Joint Review of the East Coast Forensic Hospital's Community Access Privileges

Department of Health and Wellness

Department of Justice

Capital District Health Authority

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NOVA SCOTIA

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Introduction

On April 16, 2012, Andre Denny was issued a one-hour unescorted pass from the East Coast Forensic Hospital. He did not return to the hospital on time and was reported absent without leave (AWOL) to the police. In the early morning hours of April 17, local leader and respected activist Raymond Taavel met with a tragic death, deeply felt by loved ones and the community. Subsequently, Andre Denny was charged with second-degree murder.

The province called for a joint review of the community access privileges granted to not-criminally-responsible persons at the East Coast Forensic Hospital.

The joint review was led by Deputy Ministers of the Nova Scotia departments of Health and Wellness and Justice, and the Chief Executive Officer of Capital District Health Authority.

To ensure objectivity, the province and Capital Health also engaged independent mental health experts in the specialized field of forensic psychiatry to conduct separate reviews that would inform provincial and hospital action. Psychiatrist and University of Toronto professor Dr. Alexander Simpson placed policies and procedures at the East Coast Forensic Hospital into the national and international context and assessed their quality and suitability. Dr. Johann Brink, clinical professor in the Department of Psychiatry at the University of British Columbia, reviewed policies, procedures, and practices at the East Coast Forensic Hospital.

Capital Health found that the East Coast Forensic Hospital followed existing policies and procedures when it allowed Andre Denny to leave the facility on April 16. The Department of Justice determined that the Nova Scotia Criminal Review Board adhered to the procedures found in the Criminal Code of Canada.

Dr. Simpson concluded that Nova Scotia'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 program's policies." Dr. Brink also found that the policies and procedures of the East Coast Forensic Hospital are in "broad alignment with other forensic hospitals in Canada" and found a number of those policies to be leading practice.

However, the review also clearly identified significant gaps where improvements can and must be made to increase public protection.

The 18 actions outlined in this report are designed to make certain that these improvements happen. They fall into three categories: community access, patient supervision, and public notification. They support better, more-consistent clinical decisions about community access passes, stop certain practices to increase public protection, and improve oversight, reporting, transparency, and accountability. Some of the key actions of this review:

- Require that community access decisions consider all the risks according to explicit criteria.
- End the practice of allowing unescorted community-access passes before a disposition hearing has been held by the Criminal Code Review Board.
- Provide an onsite smoking area to end unescorted offsite leaves to smoke before a disposition hearing has been held by the Criminal Code Review Board.
- Create a committee to review decisions about community access before it is granted.
- Suspend community access leave until a review is conducted after an incident when the patient did not return on time.
- Require increased reporting on absent-without-leave incidents to ensure that policies are effectively protecting the public and not-criminally-responsible persons.

Balancing the right of the public to feel and be safe and the rights of individual forensic psychiatric patients who have been found not criminally responsible on account of mental disorder to get better and reintegrate with the community is challenging. It is made more difficult by a lack of research and development in this area.

Today's justice system and practices in forensic psychiatry recognize that the patient has a right to liberty protected under the *Charter of Rights and Freedoms*. Practices reflect the present-day scientific approach to mental illness and are universally accepted to facilitate more effective forms of treatment and recovery.

It is not enough that existing policies and practices are in line with those in Canada. The bar must be set higher. The 18 actions outlined in this report and committed to by the province and Capital Health are designed to make certain that happens.

Community Access

Current Practice

People found not criminally responsible are assessed and treated at the East Coast Forensic Hospital. Part of the treatment can involve assisting patients to eventually return to the community, if it is determined appropriate by the Criminal Code Review Board.

Most patient treatment programs include progressive access to the community through leaves that allow for approved time away from hospital grounds. This depends on the facts of each case and patient. More than 90 per cent of patients at the East Coast Forensic Hospital successfully complete treatment programs involving community access. This process is part of forensic programs across Canada and is accepted best practice.

The decision to allow forensic patients to leave the hospital and enter the community, and for what period of time, is made at two levels: first, at the Nova Scotia Criminal Code Review Board, and second, at the East Coast Forensic Hospital, within the limits set by the Review Board.

The Review Board is responsible for reviewing the evidence and making a disposition, which can include a person's right to privileges, such as leaves, in cases where a person is not criminally responsible. It does so with the aim of protecting the public and treating the mental disorder. The Review Board must choose a level of privileges that is the "least onerous and least restrictive to the accused." (*Criminal Code*)

The clinical team at the East Coast Forensic Hospital determines what level of access to the community is appropriate for each patient, guided by the disposition of the Nova Scotia Criminal Code Review Board, the *Community Access Levels* policy, and considerations around the health and safety of the patient and the community.

Results and Actions

The joint review evaluated the institutions and policies involved in granting community access passes to those at the East Coast Forensic Hospital who have been found not criminally responsible.

The joint review found that some aspects of policy and practices in granting community access meet or exceed provincial standards. A number of practices at the East Coast Forensic Hospital represent leading practice in Canada. Dr. Brink writes:

It is evident that the East Coast Forensic Hospital policies are in broad alignment with other forensic hospitals in Canada. The East Coast Forensic Hospital's commitment to person centred care and assisting its patients toward the rehabilitative pathway is evident throughout the policies, protocols, and procedures reviewed and examined.

However, it is equally clear that there are significant gaps.

The review found that the Criminal Code Review Board should be more transparent in the application of its processes. The East Coast Forensic Hospital can provide more consistency around determining risk to the public and around who is granted community access. It can also enhance how decisions about leaves are made, and more clearly define what happens when patients do not adhere to the conditions.

Through the review it was also learned that unescorted community access passes are being issued to not-criminally-responsible persons, prior to a disposition hearing being held by the Criminal Code Review Board, to allow them to smoke, because smoking is prohibited on hospital grounds and in the facility. This issue had been previously raised by the Review Board at joint meetings with the East Coast Forensic Hospital and remained outstanding. It is definitively addressed in the changes outlined in this report.

Changes to community access include

- improved processes to support those who make the clinical decision for leave, to ensure that the opinions of all team members are considered, to ensure that all team members have appropriate training, and to provide additional oversight to the decision
- strengthened policies and processes to ensure that clinical decision making is consistent and clearly linked to identified risks
- enhanced new protocols after an absent-without-leave incident; for example, to inform decision making before any additional leave is granted
- improved documentation, transparency, and accountability around community access decisions and the factors that enter into them

Community Access

Action	Result
1. Develop a structured risk assessment process that includes • specific criteria to assess a patient's risk of violence and AWOL • definitions of low, medium, and high risk in the short and long term • clear guidance on how risk impacts community access decisions	• better clinical decision making • stronger connection between results of risk assessments and decisions around community access • greater consistency, transparency, and accountability
2. Develop a protocol for a daily assessment of a patient's mental state before proceeding with a leave; require more patient and staff interactions.	• changes in emotional or mental states that could affect risk and influence decisions about community access are identified • better clinical decision making • greater consistency, transparency, and accountability
3. Revise policies to provide clarity around the quality and quantity of documentation expected in community access privilege decisions.	• greater consistency, transparency, and accountability
4. Develop mechanisms that ensure that • observations and recommendations of all staff in contact with the patient are included in risk assessment and decisions around community access • dissenting opinions are documented • community-access recommendations are signed by all staff	• better clinical decision making • greater consistency, transparency, and accountability

Community Access	
Action	Result
5. Ensure that everyone involved in risk assessment is trained to a level appropriate to their involvement.	• better clinical decision making • greater consistency, transparency, and accountability
6. Include a statement about the role of the "person in charge of the hospital" in the *Community Access Levels Policy*.	• clearer roles and accountability
7. Amend *Community Access Levels Policy* to confirm that only supervised community access privileges will be granted to patients awaiting a disposition hearing by the Review Board. • Minister to direct CDHA to provide onsite smoking facilities	• practice of requesting unescorted community access passes through interim CCRB hearings is ended • decisions around community leave focus on risk and treatment and are not influenced by requests to smoke • risk factored into leave decisions • practices at the ECFH consistent with those elsewhere in Canada
8. Establish a committee of senior clinical and administrative members, external to the patient's clinical team, to advise the person in charge of the hospital whether to approve the proposed level of community access against an explicit set of criteria.	• more oversight in decisions around community leave • better clinical decision making • greater consistency, transparency, and accountability
9. Suspend leaves after an AWOL incident until the appropriateness of community access is reviewed. Identify a process for reassessment and reinstatement.	• reasons for AWOL are well understood and considered in terms of community risk • better clinical decision making • greater consistency, transparency, and accountability

Community Access	
Action	Result
10. Develop written procedural guidelines for the CCRB.	• greater consistency, transparency, and accountability
11. Prepare detailed written reasons for each CCRB disposition order. Develop criteria for decisions, including key facts, evidence, issues, and reasoning related to the CCRB legal mandate.	• disposition orders are well understood and applied in community access decisions

Notification of the Public

Current Practice

When a patient does not return from leave at the appointed time, they are considered absent without leave. In such cases, the safety and security of the public and the patient are paramount. The decision around when the public should be notified is critical.

The East Coast Forensic Hospital is responsible for immediately reporting to police when a patient is absent without leave. The responsibility for determining the level of risk and alerting the public falls to the police in conjunction with hospital staff. For clinical or safety reasons, the decision may be made to notify the public immediately.

In all circumstances, the public must be notified after a not-criminally-responsible person has not returned to the hospital within three working days.

Results and Actions

The review concluded that the East Coast Forensic Hospital policy and processes for public notification are relatively strong. According to Dr. Brink, the policy regarding absent without leave is "particularly strong" and "has a very clear protocol for staff to follow." According to Dr. Simpson, "the requirement to issue a press release after three days' absence is different and more prescriptive than other policies across Canada."

However there are three important areas for improvement:

- better definitions of when a patient is considered absent without leave
- enhanced tools to aid in quick risk assessment and ensure victims are notified if there is a threat
- increased tracking and oversight of outcomes of absent-without-leave incidents to help continuously improve performance and ensure appropriate actions take place

Public Notification	
Action	Result
12. Define absent without leave in the AWOL policy.	• ensures that police are contacted immediately
13. Include identification of any risks to potential victims and any related notifications that need to take place in the AWOL policy.	• quick risk assessment • victim notification, when neded, is prompted

Patient Surveillance

Current Practice

As discussed earlier, care of not-criminally-responsible forensic patients considers public protection and patient rehabilitation. Patient surveillance — or monitoring a patient's activities while in the community — is one method of contributing to public safety while rehabilitating the not-criminally-responsible person. Monitoring helps ensure that patients comply with the terms and itinerary of their leave, and their mental state and behaviour are tracked.

While on approved leave from the East Coast Forensic Hospital, patients are monitored by staff through a combination of methods including

- establishment of an itinerary
- requirement of patients to maintain logs
- required telephone updates
- community visits

All patients on leave are required to contact the hospital daily so that compliance and mental status can be assessed. At any point during the leave, hospital staff may terminate the community pass if the conditions of the pass are breached. If a pass is terminated, the patient must return to the hospital immediately.

Results and Actions

In his report, Dr. Brink concluded that East Coast Forensic Hospital policies around monitoring should be supported and continued.

However, patients and the public may benefit from additional surveillance methods and more evaluation of outcomes. Dr. Brink recommended the possible expanded use of technology such as cell phones and pagers to complement current monitoring tactics.

It is also recommended that tracking be strengthened to review outcomes and determine if additional or emerging surveillance tactics should be considered.

This review also considered the adoption of GPS tracking of not-criminally-responsible persons. GPS tracking technology should not, at this time, be adopted in Nova Scotia. This technology has not yet been adopted by any forensic facilities in Canada.

Dr. Simpson points out that GPS tracking is "novel in the mental health field." It is unclear what effect the use of GPS technology may have on a patient's treatment. Concerns have also been expressed about whether this could be an unreasonable and discriminatory infringement on the rights of people with mental illness found to be not criminally responsible.

Additional research is needed to determine if this technology is effective in forensic populations. Further consideration surrounding the ethics of its use and its impact on treatment and patient progress are also needed before good policy decisions can be made.

Patient Surveillance

Action	Result
14. Explore the possibility of using cell phones and pagers to monitor patients on leave.	• more tools to help identify changes in emotional or mental states that could affect risk • stronger current monitoring tactics
15. Strengthen tracking of AWOL statistics: • provide the Deputy Ministers of Justice and Health and Wellness with an annual AWOL report	• better evaluation of outcomes • continuous policy review and improvement is supported

Oversight

To ensure continuous improvement, ongoing oversight through quality and compliance review, auditing, and communication among partners is necessary. As Dr. Brink writes, structured reviews are "in keeping with empirically informed and leading practice in forensic mental health."

Results and Actions

While oversight was not the focus of this review, the province and Capital Health agree that additional monitoring will make certain that the recommendations in this report are fully and effectively executed.

The review did determine that outcomes of community access leaves are currently evaluated, that the absent-without-leave policy "explicitly references quality review," and that quality review forms are used.

However, the province and Capital Health believe that the seriousness of this issue and the importance of the changes make the addition of specific means to monitor the implementation of these measures prudent.

To this end, a number of oversight mechanisms will be implemented. They include

- regular audits to ensure consistent compliance with established policy and best practices
- significantly enhanced reviews of clinical decisions that result in absent-without-leave incidents
- greater information sharing, tracking, and performance management for continuous improvement and good decision making
- monitoring to ensure that these recommendations are executed

Oversight	
Action	**Result**
16. CDHA will adopt an audit and regular quality review process.	• compliance with community access policies, protocols, and procedures
17. CDHA will develop a review process for every AWOL incident including clinical review of the leave decision.	• compliance with community access policies, protocols, and procedures • better clinical decision making and continuous improvement
18. Commence meetings focused on information sharing, reporting, and performance: • CCRB to meet quarterly with CDHA, ECFH, and legal counsel representatives who appear regularly before the CCRB • CDHA and ECFH to meet with the CCRB to discuss the implementation of dispositions • CCRB to meet annually with the DMs Justice and Health and Wellness, CDHA, and ECFH to discuss the performance of the forensic psychiatric system • CCRB to liaise regularly with CCRBs in other provinces/territories to discuss issues and best practices	• feedback on hearing processes that could improve effectiveness is provided • clear communication around details of dispositions • ongoing monitoring of the implementation of the actions outlined in this report • opportunity to track and respond to AWOL trends • continuous improvement • good decision making • stronger understanding and relationships among partners

Conclusion

Independent reviewers Drs. Brink and Simpson found that the policies and procedures in Nova Scotia pertaining to community access privileges, patient supervision, and public notification are similar to, and in some areas more advanced than, those in other Canadian jurisdictions.

However, in total, 18 significant actions for change have also been identified through this joint review. Clearly, there are gaps in the system, and the province and Capital Health are committed to closing them.

The province, the Nova Scotia Criminal Code Review Board, Capital Health, and the East Coast Forensic Hospital will implement all the actions outlined in this report. In addition, new oversight mechanisms will make certain that these changes are made. An update on progress will be provided to Nova Scotians in six months.

All these improvements will make a difference in the safety of every Nova Scotian. In adopting them, the province is making transformative changes to a system that must effectively consider the rights and effective treatment of the patient and the important right of Nova Scotians to be safe.

A tragedy spurred this critical review. It is hoped that these improvements honour the memory of a man who was deeply committed to positive change in his community.