External Review of the British Columbia Forensic Psychiatric Services

Summary Report

June 2018

Prepared by:

External Review Team

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The **External Review of the British Columbia Forensic Psychiatric Services: Summary Report** was prepared under contract to British Columbia Mental Health & Substance Use Services, Provincial Health Services Authority, British Columbia. The views of the authors do not represent the views of the Provincial Health Services Authority or the Government of British Columbia.

The Review Team was comprised of three members drawn from Australia, Ireland and the UK with the necessary expertise to undertake the review:

Dr. James Ogloff - Dr. Ogloff is Director of the Centre for Forensic Behavioural Science at Swinburne University of Technology in Australia. Dr. Ogloff is the Executive Director of Psychological Services and Research at the Victorian Institute of Forensic Mental Health (Forensicare) and a Fellow of the Canadian, American and Australian psychological societies. As a lawyer and forensic psychologist, Dr. Ogloff has worked in a variety of settings for over 35 years and has published 17 books and more than 265 scholarly articles. In 2015, he was appointed a Member of the Order of Australia and recognized for his significant contributions as a psychologist, academic, researcher and practitioner. Prior to moving to Australia, Dr. Ogloff was the University Endowed Professor of Law and Forensic Psychology at Simon Fraser University as well as the Director of Mental Health Services in BC Corrections. He had a long history of involvement with FPS as both a contract psychologist and researcher.

Dr. Harry Kennedy - Dr. Kennedy is a Forensic Psychiatrist and Executive Clinical Director, National Forensic Mental Health Service, Central Mental Hospital, Dublin, Ireland. Dr. Kennedy is a Clinical Professor of Forensic Psychiatry Trinity College Dublin. Dr. Kennedy has been trained in University College Dublin, Hammersmith Hospital and Maudsley/Institute of Psychiatry. His research includes work on epidemiology of suicide, homicide and violence; anger and mental illness; prison psychiatric morbidity, mental capacity; structured professional judgement and benchmarking admission and discharge criteria in forensic mental health services; international human rights law and mental disabilities. He has been called to provide expert evidence in human rights cases including Whitemoor escapes (special secure units), McA (pregnancy prisoner), Napier (slopping out), Z & G V Revenue (same sex marriage).

Dr. Michael Doyle – Dr. Michael Doyle is an Honorary Clinical Chair in the Faculty of Biology, Medicine and Health at the University of Manchester, England and a Deputy Director of Nursing and Quality at South West Yorkshire Partnership Trust, UK, with over 25 years' experience in forensic mental health services and recently worked as a Nurse Consultant specializing in clinical risks. He has conducted research and published widely on psychosocial risk assessment, formulation and interventions, forensic mental health nursing and related subjects and is currently Past-President of the International Association of Forensic Mental Health Services.

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Overview - Summary of Findings and Recommendations

1.1 Overview and Approach to the Review

In February 2018, the Vice President, BC Mental Health and Substance Use Services (BCMHSUS) commissioned an international expert panel to provide the Provincial Health Services Authority (PHSA) with advice and recommendations to further improve on the effectiveness of Forensic Psychiatric Services (FPS). The focus of the review was on the 190-bed hospital, transition to community and regional clinics, and the overall model of care. In alignment with the Forensic Psychiatry Act (B.C.), Mental Health Act (BC) and Criminal Code (Canada), the scope of the review was targeted to include patient access, flow and experience, clinical programming, decision-making and accountability, organizational structure, safety and security set out in the objectives below:

1. To examine access to and quality of patient care provided by the Forensic Psychiatric Hospital (FPH) and the degree to which the services meet the needs of the patients and families.
2. To determine whether evidence-based forensic psychiatric services standards and guidelines are being followed and the degree to which the staff are adequately orientated and trained to provide high quality patient care.
3. To determine whether the current model of care (implemented in 2015) is the most effective manner in which to provide services to the patient population.
4. To determine the extent to which the various disciplines providing care and services (i.e. nurses, program therapists, rehabilitation workers, psychologists, physicians, health care workers and others) work in integrated, interdisciplinary teams to achieve improved patient experience and outcomes.
5. To examine the extent to which the current organizational structure and expert opinion to the Review Board ensure adherence to the requirement of the Criminal Code that public safety be the first priority.
6. To determine whether the organizational structure and decision-making bodies (i.e. committees, councils and task groups) facilitate teamwork and effective decision-making about patients.
7. To determine the degree to which the available training programs, facilities, equipment, policies and procedures and committees ensure patient and staff safety and security across the service as well as public safety.

Three external reviewers (Dr. James Ogloff, Dr. Harry Kennedy and Dr. Michael Doyle) conducted a series of pre-meetings, reviewed relevant documents, data and background materials, completed a 3.5 day on-site visit and interviewed 45+ key informants. Interviewees were assured that their feedback was provided in confidence to the reviewers to encourage a high level of forthright participation in the interview process.

Draft advice and recommendations were presented to the Vice President, BCMHSUS in late March 2018.

1.2 Background

Forensic Psychiatric Services provide specialized assessment, treatment and case management services through a 190 bed Forensic Psychiatric Hospital (FPH), a 42 bed Community Transition Program and six Forensic Regional Clinics. Services include:

- Court-ordered assessments and other forensic assessments
- Inpatient and community-based services to persons found Not Criminally Responsible on Account of Mental Disorder (NCRMD) or Unfit to Stand Trial
- Psychiatric / Psychological Pre-sentence Assessment Reports
- Hospital treatment of adults with mental health disorders who are in conflict with the law and in provincial correctional centres, admitted on temporary absence to FPH
- Court-ordered assessment and treatment of individuals on bail, probation and conditional sentences
- Sexual offender program
- Services to offenders on probation

Since 2013, FPS has experienced significant changes to its leadership team, organizational structure and a transition from government to the health sector. In June 2015, there was a concurrent shift in the model of care to specialized, treatment units focusing on meeting the needs of specific client populations and a transition from case management to interdisciplinary team service delivery.

Considering the complexity of the changes to structure, policy, process, clinical specialization and culture required to implement the new model of care and team-based service delivery, it is not surprising that some aspects of the planned change remain less developed than others. While many improvements have been noted as a result of the transition, further work is required to fully realize the benefits of the new model and to address some unintended negative outcomes of the transition, including concerns about fragmented communication between care delivery teams across FPH and potential issues regarding the safety and security of clients, staff and the general public.

1.3 Findings and Recommendations

External reviewers were impressed by evidence of the FPH commitment to ongoing improvement in all areas considered by the review. A detailed review of the 2016 Accreditation documentation, FPS Operational and Service plans and performance measurement reporting metrics provided by the leadership team provided evidence of positive progress. This was evident in the areas of patient and family engagement, access to and quality of care and facilities improvement plans to ensure patient, staff and public safety. Leaders and staff fully participated in interviews and group meetings, providing further input to ongoing opportunities for improvement in areas within the scope of the review.

Advances have been made in patient and staff safety. Quality measures show that patient aggression and the use of seclusion have reduced. There has been a general improvement in other measures of safety (e.g., medication errors).

Recommendations focus on clarifying and strengthening senior leadership roles, accountabilities and decision-making, mapping patient needs and the patient journey, updating and communicating the models of care to improve patient flow, identifying and improving forensic core competencies, professional development of physicians and staff and improving the physical environment.

1.3.1 Governance and Decision-making

Findings:

There is a lack of clarity regarding roles and responsibilities for senior managers within FPH (e.g., medical, nursing and operations leaders) that impedes consistent and coherent decision-making within. While the majority of committee functions reviewed were aligned to support the new model of care, associated decision-making and practice changes, some were out-dated and not aligned to support the new model of care, and expected best practice or policy.

Recommendations:

1. Clarify roles and accountabilities of the FPH senior leadership team with particular attention to the relationship between the Executive Director, the Program Medical Director and the VP, Medical Affairs and Research.
2. Shift the legal authority for the hospital "Director" and "Person in Charge" under Part 1 Section 16 of the Criminal Code from the VP, Medical Affairs and Research to the Program Medical Director, FPS.
3. Review the structure and process for the Medical Advisory Committee to better engage medical staff and ensure they have a voice in the planning and decision making in the organization.

1.3.2 Patient Access and Flow

Findings:

Access to the FPH is very good, particularly given bed pressures (with the FPH typically operating at full capacity). As the only secure hospital in British Columbia, the FPH has a heterogeneous patient population. Patient needs and associated risk management required vary considerably depending on patient characteristics and type of admission. The breadth of the FPH patient population requires both general and specialized forensic psychiatric assessment and treatment modalities, which raise a number of challenges.

A purported benefit of the new model of care and interdisciplinary team structure is to deliver improved patient flow. There is some evidence that rather than moving linearly through the hospital, patients have been discharged from programs directly to the community. However, there is also evidence that the physical environment/unit configuration at FPH creates barriers to patient transfer and specialty program access for patients. As an unintended consequence of the new model of care, service delivery between some units has become siloed due to constraints of specialized physical units versus a focus on patient-centred care pathways. This has resulted in patients waiting for admission to two of the specialized treatment units.

While running with high occupancy, FPH generally, does not experience extensive waitlists. However, some concern was expressed regarding delayed transfers of care from correctional services due to lack of beds available for Fitness to Plead assessments.

A Patient Needs Assessment (PNA) is a useful approach to determining patient needs and service delivery planning in mental health and substance use and forensic mental health.

Recommendations:

1. To further ensure patientcentred design and service delivery, complete a strategic Patient Needs Assessment (PNA) at regular intervals to maintain organizational alignment with the needs of the forensic psychiatric patient population and ability to develop and adopt appropriate client-centred care pathways in practice. The PNA should be based on:

    a) a census of current patients across service locations

    b) the last 100 discharges, and

    c) BC population characteristics, morbidity and criminality

    The PNA should inform other recommendations made in this report that address quality, safety and effectiveness.

2. The care pathway and patient flow through the forensic service should be process mapped to identify and resolve any system blockages.

3. Review the potential for completing more Fitness to Plead assessments in custody or in regional clinic settings, thereby reducing 'avoidable' admissions to hospital.

1.3.3 Patientcentred Care

Findings:

Documentation review and interview feedback supports the high priority placed on patient and family engagement and patient- centred care within FPS and at FPH, specifically. Staff members are committed to providing a high level of care and expressed concerns that the provision of such care is not always possible. FPS collects a wide range of data pertaining to quality and safety. The data show that targets for reducing patient aggression and medication errors have been achieved and the target to reduce use of seclusion episodes and time in seclusion is now well within target. While still in the early stages of maturity, the impact of this focus is evident in improvements in patient experience survey results and inpatient engagement on advisory groups and councils. This is expected to continue to improve as plans to further integrate patients and families in program design and decision-making are fully implemented. The FPS still relies on a paper-based system of clinical record keeping that is out of date.

Recommendations:

1. As part of the comprehensive Patient Needs Assessment, the quality of patient care should be reviewed for all patients on an ongoing basis.

2. Review workforce capacity and capability and develop advanced-specialist clinical roles aimed at providing high quality care and clinical leadership.

3. Make clinical supervision mandatory and a requirement to practice across all clinical disciplines.

4. Clinical record keeping standards should be reviewed, agreed, implemented, monitored and audited on a regular basis.

5. Accelerate the plan to move towards paper-light clinical records and review opportunities for other technological solutions per the BCMHSUS Information Technology plan.

6. All patients should have individual care and treatment plans prepared on admission and in detail within a week of admission. These should be revised at regular intervals determined by patient type (e.g., TA, NCRMD) and the level of acuity.
7. Develop a system where staff are aware of the need and feel confident to raise honestly held concerns about issues of patient care, a breach of safety or trust.

1.3.4 Family Involvement

Findings:

Concerted efforts have been made to better engage families and involve them, appropriately, in patient care. The plan to improve family involvement at FPH is in its early stages so outcomes in this area could not be adequately reviewed. Despite some promising initiatives, the engagement with families has been limited, and there is a greater role for social workers to play regarding family engagement. There is no child visiting policy and this carries risks for the children and hinders the maintenance of positive family relationships. Additionally, while progress has been made pertaining to victim and trauma work, the work appears to be ad hoc versus part of a standardized approach.

Recommendations:

1. Continue the work underway to develop family engagement and support services.
2. Review the social worker role to ensure their input to the clinical model is optimised and social circumstance reports of all patients are routinely completed.
3. Develop and implement a child visiting policy.
4. Develop a standardized framework and approach for victim and trauma work.

1.3.5 Evidence-based practice

Findings:

A review of the documentation provided by FPS, interviews with key informants and a review of 30+ charts from recent discharges suggest practice is mostly evidence-based and in keeping with normal practice internationally (e.g., medico-legal reporting). Some practice domains would benefit from a realignment to an outcome versus process orientation to ensure they represent current best practice (e.g. triage process, specific aspects of therapeutic and relational security, key control (in progress), suicide prevention, risk assessment and management and assessment of need for treatment programs individually or according to aggregated needs for units, groups or pathways).

A reduction in patient and staff safety incidents over those reported in 2016/17 was noted by reviewers as significant and positive. However, interview feedback and written submissions from unions and staff indicate that staff safety concerns still exist. While a detailed Facilities Improvement Plan has been initiated to improve the physical environment at FPH and the safety/security for patients, staff and the general public, the facility remains outdated and not fully fit for purpose. Environmental risks still exist due to poor design, line of sight issues and ligature risks in unsupervised areas. Additionally, there is a lack of privacy, with consequences on dignity and comfort for patients on the units that impacts the patient experience at FPH.

The Clinical Program Redesign Tracking Sheet provides an excellent start towards a quality dashboard system, although it is currently only recording activity on an aggregated basis and its use in clinical practice is not clear. FPH clinical teams appear to have a strong commitment to providing excellent care to clients; however, they are not always fully equipped to do so. The absence of a core set of specialized forensic clinical competencies and professional development planning limits the ability of staff to fully provide the level of treatment and service required in the specialized environment. Furthermore, it is unclear what treatment options exist for criminogenic needs given the lack of psychologists or clinical specialist skills available in this area.

Recommendations:

1. Develop and implement forensic psychiatric standards of care to ensure consistency in evidence-based practice and treatment. Clinical practice could be benchmarked against evidence-based guidelines, such as the NICE guidance and quality standards for secure psychiatric services regularly produced in the UK or the equivalent Canadian standard.
2. Leverage the Patient Needs Assessment outcomes to further refine the 'mix' of staff required to provide specialist services (e.g., psychologists to support treatment of criminogenic needs).
3. Expand the existing Clinical Program Redesign spreadsheet to include actual hours of treatment in each domain for individual patients and targets for each of the indicators.
4. A review of therapeutic security should be undertaken on an urgent basis.
5. Some aspects of basic clinical practice need urgent remedy including the necessity of a discharge summary for all those discharged from the FPH regardless of legal status, which should be sent to the primary care/ family practice and treating psychiatrist who takes on aftercare, and, wherever possible, should be sent prior to actual discharge.
6. As part of the review of environmental and ligature risk assessments, the protocol for suicide prevention at the FPH needs to be reviewed.
7. An ongoing review of the evidence-base for areas of practice is needed and offers an opportunity for ongoing improvement over time. The use of quantitative outcome measurement as part of the cycle of clinical work and clinical management at all levels would greatly benefit from a closer connection between research and development, training and clinical practice.

1.3.6 Efficacy of the Model of Care

Findings:

While the transition from a case management model to interdisciplinary teams in 2015 was intended to improve FPH unit to unit communication and processes, the FPH and FPS Regional Clinic physicians interviewed reported that communication between FPH units and between FPH and the Regional Clinics had actually deteriorated. Based on feedback from a cross-section of staff, this may be more the result of the shift from the previous case management model (case manager as single point of contact) to the interdisciplinary team structure. FPH leadership did not agree with the reported decline in communication and cross-service effectiveness. Additionally, the role of the social worker in the FPH interdisciplinary team seems to be less engaged in decision-making, impacting the quality of social history documentation provided on patient return to the community setting.

Recommendations:

1. Improve relationships with Regional Health Authorities to facilitate patient access to community-based beds.
2. Implement documented clear communication accountabilities and standards within the interdisciplinary team structure.
3. The FPH Model of Care should be reviewed in the context of a comprehensive Patient Needs Assessment (PNA), including general mental health needs and specific forensic mental health needs and standards with an emphasis on clinical effectiveness and systematic efficiency.
4. A review of and modifications to the clinical model should align with the updated PNA and consider lessons learned from implementation of the model in 2015, evidence-based practice from other forensic services, an up to date review of the literature and comprehensive and inclusive consultation exercise with all stakeholders (including staff, patients, carers, unions, community forensic services and external partner agencies; including CTC, Review Board, Correctional Services and non-forensic mental health services).

1.3.7 Service Quality Provided by Interdisciplinary Healthcare Staff

Findings:

Leaders, physicians and staff across FPS clearly communicated a commitment to service quality to reviewers. Some communicated frustration with not clearly understanding the model of care and the transition from case management to a multi-disciplinary team approach to patient care. The reviewers did not find evidence of a clearly defined workforce strategy across the service. While individual leadership, physician and staff roles and accountabilities within FPS and FPH are fully documented, the interaction and dependencies between roles was less clear and would benefit from an internal review to eliminate overlaps and/or gaps in accountability. Interviewees reported variability in the application of the organizational performance management process.

While practice standards exist across interdisciplinary team roles, integrated practice standards for the interdisciplinary practice were not fully implemented, resulting in avoidable practice variability from unit to unit at FPH. This was especially evident in the areas of clinical supervision, process and documentation standards (e.g. clinical assessments, discharge summaries).

Additionally, ongoing use of paper-based charts creates duplicate and inconsistent recording and communication between units and outside of FPH, reducing the potential effectiveness of interdisciplinary teams.

Recommendations:

1. Special attention must be paid to the scope and role of psychologists in the FPH. The number of psychologists is inadequate given the need to address risk assessment, risk management, and the provision of services to address patients' criminogenic needs.

2. Support staff to develop forensic psychiatric specific skills through the development and implementation of core forensic competencies and implement individual professional development plans.
3. Review current social worker role and responsibility within the interdisciplinary team to ensure shared access to patient social history documentation is available across the service and in the community.
4. Introduce new nursing standards and competencies and ensure they are implemented, monitored and evaluated. As a minimum, there should be standards on assessment, care planning, patient engagement/involvement, clinical supervision, record keeping and personal development.

1.3.8 Working with the Review Board to Ensure the Priority of Public Safety

Findings:

FPS staff members have a good understanding of the relevant provisions of the Criminal Code of Canada (CCC) governing patients found Not Criminally Responsible on Account of Mental Disorder (NCRMD) or Unfit to Stand Trial. Patients from the FPS have lower than average rates of reoffending, equivalent to Ontario and significantly lower than Quebec[1]. The Review Team noted that while many reports to the Review Board were well prepared and of a standard consistent with best practice internationally, others were of variable quality. Poorer reports did not adequately address the legal standard required by the CCC and the Review Board for decision making (i.e., whether the accused is a significant threat to the safety of the public). The threshold for recalling conditionally discharged patients was quite low, with most patients being recalled for a relapse of substance misuse.

Recommendations:

1. In light of the current model of care, psychiatrists must have the capacity and opportunity to gain adequate knowledge of patients whom they are presenting to the Review Board. For patients who are newer to their units, psychiatrists should conduct a thorough file review and receive a handover from the previous unit on which the patient was resident.
2. Given the variability in quality of reports prepared for the Review Board, steps should be taken to ensure that psychiatrists and other clinicians have a good understanding of what is required in the reports. In particular, they must address factors relating to the legal criterion the Review Board must consider. They also must ensure that an adequate level of information is provided to the Review Board for the Board to be able to properly consider whether the patient "is a significant threat to the safety of the public."
3. Steps should be taken to determine how effectively substance misuse and specific offending behaviours are addressed in treatment programs in the FPS.

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1. Charette Y, Crocker AG, Seto MC, Salem L, Nicholls TL, Caulet M. (2015) The national trajectory project of individuals found not criminally responsible on account of mental disorder in Canada. Part 4: criminal recidivism Can J Psychiatry. 2015;60(3):127-34.

1.3.9 Staff Training and Professional Development Needs

Findings:

Staff orientation and training programs appropriately focus on ensuring patient and staff safety and reducing workplace violence. There are opportunities to enhance the ethos of teaching, training, research and development required for ongoing excellence in practice. There is an accredited forensic psychiatry program available, but the initial update is unclear, and the program does not currently allow for re-entry, once completed. There is an accredited clinical psychology internship program that has been supported. Staff advised limited access to FPS funded opportunities available for personal and professional development.

Recommendations:

1. Complete a physician and staff training needs assessment based on the completed Patient Needs Assessment to support development of a comprehensive workforce strategy focused on clarifying roles and accountabilities across FPS, ensuring appropriate staff 'mix' (i.e., nurses, social workers, psychologists, health care workers, etc.) in each unit is appropriate to meet PNA outcomes.
2. There is a need for staff to have access to library facilities, and national and international continuing professional development opportunities.

1.3.10 Facilities and Equipment

Findings:

Given the ageing physical plant, the FPH is now dated and areas are not fit for purpose. There is a lack of privacy, dignity and comfort for patients on some units. There are environmental risks due to design, poor lines of sight, and multiple ligature risks in unsupervised areas. There is evidence of good planning in securing funds for much needed step-down beds outside of the FPH site.

Recommendations:

1. Consider conducting an environmental and ligature risk assessment across the acute areas of the FPH and ensure the necessary remedial action is taken as a matter of urgency.
2. Given the significant lag time for approval and construction, plans for a rebuild or refurbishment need to be revisited and capital bids should be pursued supported by the PNA.
3. Review maintenance program arrangements to ensure the FPH management team have oversight and control of the work plan.

1.3.11 Policies and Procedures

Findings:

There are multiple policies and procedures across the FPH and wider BCMHSUS. They are regularly reviewed and updated. In discussions with staff, some managers find the policies confusing and not aligned with the new model of care.

Recommendations:

1. Develop a system that helps staff understand which policies and procedures are most critical to the safe and effective execution of their role.
2. Establish a system to identify the top ten most important, relevant policies applicable to each job role within the service.
3. Audit a sample of clinical policies to check for quality, relevance and alignment with current practice and the new model of care.

1.3.12 Committees

Findings:

The type and range of committees are consistent with what would be expected in a forensic mental health hospital. The committees that are most relevant to the review meet regularly and appear functional. It was only possible to meet with a few committee chairs to review the documentation carefully. Some of the committees are co-chaired by the Executive Director and the Medical Director, which does not appear efficient or practical.

Recommendations:

1. As noted above, some of the committees are co-chaired by the Executive Director and the Program Medical Director. It is preferable to have a single chair, vested in the position that should most clearly oversee the committee given its nature and purpose.
2. The terms of references for the committees should be reviewed in accordance with the outcomes from the PNA and to ensure that they are up-to-date and aligned with changes in positions, terminology and the model of care.

1.4 Conclusion

The FPS External Review was commissioned to provide advice and recommendations to further improve the effectiveness of services and to ensure FPS is well positioned to deliver on its commitment to provide equitable access to high quality care and services to forensic psychiatric patients across British Columbia. The primary focus of the review was on the 190-bed Forensic Psychiatric Hospital, patient transitions to regional clinics and communities and the effectiveness of the overall model of care. The scope of the review included patient access, flow and experience; clinical standards and guidelines, programming and interdisciplinary team work; decision-making, accountability and organizational structure and enablers of the safety and security of patients, staff and the general public.

The forty-five recommendations within the report are submitted with the intention to further support improvement efforts underway within BCMHSUS Forensic Psychiatric Services. While there is some evidence to support improvements in quality service, treatment and care delivery and patient and staff safety over the last few years, there remains a high degree of variability in the level of forensic education and expertise; interdisciplinary, evidence-based practice; and therapeutic, relational and physical security. Completion of the recommended Patient Needs Assessment will provide FPH with the opportunity to better align programs and services to meet the needs of patients and their families and will serve as the foundation for ongoing forensic practice improvements.

The reviewers appreciated the active, forthright participation of FPH senior leadership team, physicians, managers and staff, the BC Nurses Union and the BC Government Employees Union.

Appendix A: Consultations Conducted

Interviewee	Role	Individual / Meeting
Lynn Pelletier	Vice President, BCMHSUS Review Sponsor	Individual; BCMHSUS Leadership
Dr. Johann Brink	Vice President, Medical Affairs & Research, BCMHSUS	Individual; BCMHSUS Leadership; FPH Leadership; FPS External Review Advisory Committee; P & P Committee
Angela Draude	Provincial Executive Director, FPS; Site Administrator, FPH	Individual; BCMHSUS Leadership; FPS External Review Advisory Committee
Dr. George Wiehahn	Program Medical Director, FPS	Individual; FPH Leadership; FPS External Review Advisory Committee; P & P Committee
Connie Coniglio	Provincial Executive Director, Adult MHSU; Site Administrator BCMHA/ Heartwood	Individual; BCMHSUS Leadership
Rebecca Hahn	Executive Director Corporate & Clinical Support BCMHSUS	Facilities; BCMHSUS leadership; FPS External Review Advisory Committee;
Sam Dubetz	Social Worker, FPH	Individual
Phil Oosterman	Psychiatric Nurse, FPH	Individual
Karin Jackson	Director, Planning, Performance Management & Research Admin, BCMHSUS	Individual
Mark Conklin	OH&S Safety Advisor, FPH	JOHS Committee
Lynn Meskas	JOHS Co-chair; BCNU representative	JOHS Committee
Pam Piddocke	JOHS Co-chair; Client Services Manager, FPH	JOHS Committee; Patient and Family Needs
Jane Dumontet	Manager, Pharmacy, FPH	Individual
Dr. Robert Lacroix	Psychiatrist, FPH	Individual; Unit leadership team meeting
Clem Poquiz	Regional Clinic Manager, FPS - Surrey	Individual
Dr. Mark Riley	Psychiatrist, Regional Clinic, FPS - Surrey	Individual

Interviewee	Role	Individual / Meeting
Dr. Dave Morgan	Psychiatrist, Regional Clinic, FPS - Prince George	Individual
Sharon McNulty	Director of Nursing, Professional Practice, FPH	Group meeting re: Professional Practice, Learning and Development
Helen Lingham	Director, Learning & Development, BCMHSUS	Group meeting re: Professional Practice, Learning and Development
Peter Parnell	Client Services Manager, FPH	Unit team meeting; Group session re: Professional Practice, Learning and Development; Ward rounds
Dr. Marcel Hediger	Psychiatrist, FPH	Unit team meeting
Dr. Witold Widsjewicz	Psychiatrist, FPH	Unit team meeting
Lawrence Chibangu	Client Services Manager, FPH	Unit team meeting
Peri Hanzouli	Supervisor, Rehabilitation Services, FPH	Group meeting re: Rehabilitation services
Devon Silvers	Counsellor, Rehabilitation Services, FPH	Group meeting re: Rehabilitation services
Dr. Tonia Nicholls	Distinguished Scientist, BCMHSUS	Individual
Claire O'Quinn	Client Services Manager, FPH	Unit team meeting
Drew Hart	Director, Shared Services, BCMHSUS	Group meeting re: Facilities
Prabhjot Gill	Director, Quality, Safety & Evaluation, BCMHSUS	Group meeting re: Quality Council
Lynda Bond	Director, Medical Administration	Group meeting re: Quality Council
Jennifer Hancock	Professional Practice Lead, Social Work	Group meeting re: Quality Council
Susan Heathcoate	Director, Risk Management, PHSA	FPS External Review Advisory Committee
Justine Dodds	Director, Provincial Practice, BCMHSUS	FPS External Review Advisory Committee
Trevor Aarbo	Regional Director, Correctional Health Services	Individual
Dr. Holly Stamm	Physician; Priorities and Evaluation Council	Individual
John Charles	Director, Operations & Patient Support Services, FPH	Individual

Interviewee	Role	Individual / Meeting
Dr. Andrew Kolchak	Psychiatrist, FPH	Group meeting re: Patient and Family Needs
Dr. Mira Stingu-Baxter	Psychiatrist, FPH	Group meeting re: Patient and Family Needs
Barb Lohmann	Manager, Director's Office, FPH Clinical Services	Group meeting re: Bed utilization, Intake
James White	Forensic Utilization Nurse	Group meeting re: Bed utilization, Intake
J.H.	Patient, FPH; member Family Advisory Committee	Individual
Barb Armstrong	Clinical Nurse Resource, FPH	Group meeting re: Staff Learning and Development
Mahen Ramdharry	Health Care Worker, FPH; BCGEU representative	Group meeting re: Staff Learning and Development
Yvonne Klos	Clinical Nurse Leader, FPH	Group meeting re: Staff Learning and Development
Robyn Alexander	Clinical Nurse Leader, FPH	Group meeting re: Staff Learning and Development
Ron Morley	BCNU representative, FPH	Group meeting re: Staff Learning and Development
Marie Brewer	Clinical Nurse Specialist, FPH	Group meeting re: Staff Learning and Development
	Social Worker, FPH	Group meeting re: Staff Learning and Development
Dr. Lindsey Jack	Registered Psychologist, BC College of Psychologists	Group meeting re: Psychology assessment, treatment, interdisciplinary care
Dr. Tricia Teeft	Staff Psychologist, FPH	Group meeting re: Psychology assessment, treatment, interdisciplinary care
Dr. Sarah Farstad	Staff Psychologist, FPH	Group meeting re: Psychology assessment, treatment, interdisciplinary care
Mr. Bernd Walter	Chair, BC Review Board	Individual
Dr. Todd Tomita	Member, BC Review Board	Individual

Appendix B: Documentation Reviewed

Item	Document Title
1	PHSA Organizational Structure
2	PHSA Annual Report
3	BCMHSUS Organizational Structure
4	Mental Health Act (BC)
5	Criminal Code (Canada)– relevant sections
6	Forensic Psychiatry Act
7	Ten Year Mental Health Plan – Health Minds Health People – Nov 2016
8	Forensic Psychiatric Hospital Program Redesign – Jan 2018
9	Clinical Programs Committee – TOR – Jan 2017
10	FPH Operations Committee – TOR – Jan 2017
11	FPSC Quality Council – TOR – Jan 2017
12	Joint Occupational Health & Safety Committee – TOR – Jan 2017
13	Program and Privilege Committee – TOR – Jan 2017
14	Senior Management Team – TOR (2011 – pending revisions)
15	Priorities & Evaluation Committee – TOR – Sept 2016
16	FPH Clinical Program Descriptions
17	FPS Patient Population: A Current Evidence-Based Description
18	FPS: Community Needs Assessment – June 2011
19	FPH mandate and Model of Care - Dr J Brink - Oct 3 2016
20	BCMHSUS Service Plan – Final – Aug 2016
21	FPS Operational Plan 2016- 2017 – July 2016
22	Health & Wellness Program Availability and Interventions
23	Forensic Psychiatric Services Patient and Family Handbook – May 2017
24	FPS Enhancing the Client and Family Experience – Communications Plan – Sept 2016

Item	Document Title
25	Patient Experience Survey Results FPS – June 2016
26	Ethics Framework Brochure – BCMHSUS – 2016
27	Ethics Framework – BCMHSUS – 2016
28	FPS Required Organizational Practices 2016
29	FPS – Key Policies for External Reviewers – Jan 2018
30	Patient Safety Culture Survey Results BCMHSUS – Oct 2017
31	Patient Safety Culture Survey Results FPH– Oct 2017
32	Patient Safety Culture Survey Results Regional Clinics– Oct 2017
33	Patient Safety Culture Survey Results FPH 2017 vs 2013 – Oct 2017
34	Quality and Safety Risk Framework – PHSA 2016
35	Quality and Patient Safety Plan – BCMHSUS 2016
36	Risk Management Framework – BCMHSUS 2016
37	FPH Security Review – Final – Jan 2016
38	Hospital Orientation Program Manual May 2011
39	Accreditation Report – FPS – Oct 2016
40	C Roy Accreditation Presentation – Oct 2016
41	Earthquake Plan – FPH 2016
42	Emergency Response Plan - FPH 2016
43	BCMHSUS IMIT Roadmap (v0.19) – Nov 2017
44	FPH Facilities Management Structure
45	2018-19 Master Capital List – FPH – Jan 2018
46	FPS Security Operations Guide – Aug 2017
47	FPS Patient Transfer to Community Protocol – June 2016
48	Short Term Assessment of Risk & Treatability (START) Sept 2016
49	Integrated Treatment Plan and template Sept 2016
50	Program and Privilege Committee and Privilege Levels Sept 2016
51	Clinical Program Tracking Sheet - Jan 2018
52-59	Model of Care for all FPH wards - Ashworth 1, 2, 3 and 4; Dogwood East, West; Elm; Hawthorne (multiple documents) – July 2017
60	FPS Budget 2017-18

Item	Document Title
61-64	FPH and Regional Clinic Staffing – Base Staffing Numbers; Physician Allocation by Program; Psychologist Staffing; Allied Health Staffing;
Multiple	Chart review documentation
Multiple	Management Routine Reporting including: ■ FPSC PEC Documentation & Medication Event Reporting – Quarterly ■ Patient Safety PSLS Period Reports ■ PSLS Summary Data by Fiscal Period ■ PHSA Balanced Scorecard – Semi-annual – PHSA Board ■ PHSA Patient Activity Summary YTD – 2017-18 ■ PHSA Quality & Access Report – Quarterly - Oct 2017 ■ Absentee & Overtime Report – FPS leaders 2017-18 ■ Employee Injuries Due to Aggression – Quarterly – 2017-18 ■ FPS Employee by FY 2017 Q4 ■ FPS Clinic Active Caseload 2017-18 ■ FPH Weekly Occupancy Report 2017-18 ■ FPH Seclusion Report – Fiscal Period ■ FPS Annual Report Stats – 2016-17 ■ Indicator Summary Sheet – Fiscal – BCMHSUS ■ Indicator Summary Sheet – FPS – P10 2018 ■ JOHSC Report by Fiscal Period 2018 ■ FPH Med Rec Summary CY 2017 ■ Patient Concerns Summary 2017-18 ■ Involuntary Summary P10 2017-18 FPH Unauthorized Absences Report P10 2017-18 ■ Waitlist Package v2 – 2017-18
65-68	Confidential Written Submissions