of a system of granting privileges and responding to incidents of AWOL. Thirdly, a series of questions will be used to review the adequacy of current Nova Scotia policies and procedures, both those of the Department of Health and the ECFH and evaluate them in relation to the literature and Canadian comparisons. Finally, the report adds commentary on what little is known about novel approaches to this area.

4. Methodology

To complete this review, the author reviewed an extensive array of documents provided by the Department of Health and Wellness.

Firstly, the author was provided with the policies and procedures of Capital Health relevant to these Terms of Reference.

Secondly, the author was provided with a survey of similar policies from across Canada, which had been provided pursuant to an email request from Mr. Kevin McNamara, Deputy Minister, Department of Health and Wellness, dated April 20, 2012. Most Provinces and Territories provided copies of their policies and procedures in relation to the granting of passes and the management of incidents of AWOL. Those documents are listed in the Documents Reviewed section at the end of this report.

Thirdly, the author held discussions with both members of the Department of Health and Wellness, with Dr. Aileen Brunet, Clinical Director of the East Coast Forensic Hospital, and with Prof. Johann Brink, Vice President, Medical Affairs and Research, Forensic Psychiatry Services Commission, British Columbia Mental Health and Addiction Services.

Fourthly, the author conducted a literature review of the relevant areas, and briefly summarized that (rather limited) literature. The author was greatly aided in this by the sharing of research methods with Prof. Brink, and the annotated bibliography that his group, especially Dr. Jamie Livingstone, has produced. That material will not be repeated here in great detail, but emergent themes relevant to the purpose of this review will be presented.

Finally, the author contacted colleagues in the United Kingdom who are considering the issue of the application of electronic monitoring of forensic patients whilst on community passes.

5. Literature Review and Clinical Experience

5.1 Literature Review

The literature review focused on papers which provided either quantitative data or reviewed relevant literature. Forensic populations were of particular relevance but there have been few such studies in forensic settings analogous to the ECFH. Only limited information can be gleaned from studies on the general mental health samples.

A search on Google Scholar employed a number of terms, for which the most relevant — "AWOL," "Elopement," "Forensic Psychiatry," "Reviews" — yielded 32 citations.

Excluded were papers not in English (1), papers that were not forensic (7), book descriptions or citations without data (10), purely descriptive (1), and policies only (9). This left three papers, two of which were valuable reviews. The third paper was of absconding from a high security hospital and is, therefore, not analogous to the ECFH.

The review of Bowers et al. (1998) is the first major review of absconding from mental health settings and includes a subset of forensic samples. It provides a valuable overview of absconding issues, and attempts to standardize a measure of absconding rates. However, the means employed to calculate absconding rates was not consistent and it was not possible to derive a typical or mean rate of absconding from forensic units from that study.

The second review is from the same group, that of Stewart and Bowers (2011). They were able to find 11 published studies of absconding from forensic facilities, but few from secure units analogous to the ECFH. They could derive absconding rates from four of these studies, with a median rate of 0.76 AWOLs per month per 100 beds (range 0.04 to 1.06). This translates to 9.12 AWOL events per year per 100 beds (range 0.48 to 12.72). Note the very low figure is from a maximum security hospital sample from 50 years ago so is not a fair comparator. The two rates of 0.62 and 1.06 are both from UK medium secure units, reasonably analogous to ECFH. However, the first, that of Dolan and Snowden (1994), was of escapes from inside the facility and is, therefore, not comparable. Only the study of Smith and Quaynor (1990) is comparable. They looked at all absconding and AWOL incidents over a 6 year period and found a rate of 1.06 per 100 beds per month, or 12.72 per annum.

I note that ECHF reported 25 incidents of absconding last year, for 84 beds, though they suggested this may be an under-reporting of the "true" rate. This is an annual rate of 29.8 per 100 beds per annum, but the comparability of this to the study of Smith and Quaynor is unclear.

Not well described in the literature is the motivation for AWOLs, although Bowers et al. (1998) usefully summarize these themes. Some patients may AWOL out of frustration, their progress may be too slow, they lack hope in their future directions or staff are not responding to issues they need support with. Some patients go AWOL for issues of addiction, to obtain drugs, because they lack direction, meaning or ability to contain addictive drives. Some patients are simply disorganized (whether through symptoms of illness, inattention or organic brain impairment). It is also important to distinguish those who are simply late (missed bus, traffic, other unavoidable event) from those who willfully absent themselves. A technical "AWOL" of being late back from a leave may not be a behaviour motivated by a desire to AWOL. Each of these situations requires careful assessment on the person's return to the hospital. Of more concern are the persons who go AWOL for particular issues of illness, because of delusions, depression (which may

have suicidal motivation) or because of persisting delusional ideation that may be relevant to offending. Indeed, there may well be an overlap between these motivations. There are no published typologies of these types of offending in the forensic literature, though all of these are recognized in clinical practice.

5.2 Structured Tools

There is a series of structured professional judgment and risk related tools that can contribute to assessing issues of AWOL risk. Livingston and Balmer (2006) noted there is no information on the effectiveness of these tools in predicting AWOL incidents, though Livingston has updated this study with the annotated bibliography.

Lyall and Bartlett (2010) performed a qualitative study of how clinical teams make leave decisions. In their UK sample, leave decisions were not approached using a structured approach but rather on the basis of two themes: risk and humanity, and power and responsibility. Recent compliance was more important than longer term risk.

Hilterman et al. (2011) developed a tool to assist in making leave decisions following high profile reoffending of forensic patients whilst on leave in Holland. It does not specifically reference AWOL, but instead uses a structured assessment approach to predicting those at risk of reoffending whilst on leave. Their study demonstrated that the HCR-20 predicted reoffending on leave, but their tool, the Leave Risk Assessment (LRA), added to this predictive ability.

Thus, the literature, limited though it is, argues that leave decisions should be guided by structured risk tools (see for example, Livingston and Balmer 2006; Lyall and Bartlett 2010; Hilterman et al. 2011; McDermott et al. 2008). Tools suggested include the major structured professional judgment tools such as the HCR-20 (and a specific reworking of it entitled the DUNDRUM), the SNAP and the START. Also now worthy of consideration is Hilterman et al.'s (2011) LRA. There is no published data comparing or differentiating these tools for the purpose of making leave decisions. There is professional consensus that such an approach is warranted. In part, the tool employed may depend on the types of decision to be made. The HCR-20 is best used for time frames of weeks to months, so may be best suited to Criminal Code Review Board reports and decisions about levels of leave. The START is designed for shorter time periods of risk assessment (days to weeks) so may be better suited to specific leave levels. Current mental state and engagement should, however, be assessed prior to each episode of leave, decisions which these tools are not designed to assist with. Here, a pro forma or mental state measure is more valuable.

5.3 Experience of the Reviewer

As noted, there is a dearth of published material in this area. However, the author has been involved with, or is aware of, forensic mental health services in Australia, New Zealand, and Canada, and has also discussed this subject with colleagues in Europe and the UK who have successfully addressed the issue of AWOLs. From these discussions, the author is aware that very similar problems to the ones that gave rise to this Review have occurred in other jurisdictions, and they can be successfully addressed.

All programs which faced these problems carefully reviewed and modified processes and procedures around granting of leave. Tightening such practices has been found to reduce the numbers of AWOLs. Specifically, the author is aware of, or has observed, four forensic services of moderate size (100–200 beds) who have successfully improved the incidence of AWOLs. Successful procedures employed in these programs included tightening processes by establishing privilege committees (two programs), implementation of external clinical review prior to first unescorted off-ward leave (one program) and the institution of electronic monitoring (one program).

The programs with the most serious events precipitating the review of procedures (homicides) implemented the most formal review processes after the event. There were clearly two reasons for this. The first was to ensure clinical rigour and consistency. Some forensic patients are capable of manipulating others; at times clinical teams can tend to minimize long term risks after short term stability. External review can assist in assessing long term risks. Second, it makes it clear to the patient that issues of privileges and adherence to the conditions imposed are serious and important, and conditions of leave must be adhered to. If not, there will be careful review of progress. Finally, it can be important in convincing other statutory or administrative authorities, and the public, that the clinical program takes the issues of risk seriously and responsibly in making leave decisions.

6. Review of Policies and Procedures in Other Canadian Jurisdictions

6.1 Policies

Mr. Kevin McNamara, Deputy Minister, Department of Health and Wellness, sent an email to other Deputy Minister across Canada, dated April 20, 2012. The Deputy Minister requested policies and procedures relevant to the granting of privileges to forensic patients and to policies and procedures in relation to AWOL or elopement of such patients.

The following provinces (British Columbia, Saskatchewan, Newfoundland) and one Territory (Northern Territory) provided their policies. Ontario provided policies from six of their nine forensic programs. Those documents are listed in the Documentation Reviewed section of this report, and represent a very useful comparison group for consideration in benchmarking the Nova Scotia policy. In analyzing these policies, all were read and the key factors in relation to them are summarized in the following tables. They are divided into all of Canada (note that five provinces and one territory did not submit policies, though three of these would have little need for them) and then for the six forensic programs from one provincial jurisdiction, Ontario. Despite the small number missing policies, those submitted represent both larger and smaller provinces and programs, meaning the policies are from a range of programs of similar size to Nova Scotia. This provides a sound basis for benchmarking Nova Scotia's polices against peers, as well as exploring best practice. Further, international reference is assisted by considering the approach of the Ministry of Justice in England and Wales to supervising leave decisions for forensic patients. Their approach is included in this review of policies also.

6.2 Leave-related Policies

The key issues which the literature suggests need to be addressed in policies include how the decision for privileges is arrived at, the tools and processes employed to make a recommendation, who is involved in making the decision, what client involvement is included, and immediate decision making prior to individual episodes of leave. All policies were read with these issues in mind, and the results are presented in Table 1 (all of Canada and England and Wales) and Table 2 (for Ontario programs). All policies were current; that is, reviewed or updated within the last four years. Note that some missing policies were not shared, as the program was currently updating the policy.

Table 1: Provincial and Territorial Policies of Granting of Privileges for Forensic Patients

Province or Territory	Policy name	Levels of privileges considered	Who grants the privileges	What risk assessment process used	Review prior to episode of leave	Comment
British Columbia	Program and Privileges activity levels; Patient Leaves and Ground Privileges	Six levels of privilege status within the hospital and into the community	Program and Privileges Committee, on application from clinical team	START* and clinical team review; patient engagement unclear	Yes, by clinical team, attending nurse	Very comprehensive with evidence base and rationale for policy settings
Saskatchewan	Inpatient Leave of Absence	Six levels of responsibility	Director of Forensic Services and Chief Psychiatrist	Nil stated, MDT case review appears to be where issues are considered	No comment	Covers all types of patients, forensic all deemed high risk
Northern Territory	Passes for involuntary patients	Not stated	Most responsible physician	Assessment by most responsible physician	Not stated	—
Nova Scotia	Community Access Levels	Five levels plus sub-categories	Health Services or other Manager on recommendation of the clinical team	Clinical team assessment and completion of form	Locally produced "Imminent risk rating scale"	Well structured but lacks guidance re clinical assessment
England and Wales	Leave of Absence for patients subject to restrictions	Five levels of leave	Ministry of Justice civil servants	Pro forma with nature and purpose of leave, patient's current state, risks, victim issues and absconding risk	Yes, clinical team expected to do so	Clearly stated and described; report on progress of leave no less than 3 monthly

* START is the acronym for Short Term Assessment of Risk and Treatability.

Table 2: Ontario Forensic Programs' Policies for Granting Privileges for Forensic Patients

Jurisdiction	Policy name	Levels of privileges considered	Who grants the privileges	What risk assessment process used	Review prior to episode of leave	Comment
ROHCG	Privileges for Patients with Dispositional Orders	Five levels of passes into the community	Clinical director on recommendation of attending physician	Individual clinical assessment and using a "Risk Checklist"	Not stated	Useful flow chart to guide staff
Waypoint	Discretionary Privileges in Criminal Code Dispositions	—	CEO on recommendation of the Program Director and Clinical team	Clinical Team consensus	Not stated	—
Ontario Shores	Granting Privileges to Forensic Patients	Four levels of community access privileges	Administrator on recommendation of the clinical team	Clinical case conference with the patient	Timetable reviewed by nurse of shift	Use a patient log book to make leave conditions clear
CAMH	Privileges Policy	Six levels	Administrator on recommendation of attending physician	HCR-20* based professional judgment tool	Yes, nursing review	Policy being revised
Providence	Privilege Levels	Six levels	Forensic Administrative Director, on recommendation all clinical team	Clinical form setting out current status, requested privileges, also reinstatement	Yes, by nursing staff	Helpful form, and includes log book

* HCR 20 refers to the Historical, Clinical and Risk 20 scale.

As can be seen from Tables 1 and 2, it is usual for the issues of leave to be considered by either the clinical team by consensus (or, in one case, each member and discipline signing the privilege status request), and the recommendation for increased privileges to be considered by a senior clinical or administrative figure external to the team. This takes place in all larger, and a number of smaller, forensic programs. In one province, this decision is taken by a Program and Policy Committee of senior staff working to explicit terms of reference. In England and Wales, it is performed by civil servants.

There is little to guide clinical teams in making this recommendation (or at times, this decision). Two programs employ a structured professional judgment tool, in British Columbia, the START is employed and the elements of the HCR-20 are used at CAMH. One program employs a locally developed tool; the remainder used locally developed pro forma. Prior to each individual leave being taken, a minority of programs require specific assessment of the patient's suitability to take each particular episode of leave. This takes place in half the Ontario programs and in British Columbia.

6.3 Absent Without Leave (AWOL) Policies

AWOL, elopement or missing persons policies need to have certain elements. They need to clearly define what an AWOL is, how staff must respond, the persons to be notified, liaison with the police and quality processes. Additionally, they need to describe what the effect on the person's privilege status is upon return from AWOL, and link back to the process of granting privileges, so that teams are guided in careful and consistent approaches to privileges.

AWOL, elopement or missing persons policies are summarized in Table 3 (Selected Provinces and Territories in Canada, and England and Wales) and Table 4 (Ontario forensic programs).

Table 3: Provincial and Territorial Policies for Elopement and AWOL of Forensic Patients

Province or Territory	Policy name	Definition of AWOL	Quality of AWOL procedure	Police liaison	Patient status on return	Clinical process post incident	Comment
British Columbia	Code Yellow; Missing persons	All persons not back on time and have not contacted unit	Very clear pathway and tasks; senior staff notification	Clear notification	All privileges suspended; review by Privilege and Policy Committee	Incident report, root cause analysis if needed	Comprehensive, no statement about media involvement
Saskatchewan	Person Missing	Forensic patients all "high risk." No actual definition	Clear search policy and notifications	Clear category for police notification	No description	Incident form completed	Policy covers all patients
Newfoundland	—	Person missing	Comprehensive	Clear process	No description	Occurrence report	—
Nova Scotia	AWOL	Not clearly stated	Comprehensive	Clear process	Clear statement for clinical review	Quality review of process only, not of clinical decision making	Some strong elements, including media and corporate liaison
England and Wales	Guidance for clinical supervisors	Absconding and recall to hospital	Not explicitly set out, other than notification, MOJ issue warrant for arrest	Yes, by hospital and MOJ	Yes, leave suspended until report sent to MOJ and leave reconsidered	Review and submit report to MOJ. Pro forma given	Less explicit than Canadian polices

Table 4: Ontario Forensic Programs' Policies for AWOL and Elopement of Forensic Patients

Jurisdiction	Policy name	Definition of AWOL	Quality of AWOL procedure	Police liaison	Patient status on return	Clinical process post incident	Comment
ROHCG	Unauthorized Leave	Any absence not authorized. Clearly expressed	Clear description specific for each patient group	Clearly stated	Not stated	Director and clinical director review incident	—
Waypoint	Missing Persons	Clear: person can't be found	Clear process of senior staff notification	Clear, MOU with local police describes steps	Not stated	Debriefing of team	—
Ontario Shores	Missing Patient	Yes	Clear notification to police and senior staff	—	Restricted until assessed by the treating team	No description	—
CAMH	Elopement	Yes	Very clear policy and checklist	Yes, team leader to OPP	Not stated	SCORE report. Debrief of patient and staff on return	Coordination with media. Checklist and flow chart
Providence	Grounds and Hospital Elopement and AWOL	Yes	Yes, clear processes and contacts	Yes	Assessed on return	Assessed on return, narrative statement and SafeNet Report	—

As shown in Tables 3 and 4, policies generally define missing persons or AWOL clearly. Additionally, they are all clear in the steps that staff must take to respond to incidents of AWOL. In particular, there are a number of examples of useful flow charts and checklists are impressive and valuable to ensure a clearly understood and auditable series of steps are taken.

What is less clear in most policies is the degree of "leeway" that may be given in practice. Patients may be late back from leave for unavoidable reasons. Some allow this if there is notification; others acknowledge that local searches are performed and some degree of wait time may occur before declaring the person AWOL. Other programs report that following police requests there is no leeway given; that AWOL procedures should commence as soon as the person is late back or missing, regardless of reason. This may impair the ability to compare rates of AWOLs between different programs (even in the rare event when they are published).

There is considerable variation in policy for review after the person has returned from AWOL. The issues that are relevant here are:

- Can the person's privileges be withheld or re-instated?
- Is there any process of review or debriefing of the clinical team's risk assessment?
- Is there any process of quality review?

As can be seen, policies are generally silent on these issues. Incident reports are explicitly required by five policies. Two policies require that senior staff review the incident. Debriefing is mentioned in three policies. A clear path for reassessment and re-instatement is described in only two policies, but reassessment is required in a total of four. The process of reassessment was not clearly defined.

It is likely that this summary is not an accurate description of actual practice. All forensic services will reassess persons who have been AWOL and privileges are likely to be suspended for a period. Policies may require that incident reports are completed but this may be described in separate policies. Such practices may be part of day-to-day routine. The British Columbia policy is most specific in these areas. It represents a very valuable template for considering steps that can be taken to provide rigour in this area of practice.

7. Policy and Procedure Framework of Nova Scotia

7.1 Analytic Approach

Why should we have a comprehensive approach to leave and AWOL? Why should this not be simply left to skilled individual clinical teams to decide within the framework of the Review Board decisions?

There are a number of reasons. Firstly, forensic patients have a long trajectory of care through a system of forensic care. Frequently, they will be cared for by a number of different clinical teams. It is valuable that these teams address the patient's needs and progress through gaining increased privileges in a manner that is consistent across the patient's care pathway, for the person's sense of predictability and fairness. It also matters as guidance for staff, the Review Board and public to know there is a consistent and carefully worked-through approach.

Secondly, patients rehabilitate in groups. They live together in shared wards, rehabilitation units and group homes. They are very aware of how their friends and neighbours are progressing. If one clinical team works very differently to another, this can create tension within a forensic program.

Thirdly, the nature and severity of the risk posed by some forensic patients, and aspects of narcissistic and psychopathic personalities, can place particular stresses on an individual clinical team. It is valuable for all forensic practitioners to have their decisions reviewed by a separate team or senior individual. This can frequently take tension away from the individual clinical relationships, and spread the risk and burden of caring for a person beyond the individual practitioners. This is, indeed, standard practice in most forensic programs internationally.

What should a good policy framework cover? As noted already, policies must attend to a range of issues. Review of the above policies gave rise to the development of a series of questions that can be used to evaluate a policy framework employed by individual forensic programs. These questions are presented in the following boxes.

Questions to ask

In relation to the granting of community leave privileges:

1. Are leave decisions clearly structured?
2. How does the clinical team assess risk factors:
   a. Is there a structured approach to risk factor detection and analysis?
   b. Is there a process of clear linkage of privileges to the care planning and rehabilitation goals?
   c. Are the risks clearly balanced against benefits of leave?
3. How are potential victim issues identified and how are they mitigated?
4. Are there wider public concerns that need to be considered and anticipated?
5. Who approves the leave?
6. How is the outcome of leave evaluated and reported?

Questions to ask

In relation to AWOL events and policies:

1. Is AWOL clearly defined?
2. Are procedures in response clearly defined:
   a. Notification of senior staff?
   b. Notification of police and community?
   c. Notification of relevant victims?
3. What is the impact of the AWOL on the person's future leave status:
   a. How is the incident reviewed?
   b. How does it impact leave status?
   c. How is leave reinstated?
4. Is AWOL tracked as a performance measure or within a clinical quality framework?

7.2 Specific Analysis of Nova Scotia Policies

7.2.1 Policy Number CC 65-055: Community Access Levels

This policy is entitled Community Access Levels. It has an effective date of October 2011. It defines community access for Review Board patients. Clinical teams are required to consider the health and safety of the patient, and other patients, staff and the community in considering community access levels, within the parameters of the Criminal Code Review Board "ceiling."

In relation to the **Questions to Ask** listed in Section 7.1:

Are leave decisions clearly structured?

There are five levels of Community Access, with sub-levels for levels 4 and 5. They are clearly described. Starting points of leave status are well defined.

How does the clinical team assess risk factors:

- ***Is there a structured approach to risk factor detection and analysis?***
- ***Is there a process of clear linkage of privileges to the care planning and rehabilitation goals?***
- ***Are the risks clearly balanced against benefits?***

There is little explicit guidance for this process, other than the completion and sign off of the leave form CD1660MR. Reference is made to the overall care planning process referred to as the Service Implementation Plan. There is explicit requirement for patient agreement with the plan and conditions of leave.

How are potential victim issues identified and how are they mitigated?

Are there wider public concerns that need to be considered and anticipated?

There is no explicit reference to balancing risks and benefits, and no explicit reference to victims or issues of public interest. Victim notification is provided for in the ECFH Policy 1900.

Who approves the leave?

On recommendation of the clinical team, including sign-off from the patient, the form is submitted to the Health Services Manager or delegated manager "for consideration and approval." It is not clear what issues the Manager considers. The author is unclear in practice whether this is done by one person or by a group of persons, and what the clinical or other criteria are that the person(s) brings to the consideration and approval.

How is the outcome of leave evaluated and reported?

This is performed by the clinical team with the patient. Any restriction of leave has clear criteria attached to it in terms of outcome for further review and resubmission.

7.2.2 Commentary

There are many features of this policy that are strong and robust, including the process of linking leave to CCRB disposition, to clinical team consideration, to patient engagement, to explicit levels of leave progression and communication to the Health Service Manager and support staff. Review of leave is also clearly documented after deterioration or change in behaviour.

The weak points of the policy are the lack of clarity of the basis for the clinical team consideration and the lack of use of a structured risk assessment tool, the consideration of victim issues only in relation to notification, no reference to wider public concern, and the role of the Health Service Manager signing off the leave. With regard to the last point, it is the author's view that this sign-off is better in the hands of a senior clinician or committee, rather than the Health Service Manager, and it is best that the person might also the Person in Charge in terms of the *Criminal Code*. The person or committee signing off the leave should do so against explicit criteria (refer, for instance, to the terms of reference for the British Columbia Program and Privileges Committee).

7.2.3 Policy Number 1937: Absent Without Leave (AWOL)

The above policy is entitled Absent Without Leave (AWOL). It is current; dated February 2012. It defines general procedures to be taken in relation to the AWOL of ECFH patients. The policy clearly describes the steps to be taken by staff, notification of senior staff, police and corporate staff, including media relations. It includes notification of return from AWOL, and Quality review processes.

In relation to the **Questions to Ask** listed in Section 7.1:

Is AWOL clearly defined?

No. Whilst the policy refers to actions to be taken if an AWOL is suspected, this, in technical terms, is already an AWOL. That is, the person is likely to be late returning or is not where they should be. There is considerable leniency for waiting for a period before declaring the person AWOL, which may contribute to under-reporting.

Are procedures in response to AWOL clearly defined:

- ***Notification of senior staff***
- ***Notification of police and community***
- ***Notification of relevant victims***

The policy is very strong on the processes, once initiated. The only thing that might further assist is a flow chart for staff, but the criteria are clearly set out. The AWOL Checklist is helpful, but would be improved by referencing any specific victim issues, known risks or threats. The processes for notification on return from AWOL are clear. There is no reference to victim notification. The requirement to issue a press release after three days' absence is different and more prescriptive than other policies across Canada. The policy does allow for an earlier press release if need be.

What is the impact of the AWOL on the person's future leave status:

- ***How is the incident reviewed?***
- ***How does it impact leave status?***
- ***How is leave reinstated?***

The issues of review on return and consideration of new leave status are addressed in the earlier policy, CC 65-055. The policy is explicit in terms of the process of review though, as already noted, the process is not explicitly guided by a structured professional judgment process.

Is AWOL tracked as a performance measure or within a clinical quality framework?

The policy is strong in that it explicitly references Quality Review. However, it begins stating that the Health Services Manager will "do the following, if the patient has not returned . . ." The policy does not state the time frame for this decision. Some AWOLs, even if brief, should be subject to quality review; time spent AWOL is not necessarily a good predictor of clinical risk.

Also included is a Quality Review Form which is, in the author's opinion, a "compliance quality tool" in that it records that necessary tasks were completed. This is important, but only the first step of quality review. It is not a "clinical content quality tool" in that it makes no reference to the adequacy of the clinical judgment involved in granting the leave, within a clinical quality framework. Finally, the policies are silent on the corporate tracking of AWOLs as a performance measure.

7.2.4 Commentary

The AWOL policy is robust in terms of process, but would benefit from tightening in some areas. AWOL itself needs to be clearly defined. The AWOL Checklist would benefit from the addition of specific clinical and victim risks, and needs for notification. Quality review would benefit by being expanded to include clinical quality review, not simply procedural quality review. It is recommended that clinical quality review be performed by the Clinical Director together with the Health Service Manager, not the Health Service Manager alone. Finally, whilst AWOL may be being tracked as a performance measure by ECFH, the author is unaware if it is and would suggest it be so as part of the monitoring framework.

8. Interventions to Reduce AWOL

Apart from the author's personal observations noted above, there have been few published studies evaluating steps taken to reduce AWOL events. Bowers et al. (1998) reviewed six such studies, none from forensic settings. Therefore, there is no published research within a forensic setting which describes steps taken to reduce AWOL events.

The novel issue that has arisen is the application of the use of GPS "tracking" technology to electronically monitor forensic patients on leave in the community. Frequently employed in the corrections field, this is novel in the mental health field. This involves an ankle bracelet worn by the patient during leave episodes that locates where the person is, and can have exclusion zones attached to it. It can also track where the person is or has been. This has been adopted by the South London and Maudsley (SLaM) group for forensic patients at the Bethlem Royal Hospital. Their clinical population includes a significant number of persons transferred from the prison service and a group who are detained for treatment of personality disorder that leads to criminal behaviour. This population differs from a typical Canadian forensic population where the patients are rarely serving prisoners and who almost all have a primary serious mental illness.

The use of such technology has been shown to have value in parolees in North American studies. It is under consideration by a number of forensic psychiatric services and general mental health services in the UK. It was introduced by the SLaM group in 2010 (Prof. T. Fahy, personal communication). Preliminary data indicate that the number of AWOLs was reduced while the number of community leaves increased. Unescorted community leaves increased 2.5-fold whilst AWOL incidents fell from 21 to 4 per annum. AWOL was not abolished, even with electronic monitoring, but it was very significantly reduced. Its main use was in the early phases of leave, and in the personality disordered patient group for whom risk may be less dynamic and more enduring. Electronic monitoring was used less frequently with persons with mental illness, and later in the rehabilitation process.

Whilst GPS technology use may improve the person's performance in following rules, it is not clear that this sort of "rule following" encourages the person in the ultimate tasks of forensic rehabilitation. Does the use of such technology improve the person's long term safety? Does it improve the therapeutic alliance to help the person make the life changes necessary to recover from illness and the effects of their offending? Or does its use appear a physical manifestation of distrust and create distance between the patient and the treatment team? It may allow the person more apparent personal freedom than their clinical progress actually should allow.

It is interesting that the technology is more acceptable to offenders with personality disorders, often persons transferred from prison, than to persons with a serious mental illness who have different needs and expectations of their health professionals. Adoption of the GPS technology may appear appealing, but its costs and effects are not clear, nor is it clear who the persons for whom it may have most benefit.

9. Closing Observations

Leave decisions are an example of one of many decisions clinical teams must make as a forensic patient makes progress in their recovery. There are many factors that must be considered in judging when and how quickly a patient can progress. These include the nature and origin of risk from the person's history, their progress, insight and ongoing personal challenges, issues in relation to their index offending and victim issues, and factors in the community that may support or destabilize their progress. At initial and annual reviews, Review Boards must set the envelope of leave on the basis of these and other factors, envisaging what progress may be possible for the patient during the next year.

Like much of risk assessment, these decisions have until now usually been made on the basis of clinical lore. Two procedures are now emerging as means of improving the process of leave decision making. The first is in the process of leave decision making. This process attempts to improve leave decision making by setting clear criteria for leave and reviewing clinical team recommendations against these criteria. The second innovation is the application of the process of structured professional judgment approach (now the industry best practice in risk assessment for violence and reoffending in forensic mental health). Whilst these procedures lack empirical support in relation to granting leave decisions, it follows from other work that these tools should enhance decision making. Experience, unpublished, from other programs suggests this is so.

Implementing these types of innovation could be expected to improve the rates of AWOL in a clinical program. This can be readily studied within a clinical quality framework, and should be an indicator for clinical performance monitoring. AWOLs will never be eliminated, but undue risk can be managed. All clinical decisions involve a thoughtful balancing against of competing risks. How good care is depends on the quality of the balancing of these risks.

Documentation Reviewed

Terms of Reference, May 2012

Capital Health Polices:

Community Access Levels. Number CC 65-055

Capital Health Mental Health Program policies, East Coast Forensic Hospital policies:

Absent Without Leave. Number 1937

Approved Persons. Number 1902

Notice to Police. Number 1900

Tobacco Free Policy. Number 1906

Department of Health and Wellness, Nova Scotia. *Standards for Mental Health Services in Nova Scotia. Core Program Description for Adult Forensic Services*, pages 203–20, 2009.

Documentation received from Provinces and Territories, as listed on Tables 1–4.

Leave of absence for patients subject to restrictions. Guidance for Responsible Clinicians. Ministry of Justice. England and Wales, 2008.

Guidance for clinical supervisors. Ministry of Justice. England and Wales, 2008.

References

Bowers, L., Jarrett, M., & Clark, N. (1998). Absconding: a literature review. *Journal of Psychiatric and Mental Health Nursing* 5, 343–53.

Dolan, M., & Snowden, P. (1994). Escapes from a medium secure unit. *Journal of Forensic Psychiatry* 5, 275 86.

Hilterman, E.L.B., Philipse, M.W.G., & de Graaf, N.D. (2011). Assessment of offending during leave: development of the Leave Risk Assessment in a sample of Dutch forensic psychiatric patients. *International Journal of Forensic Mental Health* 10, 233–43.

Latimer, J., & Lawrence, A. (2006). *The Review Board Systems in Canada: An Overview of Results from the Mentally Disordered Accused Data Collection Study*. Research and Statistics Division, Department of Justice, Canada.

Livingston, J., & Balmer, J. (2006). *Management for Restrictions on Patient Liberties in a Forensic Psychiatric Hospital Setting*. BC Mental Health and Addictions Services.

Lyall, M., & Bartlett, A. (2010). Decision making in medium security: Can he have leave? *The Journal of Forensic Psychiatry & Psychology* 21, 887–901.

McDermott, B.E., Scott, C.L., Busse, D., Andrade, F., Zozaya, M., & Quanbeck. C.D. (2008). The conditional release of insanity acquittees: Three decades of decision-making. *The Journal of the American Academy of Psychiatry and the Law* 36, 329–36.

Smith, J., & Quaynor, E. (1990). Absconding from a regional secure unit. *Journal of Forensic Psychiatry* 1, 245–50.

Stewart, D., & Bowers, L. (2011). Absconding and locking ward doors: evidence from the literature. *Journal of Psychiatric and Mental Health Nursing* 18, 89–93.