The 2024 British Columbia Forensic Psychiatric Hospital External Review

Managing the Risk of Reintegration

~Public Report~

Bob Rich, O.O.M., LL.B.

August 2024

Acknowledgement:

This Review was possible because the senior staff at FPH were open about what had occurred and willing to work collaboratively to make improvements. Every doctor and member of the staff interviewed added value with their insights.

Table of Contents

Executive Summary

On September 10, 2023, during a celebration in Chinatown in Vancouver, three (3) people watching a musical performance were stabbed. Blair Donnelly was arrested nearby by the Vancouver Police and subsequently charged with three counts of assault with a weapon. Mr. Donnelly is a patient at the Forensic Psychiatric Hospital (the "FPH") and was out on an unescorted leave from the FPH that day. He was under a custodial order to reside at the FPH, as mandated by the BC Review Board.

Mr. Donnelly killed his daughter in 2006. In 2008, he was found by the courts to be "not criminally responsible on account of mental disorder" ("NCRMD"). Including the homicide in 2006, this allegation, if proven, would mark the fourth time he has assaulted someone between 2006 and 2023.

This Review was requested by the provincial government to review the circumstances of this case and the policies, procedures, and practices at the FPH used to determine when a patient can have leave into the community.

The Terms of Reference for the Review included these three directives:[1]

1. Review the privileges granted at the Hospital for Patients over the past year in relation to leave from the Hospital - including those of the Accused[2] and a representative sample of other Patients selected by Mr. Rich - to determine whether clinicians routinely and regularly follow the Policies and Procedures. If the Policies and Procedures have not been followed, describe the extent of the deficiencies in the application of the Policies and Procedures.

2. Opine whether the Policies and Procedures sufficiently address public safety considerations in relation to privileges granted to Patients about leave from the Hospital.

3. Based on the review in sections 1 and 2 above, provide recommendations, if any, for how to ensure that public safety is sufficiently considered in: (a) the Policies and Procedures; and (b) Hospital decisions about granting Patients leave from the Hospital.

For many patients, doctors at the FPH can prescribe effective anti-psychotic medications. These patients then receive additional therapy and treatment, allowing for a gradual transition back into the community. However, some patients are more difficult to treat for various reasons, and some may never be well enough to be safely reintegrated into the community.

The BC Review Board is mandated by Part XX.I of the *Criminal Code* to determine if a patient found to be NCRMD by the courts is a significant threat to public safety. If the Board finds that to be the case, the Board makes a disposition order, which may be a custody order requiring the patient to be held at FPH. If the Board determines that the patient does not pose a significant threat, the law requires that the patient

[1] Appendix A - Terms of Reference

[2] The Criminal Code refers to the person found NCRMD as the Accused. In the Hospital setting, the person is referred to as the patient. The reference here is to Accused, Blair Donnelly.

be given an absolute discharge. In almost all cases, a patient is entitled to a Review Board Hearing at least once a year.

The steps taken in this Review include chronicling and analyzing the Donnelly case, reviewing other patients' files, observing how the FPH leave system works, and conducting interviews with numerous staff and other key stakeholders.

Key Findings:

1. While reviewing several files for other patients at FPH, no breaches in policy or procedure were observed. However, in observing the functioning of the Committee that processes staff requests for patient leave from the FPH (the Program and Privilege Committee), my observation was that the policy for that Committee did not clearly define the participants' roles and responsibilities.

2. In my opinion, the policy for the Program and Privilege Committee needs amendments to provide more structure and clarity regarding what must be included in each application and how that application is to be processed by the Committee.

3. In addition, I am recommending a new policy designed to add safeguards for patients that the FPH staff evaluate as presenting an elevated risk.

4. The patient care model currently in use at FPH is not optimal for managing the risk that exists with some patients when working to reintegrate the patient back into the community. I am recommending the patient care team model, used by the FPH prior to 2015, be reinstated.

5. It is my opinion that some patients may never be well enough to live unsupervised in the community.

Summary of Recommendations:

The following four (4) principles underly the seven (7) recommendations:

- *Accountability,*
- *Rigour,*
- *Expert Knowledge, and*
- *Communication*

1. **Implement a triad patient care team model of care:** Currently, the model assigns a treatment team to each ward. When a patient moves from one ward to the next, that patient is handed off to the next treatment team. Generally, the plan at the hospital is for a patient to move from more secure wards, when they are most unwell, to less secure wards, with more programs and liberties, as they recover. This process works well logistically, but has been shown to create knowledge and communication gaps between treatment teams.

   This recommendation is to assign a consistent team, comprised of a psychiatrist, a nurse, and a social worker, to each patient and for that team to stay with that patient throughout their time at the FPH. This continuity of care aims to reduce gaps in knowledge and communication enhancing the overall treatment and management of the patient.

2. **Update the Policy for the Program and Privilege Committee:** A patient is granted leave privileges from the FPH through applications made by the treatment team to this Committee. The Committee reviews the application, makes a recommendation to the Director, who ultimately decides whether to grant the leave. A more rigorous policy with clear lines of accountability and a requirement for in-person application presentations is recommended. Since April,2024, an interim version of this new policy is being utilized by the Committee. The recommended policy is **attached** to this review.[3]

3. **An Elevated Risk Patient Policy:** Not all patients present the same level of risk to the public. Some patients, like Mr. Donnelly, have illnesses that create a particularly difficult risk to manage in the community. These patients need to be identified, and extra precautions must be put in place to ensure their cases receive additional consideration and outside expert risk assessments. A draft Elevated Risk Patient Policy is **attached** to this review and is recommended for implementation.[4]

4. **Additional Staff Training:** Health care for mentally ill patients who have committed serious criminal offences requires specialized training in forensics. Currently, staff, other than psychiatrists, do not have this type of training, and there are no established courses in forensics for nurses in Canada. It is recommended that in-service training be provided, which includes learning how to use and interpret the various risk assessment tools to objectively gauge risk levels over both the long and short term. Refresher training for treating psychiatrists in the use of long-term risk assessment tools is also recommended.

[3] Appendix D
[4] Appendix E

5. **Audits:** Implementation of important programs, such as the process for granting leaves from the Hospital requires three key elements: clear policy, training on the policy, and a system to determine whether the policy is achieving the intended results and being followed by staff. It is recommended that quarterly audits be conducted on the new policies at the FPH to ensure compliance and effectiveness.

6. **Counsel at Review Board Hearings:** Currently, the Director is most often represented at Review Board Hearings by a senior nurse who functions as a Review Board liaison. These are legal hearings, and the Director of the FPH, as one of the parties to the hearing, must ensure that the Director's recommendations for next steps for the patient and the necessary expert evidence are provided to the Review Board. Additionally, legal issues may arise during a hearing before the Board. Therefore, the Director should be represented by experienced legal counsel at Review Board Hearings.

7. **Technology and Risk Management:** In some jurisdictions, GPS technology is being used as a tool to manage risk for some patients when they are out on leave. It is recommended that a GPS tracking system for patients on leave be field-tested and implemented if found to be effective.

Reintegrating patients at the FPH back into the community carries inherent risk. Generally, the FPH has managed risk effectively, with few notable incidents. However, there are opportunities to improve current risk management policies and practices. While the risk cannot be reduced to zero, it can and should be managed and mitigated to be as low as possible.

Note: This is the public version of this review. This version of the report removes certain personal information due to privacy concerns and some source materials.

Part 1 – Introduction

A major principle of Canadian criminal law is that a person is not guilty of a crime unless what they did was done intentionally or, in some cases, recklessly. Statute and case law define the degrees of the mental element required for a person to be convicted of a crime. The legal profession uses the Latin phrase, *mens rea*, meaning "guilty mind," to describe this mental element.

Our courts have grappled with the issue of mental illness in accused individuals and its impact on criminal responsibility. In English common law, the concept of a defence of criminal insanity was developed, with the seminal case being M'Naghten, decided in England in 1843.

> The House of Lords (England's supreme court) delivered the following exposition of the Rules:
>
> … the jurors ought to be told in all cases that every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.[5]

When Canada became a country, we adopted English common law for criminal matters, and this defence was an accepted principle in our early legal system. When Canada first codified criminal law into the *Criminal Code* in 1892, it included a version of the insanity defence.[6] Today, Part XX.I of the *Criminal Code* sets out the current process for dealing with the intersection of criminal law and mental illness. There are two main determinations that a court may have to make in a case involving someone who is apparently mentally ill:

1. Is the accused fit to stand trial? Are they well enough to participate in the trial? Can they give meaningful instructions to defence counsel? If the court finds someone is not fit, then the trial cannot proceed.

2. Is the accused not criminally responsible because, at the time they committed the crime, they had a mental disorder that made them unable to understand what they were doing, or they did not know that what they were doing was legally or morally wrong?[7]

[5] House of Lords, 1843, 10 C&F, 200
[6] Mental Disorder & Canadian Criminal Law (2019) PRB99-22E
[7] The terms unfit to stand trial ("Unfit") and not criminally responsible due to a mental disorder ("NCRMD") are defined in the Canadian Criminal Code and have been extensively interpreted by Canadian courts. Unfit is defined in Section 2 of the Criminal Code and NCRMD is defined in Section 16 of the Criminal Code.

Not Criminally Responsible

When a person is declared by a court to be not criminally responsible on account of mental disorder ("NCRMD"), the court has found that the accused committed the act or omission that constituted the crime, but due to their mental illness, they are not to be held responsible. Generally, the person is then subject to the authority given to a Review Board under Part XX.I of the *Criminal Code* and is held in the secure custody of a forensic psychiatric hospital.

The concept of "not responsible" is difficult for many in the public to accept as appropriate. This is especially true for those close to the victim of the index crime[8] that led to the NCRMD finding. One objective of our criminal justice system is punishment. The courts refer to proportionality when they sentence an offender; a sentence should reflect the seriousness of the harm done. In Canada, first-degree murder comes with a minimum of 25 years in prison.

When an accused is found NCRMD, the court is deciding that the person is not to be punished because they were not responsible for their actions. There is no minimum sentence they must serve, even within a psychiatric hospital. Part XX.I of the *Criminal Code*, and the case law that has interpreted its provisions, make it very clear that the only consideration for an accused found by the court to be NCRMD is whether that person creates a significant risk of safety to the public or not. If there is a finding the person does not create a significant risk, they are to be released without conditions.

Not everyone agrees with the principles this process is based on. The following quote is from an article titled, Controversies Concerning the Not Criminally Responsible Reform Act.[9]

> The public often has difficulty accepting the idea of the insanity defense and believes the safety of the public is put at risk as a result.

However, this process has been upheld by the Supreme Court of Canada[10] as meeting the requirements in the Charter[11] to protect an individual's rights to freedom and due process.

In this report, the sole issue to be considered is the process the FPH uses to manage the risk while working to reintegrate the patient back into the community, as it is mandated to do.

The BC Review Board

Part XX.I of the *Criminal Code* requires each province and territory to establish a Review Board. A Review Board takes on the legal responsibility for the patient who has been declared NCRMD. The Review Board must hold hearings and make determinations at least annually as to whether the patient still presents a significant risk to the public if released. This is a legal process, and the evidence before the board must

[8] The crime that led to the NCRMD designation is referred to as the index crime in the psychiatric reports.
[9] Controversies Concerning the Not Criminally Responsible Reform Act, J Am Acad Psychiatry Law 45:44 –51, 2017, Dr. Lacroix et al
[10] *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625, 1999 CanLII 694 (S.C.C.)
[11] Part I of the Constitution Act, 1982

meet that legal test, or the board is obligated to release the patient and give them an absolute discharge. The key section is 672.54:

> When a court or Review Board makes a disposition under subsection 672.45(2), section 672.47, subsection 672.64(3) or section 672.83 or 672.84**, it shall, taking into account the safety of the public, which is the paramount consideration**, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is necessary and appropriate in the circumstances:
>
> **(a)** where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, **in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely**;
>
> **(b)** by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
>
> **(c)** by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate. (*emphasis added)*

The BC Review Board (the "RB") and the FPH are charged with balancing the constant tension set out in this section. The RB **must** order that an NCRMD patient be released with an absolute discharge if the Board finds the person does not pose a "**significant threat to the safety of the public.**" On the other hand, the RB shall also take into account **"the safety of the public, which is the paramount consideration."**

The section leads to the legal requirement, that, following a RB Hearing, the RB either makes a finding that there remains a significant threat to public safety or grants the patient an absolute discharge. The RB includes in each of its decisions whether or not this legal test has been met.

On top of that requirement, the courts have held, based on the rights all Canadians have under the Charter, that a patient must only be held with the least restrictions practical.[12]

If the RB finds that the person still represents a significant risk to the public, the Board must make a further decision: Can the risk be managed by giving the patient a conditional discharge? With a conditional discharge, the patient lives in the community, but is subject to conditions such as mandatory reporting to a forensic clinic, taking prescribed medications, and engaging in ongoing treatment. If these conditions are breached, the patient can be brought back to the hospital.

If the RB decides that the patient must remain in custody to keep the public safe, they make a custodial order and provide a warrant of committal and a disposition order to the hospital that sets the conditions

[12] Winko, (supra)

the patient is to be held under. These include whether the Director of the FPH has the discretion to grant privileges that allow the patient to spend some time outside the confines of the hospital. The Review Board may allow for escorted day passes, unescorted day passes, and/or longer overnight absences up to 28 days at a time. Generally, these overnight stays are in facilities staffed by mental health workers under contract to the Provincial Health Services Authority ("the PHSA") or other appropriate supported housing facilities.

The RB holds its hearing and provides a written decision and, if the patient is not given an absolute discharge, provides a disposition order that prescribes what permissions the Director at the FPH can grant to a patient held in custody, or the living conditions for the patient who is granted a conditional discharge to live in the community. For example, along with the written decision made by the RB in April, the RB issued a Disposition and Warrant of Committal that ordered that the accused be detained in custody and reside at the FPH subject to 11 conditions. In his case, the conditions included giving the FPH's Director the discretion to grant escorted and unescorted leave and have overnight stays in the community for up to 28 days. The conditions also included a weapons prohibition and to abstain from using alcohol and drugs, other than drugs approved by the Director.[13]

The Director at the BC Forensic Psychiatric Hospital

The FPH is the only hospital in BC where Unfit and NCRMD patients are held in custody. The legal responsibility to manage the risk posed by a patient held at the FPH belongs to the Director (the "Director") of FPH. While several staff positions at FPH use the managerial title of director, in reference to carrying out the mandate set by the RB, there is only one Director. In BC, the Director role is currently established by contract with PHSA, as will be discussed below.

The *Criminal Code* refers to the person in this legal role as the "person in charge"[14] The RB Rules define the "person in charge" of the hospital as the Director.[15] The Director is in charge of patient risk management and is responsible for following the directions of the RB. When a patient's disposition, which has been issued by the RB, allows the Director to give that patient unescorted absences, it is up to the Director to determine if, when, and how to provide that permission. This is a difficult task. The Director must always consider the legal rights that the patient has to be held in the least restrictive way possible. Further, the Director must also consider the therapeutic value of providing access to programs and spending time in the community. The mandate of the FPH is to help patients get well, be rehabilitated, and eventually be integrated back into the community. However, the Director must always also consider the need to protect the public. That tension is ever-present. The Director is a party at RB Hearings. In this role, the Director must ensure that the RB gets the most accurate factual and expert evidence to inform the RB decision-making process.

[13] C. (Donnelly Chronology Binder), Tab 53 RB Disposition on Donnelly, April 2023
[14] *Criminal Code*, section 672.1
[15] British Columbia Review Board, Rules and Procedures Governing the Review Board Process (December, 2023)

Part 2 – Conducting The Review

A. Terms of Reference

The Minister of Health provided the following terms of reference for this review:[16]

1. Review the privileges granted at the Hospital for Patients over the past year in relation to leave from the Hospital - including those of the Accused[17] and a representative sample of other Patients selected by Mr. Rich - to determine whether clinicians routinely and regularly follow the Policies and Procedures. If the Policies and Procedures have not been followed, describe the extent of the deficiencies in the application of the Policies and Procedures.

2. Opine whether the Policies and Procedures sufficiently address public safety considerations in relation to privileges granted to Patients about leave from the Hospital.

3. Based on the review in sections 1 and 2 above, provide recommendations, if any, for how to ensure that public safety is sufficiently considered in: (a) the Policies and Procedures; and (b) Hospital decisions about granting Patients leave from the Hospital.

4. Consult with forensic clinical psychiatrists or other experts in considering sections 1 to 3 above.

5. Use the information sharing authorities under Part 2 of the *Ministry of Health Act* that I hereby delegate to Mr. Rich for the purpose of conducting the review described in this Terms of Reference, in furtherance of conducting an informed review and making recommendations.

6. Provide answers to sections 1 to 3 above in a written report to me within 6 months.

B. Relevant Legislation

i. Part XX.I, *Criminal Code*
ii. BC *Mental Health Act*
iii. BC Review Board Rules
iv. *Forensic Psychiatry Act*

The pivotal section in Part XX.I is section 672.54. It is the section that sets out the difficult tension between the rights of the accused (patient) and the need to protect the community.

> **672.54** When a court or Review Board makes a disposition under subsection 672.45(2), section 672.47, subsection 672.64(3) or section 672.83 or 672.84, it shall, taking into

[16] Appendix A - Terms of Reference
[17] The Criminal Code refers to the person found NCRMD as the accused. In the Hospital setting, the person is referred to as the patient. The reference here is to Accused, Blair Donnelly.

account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is necessary and appropriate in the circumstances:

(a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;

(b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or

(c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

672.5401 For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public - including any victim of or witness to the offence, or any person under the age of 18 years -resulting from conduct that is criminal in nature but not necessarily violent.

C. Case Law

Winko v. BC FPI, 1999 CanLII 694 (SCC) - This was a *Charter*[18] challenge of the pivotal section 672.54 in Part XX.1 of the Criminal Code. The SCC upheld the provisions of the section, finding that section 7 and 15(1) of the *Charter* were not violated and noting that, the Review Board must impose conditions that are "**the least onerous and least restrictive to the accused."**

ii. *Mazzei v. BC Director of FPS*, 2006 SCC 7 (CanLII) - Review Boards have the power and authority to make their orders and conditions binding on the Director, hospital authorities, and treatment teams.

iii. *Calles v. BC Adult FPS*, 2016 BCCA 428 - An accused (patient) may appeal a BC Review Board decision to the BC Court of Appeal under section 672.78 of the *Criminal Code and the Court may overturn the Review Board decision if:*

(a) it is unreasonable or cannot be supported by the evidence;
(b) it is based on a wrong decision on a question of law; or
(c) there was a miscarriage of justice."

[18] Part 1 of the Constitution Act, 1982

D. Reports and Articles Reviewed

Numerous reports and articles in relation to FPH were reviewed, including in relation to risk management.

E. Interviews

FPH Leadership Team:

a. Blaine Bray, RPN, MA, Provincial Executive Director, FPS
b. Dr. Emlene Murphy, MD, FRCPC, Senior Medical Director of FPH and FPS (new position added in 2024)
c. Dr. Rakesh Lamba, MBBS, FRCP, Director and Person-in Charge, FPH
d. Dr. Sophie Anhoury, BSc, MB, BS, FRCPsych (UK), MSc, Medical Director FPH
e. The FPH Leadership team report to the dyad leadership team of Ms. Duff and Dr. Seethapathy: Jennifer Duff, RN, BSN, MHA, CHE, MBA, Chief Operating Officer, BCMHSUS
f. Dr. Veejay Seethapathy, MBBS, FRCPC, MRCPsych, MBA (Exec), Chief Medical Officer, BCMHSUS

FPH Staff:

g. Dr. Neeta Nagra, Ed.D., MMHN, BSPN, RPN, Director, Professional Practice, Forensic Clinical Risk, and Access – Dr. Nagra is the Director responsible for risk management (as of September 1, 2023). Dr. Nagra provided extensive input into the draft recommendations and policies in this review.
h. Trevor Aarbo, RN, BPE, BScN, MN, Senior Director of Patient Care Services
i. Jodi Eckland, MFMH, BSPN, AACrim, RPN, Manager, Forensic Review Board Services - Ms. Eckland manages the RB liaison work and frequently represents the Director at RB Hearings.
j. Mandi Higenbottam, RPN, BA, BSPN, MPN, Clinical Services Manager, Ash 3 & Ash 4 - Ms. Higenbottam manages two of the wards and holds a large amount of corporate history.
k. Dr. Leeanne Meldrum, MD, FRCP (C), Vancouver Regional Clinic
l. Dr. Johann Brink, MB ChB BAHons FCPsych (SA) FRCPC Founder, Forensic Psychiatry
m. Dr. Martin Zakrzewski, Psy.D., R.Psych., Director of Psychology, BCMHSUS
n. Chad Miller, RPN, ADPN, BSPN, Access and Discharge Coordinator
o. Derrick Carew, MSW, RSW, Social Worker
p. Dr. Liam Dodge, BSc (Hons) MBBS(Lond) FRCPsych(UK)
q. Dr. Mandeep Saini

Interviews outside of FPH:

r. Dr. Todd Tomita, M.D., FRCPC (Provided an external risk assessment of Donnelly in 2012)
s. Brenda L. Edwards, Chair, BC Review Board
t. Dr. Tonia Nicholls, PhD, Distinguished Scientist, Lead, Forensic Research, BCMHSUS – Co-designed the START risk management tool, extensive research on the NCRMD cohort in BC.
u. Ms. Sybila Valdivieso, Executive Director & Senior Legal Counsel, PHSA

Outside Expert Opinions:

Two independent expert opinions were obtained. Both experts provided input which have been incorporated into the recommendations.

a. Dr. Graham D. Glancy, MB, ChB, FRCPsych, FRCP(C)Founder, Forensic Psychiatry (Canada), Professor, Forensic Division Director, Department of Psychiatry University of Toronto, Toronto, ON
b. Dr. Steven Hart, PhD, CTAP(C) Director and Threat Assessment Specialist, Protect International

F. Meetings and Hearings Audited

Seven (7) Program and Privilege Committee Meetings and two (2) Review Board Hearings were audited.

G. Review the Privileges Granted to Patients in the Preceding Year

Point 1 of the Terms of Reference was to review the privileges granted at the Hospital for Patients over the past year in relation to leave from the Hospital - including those of the Accused[19] and a representative sample of other Patients — to determine whether clinicians routinely and regularly follow the Policies and Procedures. In collaboration with FPH staff, we reviewed the files of patients who were perceived to pose a potentially elevated risk to the community when granted leave. It was observed that the existing policies were generally being adhered to. In reviewing other patients' files, there were no instances observed where existing policies and processes were not followed.

However, in some cases, it was noted that there was room for improvement in how the procedures and policies were implemented. The policy setting out how patients are be granted leave is the Program and Privilege Committee Policy. While auditing Program and Privilege Committee meetings, it was noted that the Committee were considering applications that were incomplete. In a number of cases, especially when the staff member making the application was not present to answer questions, the Committee had limited information about the current status of the patient or whether they had all the components of the risk management assessment and plan for that patient.

Risk management requires rigour, in-depth knowledge, and attention to individual risk factors. In many applications, there needs to be a healthy debate and discussion about whether all the relevant factors have been considered. For example, the documentation may show that a risk management plan was provided as required, but is it the right risk management plan? Does it actually manage the risks that exist?

[19] The Criminal Code refers to the person found NCRMD as the accused. In the Hospital setting, the person is referred to as the patient. The reference here is to the Accused, Blair Donnelly.

The focus of this review has been to determine what changes to policy and additional steps are needed to add in-depth patient knowledge, accountability, communication, and rigour to the risk management process going forward.

Part 3 – The Current Model of Care for NCRMD and Unfit Patients in BC

The only hospital in BC for holding and caring for unfit and NCRMD patients is the FPH. When someone is charged with a criminal offence in BC, and it appears that the person may be unfit and/or NCRMD, the court will order an assessment. Usually, the person is then transferred to the FPH for that assessment. Patients being assessed are not granted privileges to leave the hospital except in rare circumstances and, in those cases, they will almost always be accompanied.

A person who is found to be fit after an assessment is usually moved to a pretrial corrections facility. However, some patients who are classified as "fit but fragile" stay at FPH. A patient who is found to be unfit will stay at FPH until they are fit to stand trial or their matter is otherwise disposed of. Generally, an unfit patient will not be given privileges to be outside the hospital.

Most often, when the courts declare someone to be NCRMD, the RB holds an initial hearing within the prescribed 45 days of the court decision.[20] At this initial hearing, the most frequent disposition is a custody order. The RB will consider the facts and expert opinions submitted and determine whether the disposition includes the discretion for the Director to give escorted or unescorted leaves from FPH, as well as other conditions that may be similar to a probation order.

RB hearings are to be held at least every year and may be held more often, depending on the circumstances.

At a RB Hearing, these three parties always have standing:[21]

- The Director (Person in charge)[22]
- The Attorney General (Crown counsel)
- The Accused (the patient)

Providing the information and expert opinions needed by the RB to make an informed decision regarding the custody of the patient and the disposition for the following year is the responsibility of the Director.

Forensic Facilities in BC

The patients that come under the responsibility of the RB are either held in the FPH or they are out in the community on a conditional discharge and reporting to one of seven forensic clinics in BC.

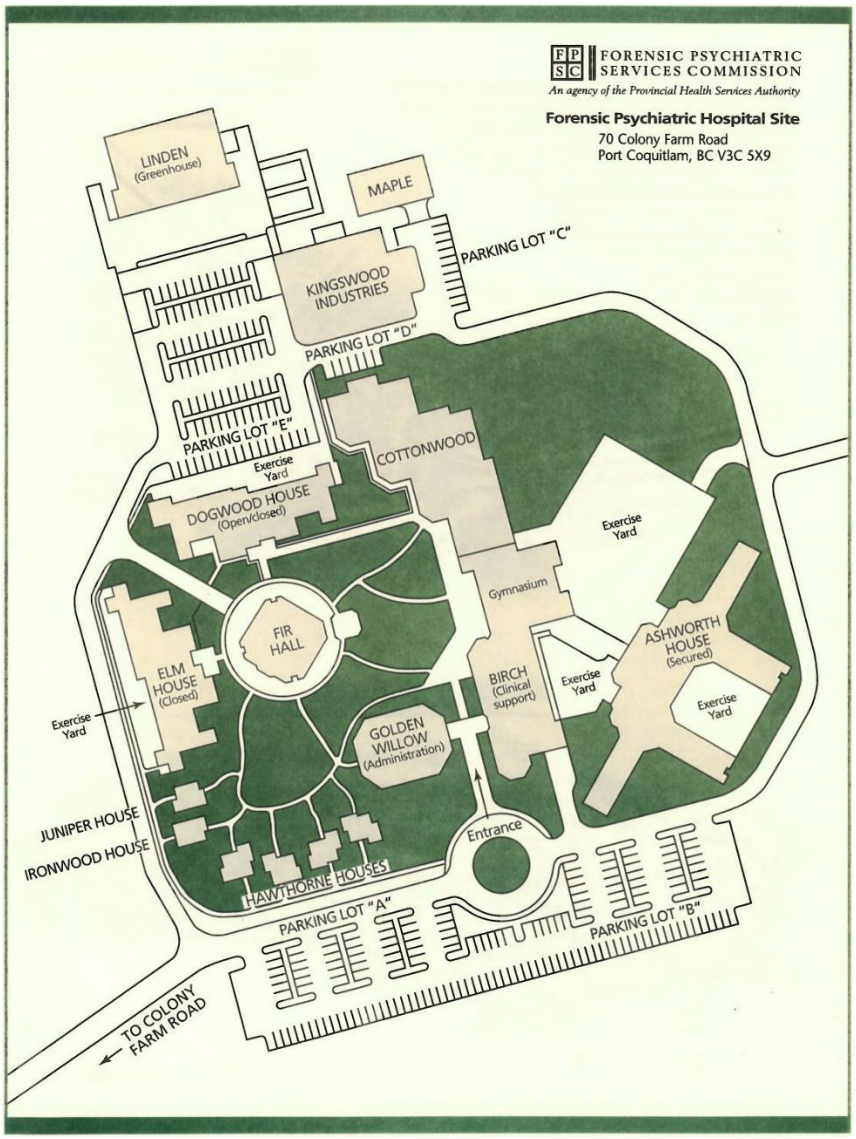
In addition, PHSA contracts with other organizations to care for patients who are being transitioned into the community. The RB may provide in the disposition for a custody order that a patient may be given

[20]Section 672.47(1) *Criminal Code*
[21]Section 672.1(1) Criminal Code
[22] The Criminal Code refers to the "Person in charge"

overnight visits up to 28 days. The main facility used for these "visits" to help reintegrate patients is the Community Transition Care Program (the "CTC"), sometimes referenced as the "cottages". This is a contracted facility that provides supportive housing near the FPH in Port Coquitlam.

The FPH Facility

The Hospital was built in 1997 and has space for 190 patients. It is a campus of several buildings contained by a high fence and is located in Port Coquitlam near Colony Farm Park between the Lougheed Highway and the Mary Hill Bypass.



The facility is divided into the following wards:

Ashworth 1:
Remand Unit. Maximum security

Ashworth 2:
Specialized assessment and psychiatric intensive care program. Maximum Security.
Ashworth 3:
Neuropsychiatry Unit. Maximum Security.

Ashworth 4:
Severe psychosis/intensive management program. Maximum Security.

Dogwood East:
Female unit. Mixed security (maximum and medium/minimum due to it being the only female unit – a facilities issue)

Dogwood West:
Geriatric/Medically Frail Unit. Medium/Minimum Security.

Elm South:
Intensive Rehabilitation program. Medium/Minimum Security.

Elm North:
Intensive Rehabilitation program. Medium/Minimum Security.

Hawthorne Houses:
Pre-Discharge - patients do their own cooking, cleaning, laundry etc. Medium/Minimum Security.

Staffing at FPH

Each patient is assigned a psychiatrist. At one point, if a patient moved to a new ward, they were treated by the psychiatrist assigned to that ward. More recently, a patient keeps the same psychiatrist during the time they are at FPH. The ideal model is the subject of various viewpoints and will be discussed at length in the recommendations.

Other professionals on the Treatment Team

The hospital utilizes the services of many other professionals, including psychologists, social workers, nurses, occupational therapists, and addiction counsellors.

Frontline staff

Nurses and mental health workers are the primary frontline staff interacting with the patient. About 50% of the frontline staff are mental health care workers. The training for these staff members is mostly on the job training. This is the only hospital in the province to have about one half of frontline staff caring for patients who are not nurses.

As an example, Ward Ashworth 1 would typically have 22 patients. During the day and afternoon shift there would be four (4) nurses and three (3) mental health care workers. At night the number is two (2) nurses and two (2) mental health care workers. Currently, the model is that a nurse on shift is assigned to a number of patients and has the responsibility to care for them, ensure they take their medication, and do an assessment each shift (if the patient is awake). This is called a mental status evaluation (an "MSE"), which includes a risk assessment of the patient.

Security

Security is provided by a team of uniformed special provincial constables referred to as Forensic Security Officers.

Capacity

- FPH was built in 1997 and has 190 beds.
- The population in BC has increased by 35% since 1997.
- Occupancy in the 2022/23 Fiscal Year was 92%.
- The lone female ward of 20 beds was at 50% capacity in year 2019/20, but is now at 100%.
- Increases in length of stay: In 2013, 10 patients had been at FPH for over four years. In 2023, the number of these patients had risen to 53.
- There are significant capacity and staffing issues for FPH.

A Patient's Journey When Things Go Well

A patient's journey will generally start in the more secure wards at FPH. If the patient arrives in a psychotic state, the staff may need to certify the patient under the *Mental Health Act* so they can provide medication without the patient's consent. Generally, as the medication takes effect, the patient will become more reconnected to reality. It is hoped the patient will be able to come to a baseline where they are connected to reality, have insight, and are motivated to get well. If that occurs, the patient will be moved to one of the less secure wards and will be given the opportunity to access more programs within the Hospital. Over time, if authorized by the RB, and if approved by the Director, the patient may be granted escorted absences from the FPH. If things go well, these would then be followed by structured unescorted absences and then unescorted absences that extend more liberties to the patient. An example of on an unescorted absence would be leaving the hospital to go grocery shopping or go on a bike ride. If the patient is able to comply with their conditions while on leave and no issues are noted, the next step is to be allowed overnight stays at CTC, which can be up to 28 days at a time. Eventually, the Director may then recommend to the RB that the patient is ready to be given a conditional discharge ("CD"). The team at FPH will work with the assigned forensic clinic to transition the person into housing in the community. Once in the community, the patient's progress will be monitored by the forensic clinic. There are seven forensic clinics spread around the province. If issues arise or there is a relapse, the patient can be required to return to the FPH. If their time in the community goes well over the next few years, the patient may be ready for an absolute discharge. The average time for a NCRMD patient to go from intake to no longer being in custody at the Hospital is less than four years.

The Program and Privilege Committee

The risk management system for determining how a patient moves through the Hospital towards recovery is anchored by the Program and Privilege Committee. How secure a ward the patient should be held in, when the patient can take part in programs, or be granted leave from the Hospital, is managed by this Committee according to policy.[23] When a treatment team believes a patient should be granted more liberty at any level, the team submits an application to the Program and Privilege Committee. The Committee, which meet weekly, considers the application, makes recommendations, and the Director ultimately determines whether the application will be granted and on what specific terms.

Patient Profiles

The average patient at FPH is a Caucasian man in his 30s or 40s who has a history of violent offending prior to the index admission. The most common psychiatric diagnoses among patients admitted to FPH are schizophrenia spectrum disorders (61-77%) and substance use disorders (39%-63%), with the majority of patients diagnosed with concurrent disorders.[24]

The index offences for patients at FPH vary, but a significant number are violent offences at the highest level. By reviewing a patient list in February of 2024, it was noted that 18% of current patients held at FPH had committed homicide. This did not include attempted homicide or other very serious offences.

In comparison, a NCR fact sheet[25] looking at patient profiles in three provinces, including BC, showed that between 2000 and 2005, only 9% of the patients had committed serious violent crimes, and only 31% had a substance use disorder. The profile of patients in relation to the seriousness of the index crime and the number that are dealing with substance abuse has changed significantly since 2005.

Number of Absent without Leave ("AWOL") Patients:

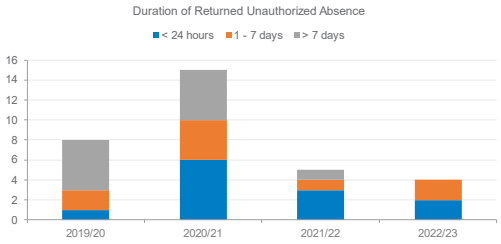
The number of patients granted leave from FPH, who do not return to the Hospital when required, is very low. In the fiscal year ending in 2023, out of 4,846 leaves from FPH, there were only four incidents of patients being AWOL.

[23] Appendix D - PHSA CCR-712H Program and Privilege Committee and Privilege Levels
[24] Appendix B - BCHMSUS Quaternary Inpatient Model of Care, FPH, p. 10 (undated)
[25] Appendix C - Data sheet from the Mental Health Commission

Unauthorized Absences

Fiscal Year	< 24 hours	1 – 7 days	> 7 days	Total
2019/20	1	2	5	8
2020/21	6	4	5	15
2021/22	3	1	1	5
2022/23	2	2	0	4

Source: Forensic Cerner



Part 4 – Patient Blair Donnelly

This review arose from concerns over the risk to the public after patient Blair Donnelly was arrested and charged with stabbing three (3) strangers at a public event in Chinatown on September 10, 2023.

The following steps were taken to review patient Donnelly's file:

1. Reviewed the documents held by FPH on Donnelly's medical and background files since his arrival at FPH. These files included police reports, RB decisions, treating psychiatrist, nurse, and social worker reports (Four (4) main files containing approximately 3,000 pages.)[26]
2. Interviewed several of Donnelly's treating psychiatrists over the course of his time at FPH.
3. Interviewed other staff who oversaw Donnelly's care.
4. Interviewed the Vancouver Police Detectives who investigated the September 10, 2023 stabbing.
5. Prepared a chronology based on the information above.
6. Provided an analysis.
7. Submitted the chronology and analysis to two (2) outside experts for review.

[26] "Donnelly Records" The four medical records files for Mr Donnelly were provided by FPH staff. Relevant reports and documents were extracted and are in the Donnelly Chronology Binders that I assembled. It is part of the documentation I will turn over to MoH at the conclusion of this review process. Other relevant documents outlining events on September 10, 2023 were also included in the chronology.

A. Chronology

Unlike the authors of the various reports and the decision makers at FPH, this report is written with the assumed presumption, not yet proven in court, that Mr. Donnelly stabbed three people on September 10, 2023. The "20/20 hindsight" adds a perspective the FPH staff did not have and needs to be acknowledged.

Index Offence: November 23, 2006

1. In 2006, Mr. Donnelly lived in Kitimat.

2. On November 23, 2006, Mr. Donnelly killed his daughter.

3. On January 8, 2008, the court found that when he killed his daughter, he was suffering from a psychotic delusion that God wanted him to kill her. The court then found he was not criminally responsible on account of mental disorder (NCRMD).

4. Once declared NCRMD, Mr. Donnelly came under the jurisdiction of the BC Review Board (RB) and was ordered to reside at the FPH. Like all patients, the staff began to treat him, using medications, therapy and various programs.

The Second Assault

1. On October 10, 2009, Mr. Donnelly was out on an unescorted day pass.

2. That evening, Mr. Donnelly went to a residence in Surrey. He attempted to stab a male.

3. Mr. Donnelly was charged with one count of assault with a weapon.[27]

4. Mr. Donnelly was convicted for assault with a weapon and received a 45-day sentence. There was no NCRMD finding.[28]

Eight Years Without Incident

1. The Review Board Hearing, February 1, 2010: Mr. Donnelly was given condition that the Director could give **escorted** passes into the community.[29] This was continued in 2011.

[27] C.15, Vol.2
[28] C.19
[29] C.20

2. The Review Board Hearing, July 18, 2012: The RB granted unescorted absences to attend a worksite once a week under a set of strict conditions.

3. In 2013, the Review Board allowed the Director the option to allow Mr. Donnelly to access a treatment program one day a week under similar conditions to the ones used to allow him to attend his work.

4. In the following years, the Review Board gave Mr. Donnelly the ability to reside for up to 28 days at a time at the CTC (the Cottages), a supervised facility. The use of this facility is one step in the process that the FPH uses to help reintegrate a patient back into the community.

Third Assault - March 21, 2017

1. Mr. Donnelly was residing on a ward at the FPH and attempted to assault another patient.

2. Mr. Donnelly was charged with assault with a weapon.

3. Board Hearing, May 31, 2017: The RB Decision was that he be held in custody for a further 12 months. The Director was given the authority to give Mr. Donnelly unescorted day passes.

4. August 18, 2018: Mr. Donnelly was found NCRMD for the March 17, 2017 assault and given an absolute discharge by the court (as opposed to the Review Board).[30]

5. Review Board, May 5, 2021: RB disposition was maintained from the previous year. Unescorted passes and overnight stays at CTC were permitted. After spending time at the CTC, Mr. Donnelly was returned to the FPH due to staffing issues at the CTC.

6. Review Board, April 13, 2023: The RB noted that Mr. Donnelly should be transitioned back to the CTC once the CTC's staffing issues had been resolved. Mr. Bray, the new Executive Director of Forensic Psychiatric Services, was asked to provide an update on the work being done with programming at the CTC. The RB disposition order was on the same terms as before, but was shortened to eight months, which would have led to another RB hearing at the end of 2023.

7. FPH Records: From August 10, 2022 to September 9, 2023, Mr. Donnelly was given 99 unescorted leaves from FPH.[31] No issues were noted during this time.

Fourth Assault - September 10, 2023

1. September 10, 2023 was Mr. Donnelly's 100th unescorted leave for the leave was to go for a bike ride in Port Coquitlam.

[30] Supra, 44
[31] C. 57, FPH records

2. On that day, a "Light Up Chinatown Festival" event was taking place on Columbia Street south of Pender Street.

3. As the event was concluding, three people were stabbed. Their wounds were serious but not life threatening.

4. Mr. Donnelly was located in the area shortly after the assaults and was arrested by the Vancouver Police. The police forwarded a report to Crown counsel that alleges that Mr. Donnelly was the person who stabbed the three people.

5. Crown counsel laid three counts of assault with a weapon. This matter is still before the courts.

B. Analysis:

The staff at FPH work in a system with three (3) underlying pressures to return patients to the community:

1. **Legal Requirements:** The law requires that the least restrictive measures to ensure public safety are used. Staff knows there is always a balancing act with risk to the community versus the right of liberty that a patient is entitled to if that risk can be managed. The Review Board provides oversight of this balancing act and has occasionally been critical if it finds that the FPH is proceeding too slowly to provide liberty to a patient.

2. **The Capacity of the FPH:** The Hospital operates at close to maximum capacity at all times. Approximately 50 NCRMD (long-term) patients will be sent to the FPH by the courts in 2024. For the FPH to function, that many patients need to transition out of the hospital.

3. **The Therapeutic Model:** Hospital staff are dedicated to helping patients become as well as possible so they can re-integrate into the community. Staff come to work each day trying to make that possible for each person assigned to them. The Hospital is not intended to be a correctional facility that holds people indefinitely. The model is to be moving patients through the levels of treatment and programs with the goal of helping that patient's recovery. If a patient on leave, or a conditional discharge, relapses, the staff work to help that patient succeed the next time they are ready to try for re-integration into the community. To some degree, like recovery from addiction, a relapse can be part of the process towards a full recovery.

The net effect of these systemic pressures is an underlying presumption that a patient is to be moved through the system and eventually out of FPH. It is not that staff are not aware of the need to manage risk, but this presumption is part of the culture in the hospital. Treatment teams have been noted to apply for a higher level of permission for a patient because they don't know what else to try, even when they are not sure the patient is ready for the next step. Respectfully, this culture and systemic pressure may have led to some degree of an element of Groupthink, where staff are collectively focused on the goal of returning the patient to the community.

Assessing Mr. Donnelly's Risk

1. The average NCRMD patient is at FPH under a full custody order at the FPH for less than four years, even when the index offence is at the very high end. Mr. Donnelly has now been in the FPH for 17 years.

2. If the police investigation is correct and Mr. Donnelly is the person who assaulted people at the event on September 10, 2023, Mr. Donnelly has assaulted people on four occasions. The intervals between these four events is approximately three years, eight years and six years.

3. The staff at FPH continued to work to try to reintegrate Mr. Donnelly back into the community during the 17 years.

4. My opinion is that long periods of time without a relapse was not an indication that there was no longer a serious risk if Mr. Donnelly was given unescorted access to the community.

5. The treatment culture at FPH is positive and helpful. The primary role for staff is to help patients heal and be reintegrated back into the community. However, all staff need to accept this role exists in tension with ensuring that the risk management system, they also must support, works to protect the community.

6. The risk assessment evaluation for Mr. Donnelly was too short-sighted. The question was not whether it was an acceptable risk to the public each time he went out. It is essential to consider what the level of risk was over a much longer period of time.

7. It is my opinion that an assault, like the one on September 10, 2023 was more likely to occur at some point, than not.

8. It is my opinion that there will be situations where further treatment, programs, or therapy, will not resolve the underlying risk that a patient's illness poses to the public. This assertion sits in contrast to the underlying presumption (and legal obligation) of always trying to re-integrate patients back into the community.

Expert Reviews:

Two experts were retained to provide their input into this Review. They were provided the complete Donnelly chronology and a draft of the Recommendations. They did not have access to the primary source documents. Although their analysis of the risk presented by Mr. Donnelly's illness could not be included in this report, both Dr. Graham Glancy and Dr. Steven Hart's provided their opinion that Mr. Donnelly did present an elevated risk.

Conclusion:

Taking into account the opinions of Dr. Glancy and Dr. Hart and my review of the documents and the interviews of several of his treating psychiatrists, I came to the following conclusions:

1. There are patients who present elevated risk management issues for a variety of different reasons.

2. The recommendations that follow are designed to bolster the risk management process at FPH. One issue that is particularly emphasized in Recommendation 3 is that there is a cohort of patients who present an elevated risk. The need to identify these patients and provide additional safeguards is critical to reducing the risk to the community.

3. It is submitted that it is necessary to acknowledge that there will be patients who cannot be reintegrated into the community and may always need to be held in a secure setting and/or accompanied by staff when in public. Some patients reach an endpoint in their recovery and unfortunately, their illness and/or other deficits continue to mean that they pose a serious risk to the public. More treatment, more programs, and more time will not cure or adequately manage their illness or reduce the risk to the public.

Part 5 - Recommendations

The Four (4) Principles Underscoring the Recommendations:

- *Accountability,*
- *Rigour,*
- *Expert Knowledge, and*
- *Communication*

Recommendation 1: Patient Care Teams

Introduction – The Ward Model

The ward model was implemented at FPH in 2015. Prior to 2015, FPH assigned a psychiatrist, a care coordinator (nurse), and a social worker to each patient. This care team generally had that patient in their care for the duration of the time the patient was at FPH.

The wards at FPH are designated to help patients with particular illnesses or at different stages of treatment and recovery. Patients who are still suffering from psychosis are held in one ward, but once that is under control, they are moved to another ward where various kinds of treatment and rehabilitation programs can be utilized. When they have shown enough stability and are far enough along in their recovery, they can be moved to a ward where they do their own shopping and cooking and begin to exercise more liberties. All of this in preparation for the patient moving back into the community. Under the ward model, a psychiatrist is assigned to a ward and works with a treatment team. As a patient begins to get better, the patient moves on to a ward with more programs, therapy and liberties. Under the ward model, this means having a new psychiatrist and treatment team take over their care. There are head nurses (managers) overseeing each ward and the care of the patients, but a specific nurse is not assigned to each patient. The work of assembling the nursing reports, psychiatrist, and social worker reports for the Review Board ("RB") is assigned to the RB liaisons who are usually senior nurses. The RB Liaison also represents the Director at the RB Hearing, unless the Director has arranged for counsel. There are currently four RB liaisons and one manager.

The Treatment Team: Under the current model, each patient has a treatment team which will include various professionals, depending on the needs of the patient. The team will include the treating psychiatrist, unit nurse, a social worker and could include rehabilitation and counselling staff.

Under the ward model, when a patient moves to a new ward, they will be assigned a new treatment team that specializes in working with the patients who are being held on that ward. Using the ward model means that there is a consistent treatment team for all the patients on that ward. Weekly patient rounds

are easily scheduled as the same team treats all the patients on that ward. This model, or a variation of it, is the most widely used model in forensic hospitals in Canada.[32]

Prior to 2015, FPH had a model in place where a psychiatrist, nurse, and social worker were assigned to each patient. There were some issues with this model that were logistical. For example, there were issues with the level of integration with the rest of the treatment providers, and with too many of the nurses in this role having the same time off during the summer months.

The Debate:
Currently, FPH uses the ward model, but it is in some flux and uses somewhat of a mixed model at present. Dr. Anhoury, the Medical Director of FPH, has been working with a team to look at what other hospitals are doing and is holding workshops and town halls with FPH staff. The goal of the team is to develop a model of care with best practices.

Dr. Anhoury believes the ward model has many advantages when it comes to treatment. There is no doubt that having patients assigned to wards by types and levels of illness is logical. Dr. Anhoury also believes the ward model is the most workable for staff to work together and be included and present for patient care meetings.

After interviewing a number of staff, receiving input from both Dr. Glancy and Dr. Hart, and observing how the hospital staff interact, I formed the opinion that the current model of care is not functioning that well. The system lacks accountability, effective communication, and there is a need for staff to have in-depth knowledge of the patients who are assigned to them.

Dr. Glancy, who provided an expert opinion on these recommendations, is of the opinion that the ward model is the most effective model for a forensic hospital and believes that scheduling rounds under the patient care model would be difficult.

Mr. Blaine Bray, the Executive Director, believes that the scheduling rounds for a patient care team model is workable and that the advantages of the patient care team, as discussed below, make it worth overcoming the scheduling challenges.

Transition:
Two more positions are being added to the RB Liaison team as the FPH works to modify the current model of care. Currently, with the ward model in place, there is no assigned care coordinator for each patient. The RB liaison reviews the ward nurses' notes and prepares a summary report for the RB of the nursing staff's observations. The RB liaison then attends the RB Hearing and is available to answer questions about their report, but as they have had no direct contact with the patient, they cannot provide testimony about their observations.

The Executive Director of FPH is working to transition FPH to return to having a nurse, in the role of Forensic Care Coordinator ("FCC") assigned to each patient. It is noted that the forensic clinics do assign a care

[32] Interview with Dr. Glancy on 24-04-01

coordinator to each patient. The FCC will have ongoing direct contact with the patient they work with. They will also have the ability to review all the nursing reports. When they write their RB reports, and attend a patient's RB Hearing, they will have in-depth knowledge and be able to answer questions about the patient for the RB.

Currently, as a new model of care is being worked on, there is a hybrid model in place. Many patients are now being assigned a psychiatrist who will stay with that patient regardless of what ward they are placed in.

A Triad Patient Care Team:
Under this model, each patient at FPH is assigned a treating psychiatrist, an FCC, and a social worker. This triad patient care team ("PCT") works together to address the needs of the patient and manage their treatment and potential rehabilitation into the community. The team stays with the patient throughout the time they are held at FPH.

The advantage of a PCT is that three key aspects of risk management can be addressed more effectively (accountability, effective communication, and in-depth patient knowledge).

The treating psychiatrist, as the most responsible physician, is responsible for developing the treatment plan and for assessing and managing risk. By treating the patient for a longer period of time, the psychiatrist will have direct knowledge of that patient, including when they are unwell, displaying risk factors, or potentially still psychotic. They will be more aware of the patient's potential triggers at a level different from what they would be after just being briefed or reading a report.

The Chair of the RB noted that there have been times when the psychiatrist, who appears as an expert witness at an RB hearing, has been newly assigned to the patient. The RB has been frustrated when this occurs as there is a reduced ability to answer RB member's questions, particularly about the history of the patient or changes in their clinical presentation or risk profile.

Currently, at a RB hearing, the RB liaison is a senior nurse who has reviewed the nurses' notes about their observations of the patient's behaviour since the last Hearing. The RB liaison cannot provide evidence about the patient to the Board. In the PCT model, the FCC will also prepare a report from the nurses' observations, but will also have direct personal and in-depth knowledge of the patient.

The FCC is responsible for coordinating the treatment plan and collating and make available all relevant knowledge about the patient which will be based on direct interactions and knowledge of the patient. The FCC takes the lead in ensuring that all relevant reports and communication are provided to the P&P Committee, the Review Board, the courts, and the forensic clinics, in a timely way. The FCC will be the one point of contact for anyone who needs information about the patient. That point of contact is noticeably absent now.

The social worker will provide their expertise to the treatment plan and programs that would assist the patient and the liaison to the family and outside support for the patient. When reintegration with the

community is being considered, the social worker will take the lead in developing the transition plan to re-integrate the patient into the community, having regard for the risk management issues that the patient presents.

Advantages:
In interviews, some staff advanced the position that having a consistent team assigned to a patient would have a significant therapeutic advantage. As discussed above, there are other opinions about which model is the best for the patient and for the functioning of the Hospital. However, it is submitted there is a higher priority that must prevail. The priority is to put in place a system that strengthens risk management. Having a team that knows the complete history of the patient at FPH and knows the triggers and warning signs for potential decompensation, especially in elevated risk patients, is critical.

It has been noted in my observations of the P&P Committee meetings, several treatment teams who provided applications for more privileges for their patients have either not known or been mistaken about the history of the patient, including understanding the level of violence the patient has demonstrated in the past.

Having a team that has witnessed the entirety of a patient's hospital stay, and has in-depth knowledge of their index offence, is essential. A team that is fairly new to treating a patient may be limited in their understanding of the risks posed in that their only direct exposure to the patient is the baseline that patient had achieved at the time they took over the patient's treatment.

Even with a PCT model of care, there will be need to be changes in the members of the team or a patient will sometimes need to transition to a new PCT, especially if the patient's stay at the FPH is an extended one. When that occurs, care must be taken to ensure the new team member or new PCT is properly briefed by the previous PCT members as part of the transition.

Psychiatrist: Whether it is instructions to the point-of-care nurse responsible for gatekeeping a patient's leave, applications being made to the P&P Committee, or for an RB hearing, the psychiatrist who knows the patient well, will be able to provide in-depth and accurate information to staff and answer questions from either the P&P Committee or RB. The psychiatrist has to understand the risks posed by the patient, their triggers, the signs of relapse, and have an in-depth knowledge to know what the risk management plan needs to be to protect the community as they work to rehabilitate the patient.

Forensic Care Coordinator: The FCC will be the one point of contact for anyone needing information about the patient. Currently, staff in the forensic clinics have expressed frustration in their efforts to obtain the most current information on a patient. In the clinics, each patient is assigned a case worker that fulfills this function and ensures the flow of essential communication. The staff at the Clinic advise that this works well. When the FCC presents to the Review Board, or answers questions at the P&P Committee, it will be from in-depth personal knowledge about the patient, including their history and current progress.

Social Worker: The social worker will develop connections with outside family members, friends, and community supports for the patient. Frequently, family members are the people most at risk when a

patient begins to try to reintegrate into the community. Family, however, may be the patient's greatest support. Having a social worker who knows the family well, who can advise the team of all the circumstances, and can plan the reintegration in ways that minimize risk, addresses the needs of the patient, and takes advantage of social supports the patient may have, increases the chances of success.

Recommendation: A Triad Patient Care Team (PCT)

FPH should implement a triad patient care team model for treating each patient. This model makes it very clear who is responsible for each step in the process. Lines of communication outside the FPH to the RB, the clinics, and other agencies will be greatly enhanced. In-depth knowledge of patients, from the index offence, to their response to treatment, to their level of support in the community, or risks they pose to specific members of the community, will be enhanced.

The ward model should be retained as much as possible; however, it should be modified as needed to make the PCT model successful. Given the complexity of making both systems work in harmony, some flexibility in both models will be necessary.

a. An FCC should be assigned to each patient as soon as possible.
b. Given the caseload at FPH, 10 PCTs are needed.
c. The FPH should organize staff into the needed number of PCTs and assign patients to these teams.
d. The priority for assigning PCTs should be elevated risk patients as defined in Recommendation 3.
e. Where possible, the PCT assigned to a patient should have the care of that patient until they transition out of FPH.
f. The PCT must work with the rest of the treatment team working on each ward. The PCT must attend scheduled patient care meetings on the ward.
g. There must be a formal transition plan if a patient has to be assigned a new PCT.

Recommendation 2: The Program and Privilege Committee

There are three (3) permissions that are needed before a patient, held at FPH, can step outside the walls of the hospital.

Review Board
The RB must have granted the Director the discretion to allow the patient to have absences from the FPH. This is done on the Disposition Order issued by the RB after determining that a patient will remain in custody. The absences can be restricted to escorted absences, where staff must accompany the patient, or they can be unescorted absences and/or overnight visits up to 28 days.[33]

The Director of the FPH (Person in Charge)
The Director then decides when and how to allow the patient to exercise the privileges permitted by the Review Board.

Practically, these decisions are made through the process used by the P&P Committee pursuant to PHSA Policy.[34] Currently, this policy needs revision. One reason is that it does not clearly acknowledge the oversight role of the Director/Person in Charge.

The relationship between the Director and the P&P Committee is described in **Attachment A** of the Person in Charge Contract that the Director has with PHSA.

> Risk Management …
>
> Authority to direct restrictions on a patient's liberty as set out in the RB disposition. RB annual dispositions set out privileges which represent the maximum allowable freedom and access to the community allowed by the RB. These privileges are exercised at the discretion of the hospital. The Person-in-Charge is responsible for the final approval of the privileges to be exercised, depending on the recommendation of the Program and Privilege Committee, based on a review of the application by the Treatment team regarding the clinical status of the patient, and on any other relevant factors.[35]

When the treatment team believes that a patient they are treating is ready for a higher level of privilege, the team submits an application to the P&P Committee. The P&P Committee meets weekly to discuss these applications and decide whether to recommend the Director approve the application or not. Until April of this year, these meetings were being held virtually. Generally, the Director attends the meeting. Most P&P members understand that the Director has final say, however, initial decisions are made by consensus.

---

[33] The functioning of the Review Board is not within the Terms of Reference for this Review.
[34] Appendix D - CCR-712H, Program and Privilege Committee and Privilege Levels (October 8, 2019)
[35] Person in Charge Contract (Feb. 15, 2023 – PHSA Contract)

There is confusion among some staff regarding the role of the P&P Committee and the authority of the Director. This Committee operates at the intersection of patient medical therapy and the Director's legal authority and responsibility. The treatment team is responsible for assessing the risk associated with granting a specific privilege. However, their efforts to support the patient's recovery and reintegration may lead them to advocate on the patient's behalf, making objective risk evaluation challenging. The P&P Committee must weigh the therapeutic benefits of the requested permission against the potential risk to the community. The Director must then consider the Committee's recommendation and decide whether the risk factors have been adequately addressed before granting the permission.

The following issues were observed:

- **Inconsistent Quality and Completeness of Requests:** The quality and completeness of the requests from the treatment teams varied widely. In some cases, the applications were missing required documents, such as a recent START (Short-term Risk Assessment Tool) or a risk management plan for the patient upon leaving the FPH grounds.

- **Lack of Representation at P&P Meetings:** Often a treatment team member did not attend the P&P meeting to present their patient's application. In such cases, a member of the Committee tried to present the written application on behalf of the treatment team. This almost always resulted in unanswered questions about the application.

- **Confusion About Roles:** When some treatment team members did attend, they were often confused about their role, acting as though they were there to make the decision rather than to present the application and answer questions.

- **Insufficient Knowledge of Patient History:** In some instances, the treatment team lacked sufficient knowledge of a patient's history to answer questions and properly assess risk. This ranged from not understanding the full context of the index offence to being unaware that a family member might be at risk if the permission was granted. The depth of understanding of the risks to be managed varied greatly among treatment teams.

A New Policy for Granting Privileges

The functioning of the P&P Committee is critical to managing the risks faced by the FPH when allowing patients access to the Community. There are generally no issues when patients are on escorted leaves with FPH staff or when unescorted leaves are structured. Problems typically arise when patients are given freedom for several hours to engage in leisure activities without close monitoring. It is important to note that approximately 60% of patients struggle with substance use issues, which can significantly impact their ability to manage their illness and behaviour when granted liberty. While not every patient granted access to the community poses a high risk of violence, there is a need to determine who the patients are that do.

In a 2018 review of the FPH, it was recommended that the Director delegate the authority to make privilege decisions to the P&P Committee. Respectfully, this is contrary to what is needed to manage risk effectively. One person must bear the responsibility for making the final decision regarding unescorted leave. Legally and ethically, the Director holds the responsibility and is accountable for this critical decision.

It is therefore recommended that the P&P Committee function using a more structured policy:[36]

A. **Revision of Policy:** The policy for the P&P Committee will be revised to include a clear description of the role and authority of the Director.

B. **Application Vetting:** Only applications that have been vetted for completeness will be forwarded to the P&P Committee.

C. **In-Person Meetings:** P&P meetings will be held in person. Virtual attendance is permitted only when in-personal attendance is not feasible.

D. **Treatment Team Attendance:** A member of the treatment/care team will attend to present the application and answer questions. If the privilege requested involves unescorted absences, the application cannot be considered unless the treating psychiatrist is present.

E. **Quorum Definition:** Quorum for the P&P Committee will be defined as including the Director (or delegate), the Medical Director (when available), two other directors, and a Clinical Services Manager.

F. **Minutes of the P&P Meetings:** Minutes will include:
   i. Composition of the P&P Committee on that day
   ii. List of risk factors considered in making a decision
   iii. Presenter(s) from the treatment/care team
   iv. Committee's recommendation
   v. Director's decision

G. **Training Course:** A training course will be established for all members of the P&P Committee, patient care team, and treatment team. This course will outline the responsibilities of each member and the essential components of an application.

H. **Interim Policy:** An interim policy to replace PHSA CCR-712H has been drafted with input from FPH staff.[37]

[36] Appendix D
[37] Appendix D - For reference, both the old policy (PHSA CCR-712H) and the new interim policies for P&P Committee

I. **Field Testing:** As of April 3, 2024, FPH staff are field testing the interim policy and may propose amendments before forwarding it to PHSA for formal approval.

Recommendation 3: An Elevated Risk Patient Policy

The following recommendation flows, in part, from the analysis of the Donnelly Chronology.

1. It is my opinion that some patients at FPH may never successfully reintegrate into the community and may always need to be held in a secure setting or accompanied when in public. Legally, at each RB hearing, a patient must be granted an absolute discharge if it is determined that they do not present a significant threat to public safety. However, the reality is that some patients reach an endpoint in their treatment where their risk level remains high despite ongoing medications, treatment, programs, and therapy. Until there is a significant change in their profile, their risk level will not decrease.

2. Regardless of the issues presented by an elevated-risk patient, the Director must continually assess the risk each patient presents and provide sufficient evidence to the RB to justify the patient's continued custody at FPH.

3. When a patient is known to present an elevated risk, extra caution and safeguards must be implemented to manage the risk effectively.

4. The FPH should establish a process for determining if a patient presents an elevated risk of violent re-offending. If a patient is identified as presenting an elevated risk, additional steps and safeguards should be employed to manage this risk.

5. The following factors may be considered in determining if a patient presents an elevated risk:

    a. The patient's illness is resistant to anti-psychotic medication.
    b. The patient lacks insight.
    c. The patient relapses quickly.
    d. The patient has addiction to drugs or alcohol.
    e. The index or other crimes committed were very violent.
    f. The patient has untreatable deficits (e.g., borderline personality traits or traumatic brain injury).

6. In collaboration with senior staff at FPH, a new draft/interim policy for Elevated Risk Patients has been developed to address the risks presented by certain patients.[38]

[38] Appendix E

7. The policy prescribes the following for patients presenting an elevated risk:

    a. Before granting unescorted absences, an outside expert risk assessment must be obtained.
    b. An outside expert risk assessment will be obtained prior to RB Hearings.
    c. Having legal counsel represent the Director at RB Hearings is essential.

8. The Director and key FPH staff will meet with each treating psychiatrist to identify patients assessed as elevated risk patients. The Elevated Risk Patient ("ERP") Panel will then meet and establish a list of ERPs.

Recommendation 4: Staff Training on Forensics and Risk Assessment Tools

Frontline Staff:
Before a patient can leave the FPH for an outing, an additional risk assessment must take place. If the RB has granted the Director discretion to allow unescorted absences and the P&P Committee application has been approved by the Director, the patient may prepare for the outing. However, before leaving, the patient must present themselves to their nurse. The point-of-care nurse must be satisfied that the patient is currently functioning well enough to manage the risk of allowing them leave.

The front-line staff consists of nursing staff and mental health care workers. The use of mental health care workers who have received little or no formal training places a higher burden on the nursing staff.

The nursing staff are a mixture of Registered Psychiatric Nurses and Registered Nurses. However, few, if any, have received training in forensics. There is no forensics training course for nurses in Canada. In the context of health services, forensic training primarily involves learning how to do risk assessments. All patients at FPH pose a risk of violence, and assessing and managing that risk daily is a key responsibility of point-of-care staff.

To improve the overall quality of the point-of-care risk assessments that nurses must perform daily, it is recommended that they receive forensic training. This training will enhance their ability to contribute more meaningfully to patient care meetings.

The Director at FPH is in charge of risk management and has developed a five-week course for frontline staff, potentially in partnership with Douglas College. The training includes risk assessment and risk management in the context of the wards and hospital grounds, aiming to reduce risks to staff and other patients. It provides instruction on specific risk assessment tools that staff are required to use. The training will be classroom-based and include practical scenarios (simulation training). The course is currently planned to last five weeks.

Training Plan:
It is recommended that the FPH develop a comprehensive training plan to provide in-service forensic training for all staff, including:

- **Five-Week Forensics Course:** For staff who have not had forensic training (most have not). This will include training on the various risk assessment tools, how to complete them, and how to use them in practice;
- **Onboarding and Orientation:** For new staff to ensure they are adequately prepared;
- **In-Service Training for Psychiatrists:** Focusing on long-term risk assessment tools, including the HCR-20v3;
- **Ongoing In-Service Training:** At least 16 hours annually for all staff on risk management; and
- **Two-Day Annual Workshop:** For FPH and forensic clinic staff to stay updated and enhance their skills.

Providing this training will likely require a significant increase in the training budget, primarily driven by the cost of coverage for staff so they can attend training – in particular during the first stages of implementation when the number of staff needing to complete the training will be higher. Nevertheless, training is a key component of risk management at FPH. It is recommended that an in-service forensic training plan be developed and implemented.

Dr. Hart provided very specific training recommendations – which will be provided to FPH – that should be used to assist in implementing this recommendation.

Recommendation 5: The Accountability Feedback Loop

To ensure staff in any organization consistently make good decisions, three key elements must be in place: policy, training, and an accountability mechanism to ensure policies are producing the desired outcomes and are being complied with.

Recommendations 2,3 and 4 address policy amendments and enhanced training. To support these and other key policies, FPH must implement systems to verify compliance and assess the effectiveness of these policies.

- **Policy Compliance Audits**: Conduct audits on policy compliance within FPH once a quarter for the next year, and thereafter as needed (but ongoing).
- **Outcome Assessment:** Evaluate these new policies and related policies to ensure they lead to the appropriate outcomes.
- **External Assessment**: An external assessment by the end of 2025 is recommended to determine if these recommendations have been implemented and are achieving the desired results.

Recommendation 6: Counsel for the Director at the Review Board Hearings

Currently, at Review Board hearings, there are at least three parties with standing: the Director, the Attorney General, and the Patient.

The Attorney General is represented by Crown counsel. The Patient has counsel, often funded by Legal Services Society. However, the Director is most often represented by an FPH staff member. Currently the

RB manager and four RB liaisons, all experienced nurses at FPH, perform this role. (Note: If this recommendation is followed, several of these positions can be transitioned to the FCC positions needed for the PCTs.)

These RB liaisons understand the process and can articulate the Director's position at RB Hearing. However, given the risks involved and the complexity of legal issues that can arise during a hearing, this is no longer sufficient.

Particularly with patients who present an elevated risk, the Director's position before the RB needs to be a well-represented case, supported by necessary factual assessments and expert reports. When the Director determines that a patient has reached an endpoint and still represents too much risk to be granted unescorted access to the community, it is crucial to ensure that expert evidence and appropriate submissions are made at the RB hearing to support this position.

To be properly represented at a RB Hearing, the person presenting must be able to:

a. Receive instructions from the Director.
b. Assess the reports by the treating psychiatrist, the clinical nurse coordinator, and the social worker (the Patient's Care Team).
c. Determine if additional evidence is needed before proceeding to the RB hearing.
d. Understand the legal test the RB uses to determine if continued custody of the patient is justified and necessary.
e. Have a working knowledge of Part XX.1 of the *Criminal Code,* which outlines the legal steps the RB must follow as well as the RB hearing rules.
f. Prepare and present the Director's position before the RB, including eliciting direct evidence from each expert witness.
g. Cross-examine witnesses called by other parties, including the patient, when necessary.
h. Provide submissions to the RB and answer questions from the RB after the evidence has been presented.

This work is beyond the scope of training for nurses at FPH, regardless of their experience. It is recommended that this work be performed by legal counsel.

Using the Donnelly file as an example, the RB was considering this patient for conditional discharge in the months leading up to September 10, 2023. Donnelly's treating psychiatrist did not oppose that outcome, although he was uncertain if Donnelly could be placed anywhere other than the CTC cottages, where he would be monitored by staff before and after going out for the day. If the Director felt that Mr. Donnelly represented too high a risk to be given a conditional discharge at that hearing, the Director would need to provide more than just his position to the RB; there would need to be evidence and submissions to support that position.

Elevated Risk Patient Policy - The Priority for Counsel: In the proposed Elevated Risk Patient Policy, when a patient who presents an elevated risk has an RB Hearing, the Director is to be represented by counsel. These cases should immediately be assigned to legal counsel going forward.

Workload

Legal counsel for PHSA, Ms. Sybila Valdivieso, advises that PHSA already provides counsel for many hearings. To meet the workload of representing the Director at RB hearings, she believes that two full time lawyers and a paralegal assistant would be needed.

Added Value

Dr. Glancy, in his review of these recommendations, noted that in Ontario, legal counsel provides an additional layer of risk management by reviewing and advising the Director on the position to take at RB hearings.

Recommendation: That the Director be represented by experienced legal counsel at RB hearings.

Recommendation 7: Risk Management Using Technology

It is recommended that the FPH explore using GPS technology as a tool to manage the risks of providing liberty to patients outside the walls of the FPH. Dr. Glancy advises that in some jurisdictions in the UK, GPS tracking via a patient's phone or a tracking device is used with elevated risk patients on unescorted leave from their hospital. Some hospitals have hired private companies to monitor patient locations to ensure they are where they are supposed to be. While there are legal (consent) issues to address in policy, using this tool can allow a risk management plan responsive to the level of risk posed.

To trial this technology tool, it is recommended that the FPH provide phones to patients on unescorted leave for the day. The trial could start with five (5) phones to work through the implementation phase. The FPH will need to set up a tracking system either in-house or by contracting a security firm. One way to help verify that the phone is with the patient is have the patient text the FPH once an hour as a safety check.

The phone can also be used as a lifeline for patients who encounter difficulties while on leave, such as getting lost, needing medical attention, or seeking help during a crisis.

Additionally, there are software applications being developed that monitor a patient's vital signs and attempt to assess the patient's mood. While these applications are still in the experimental stage, they may prove useful in the future.[39]

Dr. Glancy and Dr. Hart

Both Dr. Glancy and Dr. Hart provided their input on these recommendations, and they endorse the approach taken in the recommendations. Some of the recommendations were modified after receiving

[39] Information from Dr. Glancy

their input. In interviews with both experts, they pointed out how important it was to have fully trained staff following clear policies in order to manage risk on an ongoing basis.

Part 6 – Conclusion

Risk management exists on a continuum. The only sure way to eliminate all risk to the public would be to keep all NCRMD patients in a facility indefinitely. However, this option is neither legal nor ethical. The other extreme would be a system similar to our penal system, where individuals are released back into the community at prescribed dates, even when there is still a known risk to the public.

The current system for dealing with NCRMD patients in Canada balances the need to protect the public against the rights of every individual to have the least possible restrictions placed on their liberty.

To fulfill their mandate, the staff at the FPH must continue to provide unescorted leaves and overnight stays to patients who they evaluate are well enough to enjoy those liberties without placing the public at undue risk. Each decision to provide those leaves carries some risk. The staff must evaluate that risk and develop and implement a risk management plan tailored to each patient to reduce that risk as much as reasonably possible.

The assaults that occurred on September 10, 2023 alarmed the public and brought attention to the BC Review Board and the Forensic Psychiatric Hospital. This is the type of event that FPH staff work diligently to prevent. The question that must always be asked is whether such an event is preventable within the confines of the law.

The answer is that there are ways to reduce the risk of such an event occurring again, and this review's recommendations are designed to move the FPH closer to that goal. It is also true that the risk will never be reduced to zero, and adverse events will occur.

The staff at the FPH recognize the constant need for vigilance in managing the risks associated with the reintegration process. While some patients benefit greatly from treatment and programs, with their illness well-managed with medication, there will always be exceptions. Some patients have illnesses resistant to medications or other deficits that cannot be cured or adequately managed by additional treatment or programs. Extra care is required for those patients who present an elevated risk. The recommendations made here aim to enhance the staff's ability to understand all the risks their patients present and to provide an improved process for granting leave from the hospital.

The Donnelly case exemplifies the challenges of managing a patient's atypical and difficult-to-treat illness. A key component of this risk management strategy will be advocating that, in exceptional cases, there will be certain patients that cannot be safely managed in the community without constant supervision.

Appendices Index

Appendix A

PROVINCE OF BRITISH COLUMBIA
MINISTRY OF HEALTH

In the matter of a review of the policies, practices and procedures of the Forensic Psychiatric Hospital used for the purpose of assessing patients to be permitted leave from the Forensic Psychiatric Hospital, and whether the policies, practices and procedures adequately ensure safety of the public.

TERMS OF REFERENCE

BACKGROUND:

A. If an accused is determined to be unfit to stand trial or found to be not criminally responsible on account of mental disorder ("NCRMD") under the *Criminal Code,* the accused may be diverted to the forensic psychiatric system to be a patient (each a "Patient") under the jurisdiction of a provincial or territorial Review Board established under the *Criminal Code*;

B. In British Columbia, the British Columbia Review Board (the "Board") is established for the above purpose. Section 672.54 of the *Criminal Code* provides that the Board must take into account the safety of the public (which is the paramount consideration), the mental condition of the accused, the reintegration of the accused into society and other needs of the accused when making dispositions;

C. The Forensic Psychiatric Commission (the "Commission") is established pursuant to the *Forensic Psychiatry Act*. The Minister of Health is responsible for this Act. Section 5(b)(ii) of the *Forensic Psychiatry Act* provides that a function of the Commission is to provide forensic psychiatric services for persons held under the *Criminal Code* or the *Mental Health Act*;

D. The Commission operates the Forensic Psychiatric Hospital (the "Hospital"). The Hospital is also a Provincial mental health facility for the purposes of the *Mental Health Act*;

E. Each Patient receives a review hearing before the Board on an annual basis (unless the Board extends the review period, up to a maximum of twenty-four months). The Board determines whether the Patient should remain at the Hospital or be discharged. If the Patient is to remain at the Hospital, the Board may also determine conditions in relation to the Patient. The Board may also delegate to the person in charge of the Hospital the authority to direct that restrictions on the liberty of the Patient be increased or decreased, within any limits and subject to any conditions set out by the Board;

F. The Hospital is staffed by clinicians (physicians, nurses, psychologists, social workers and others) with experience dealing with the unique clinical case management needs of Patients detained at the Hospital;

G. A person who is determined to be unfit to stand trial or NCRMD and who is ordered to be detained in a Provincial mental health facility must receive care and psychiatric treatment appropriate to the condition of the person pursuant to the *Mental Health Act*;

H. Psychiatric treatment includes clinical assessment, medication therapy, and consultation with clinicians. A Patient's overall psychiatric treatment also includes recovery planning, including discharge planning (in the event that the Board orders the discharge of the patient) and may include planning for community outings on an escorted or unescorted basis. The Hospital website, in part, describes the safety of community outings as follows:

> While community outings are an important part of many clients' and patients' treatment plans, public safety is equally important. We take every precaution to protect the public from clients and patients who may be disruptive.
> ...
> For every community outing, whether escorted or not, we follow careful safety and risk protocols to make sure clients, patients and the public stay safe;

I. The clinicians and committees of the Hospital have clinical policies and procedures ("Policies and Procedures") in the event that the Board allows a Patient to be considered for community outings or other leave away from the Hospital. The Policies and Procedures guide clinicians in their assessment of Patients in furtherance of their treatment and recovery plan, while also weighing the risk to the public associated with their outings in the community;

J. In September 2023, a Patient on a community outing (the "Accused") was arrested for stabbing three strangers at a festival. There has been significant public and media interest in the stabbings, particularly about why the Accused was granted a community outing and whether there are adequate safeguards in place for Patient community outings;

K. The *Ministry of Health Act* provides the Minister of Health with duties, powers and functions relating to all matters of health that are not otherwise assigned to the Minister of Health, or to another minister, ministry, branch or agency of the government by an Act or Lieutenant Governor in Council. Part 2 of the *Ministry of Health Act* provides the Minister of Health with broad authority to collect, use and disclose personal information in relation to public bodies for stewardship purposes – which includes evaluating a program or activity authorized under a health enactment, engaging in health system evaluation or improvement, and evaluating health care bodies.

L. The Minister of Health wishes to delegate his authority to collect, use and disclose personal information under the *Ministry of Health Act* for the limited purpose of this review, in addition to the authorities under the *Freedom of Information and Protection of Privacy Act* – such as evaluating the program or activity of a public body.

THEREFORE, I, Adrian Dix, Minister of Health, retain Robert (Bob) Rich, barrister and solicitor, to:

1. Review the privileges granted at the Hospital for Patients over the past year in relation to leave from the Hospital – including those of the Accused and a representative sample of other Patients selected by Mr. Rich – to determine whether clinicians routinely and regularly follow the Policies and Procedures. If the Policies and Procedures have not been followed, describe the extent of the deficiencies in the application of the Policies and Procedures.

2. Opine whether the Policies and Procedures sufficiently address public safety considerations in relation to privileges granted to Patients about leave from the Hospital.

3. Based on the review in sections 1 and 2 above, provide recommendations, if any, for how to ensure that public safety is sufficiently considered in: (a) the Policies and Procedures; and (b) Hospital decisions about granting Patients leave from the Hospital.

4. Consult with forensic clinical psychiatrists or other experts in considering sections 1 to 3 above.

5. Use the information sharing authorities under Part of the *Ministry of Health Act* that I hereby delegate to Mr. Rich for the purpose of conducting the review described in this Terms of Reference, in furtherance of conducting an informed review and making recommendations.

6. Provide answers to sections 1 to 3 above in a written report to me within 6 months.

Date: November 4, 2023

Adrian Dix, Minister of Health
Government of British Columbia

APPENDIX B

Provincial Health Services Authority
Province-wide solutions. Better health.

BC MENTAL HEALTH & SUBSTANCE USE SERVICES
Provincial Health Services Authority

BC Mental Health and Substance Use Services Quaternary Inpatient Model of Care

Forensic Psychiatric Hospital

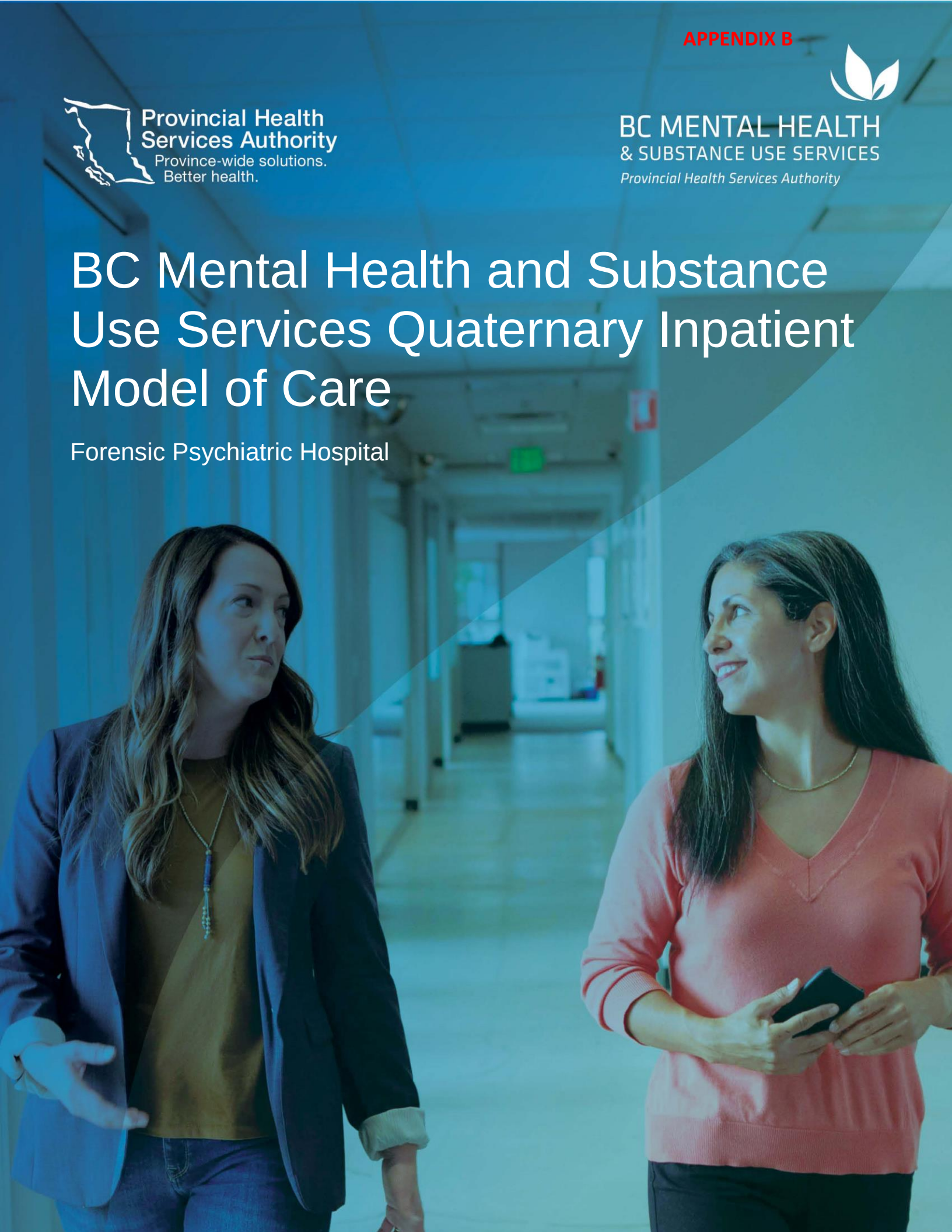


TABLE OF CONTENTS

EXECUTIVE SUMMARY

BC Mental Health and Substance Use Services (BCMHSUS) is a program of the Provincial Health Services Authority (PHSA) that provides a range of provincial, specialized services for people with complex needs in British Columbia. The service continuum includes the Forensic Psychiatric Hospital (FPH).

FPH is a 190-bed, secure facility in Coquitlam, BC that provides specialized quaternary inpatient services for people who have been found not criminally responsible on account of mental disorder (NCRMD) or have been found unfit to stand trial (UST), as well as correctional inmates who are transferred temporarily for treatment under the BC Mental Health Act.

FPH patients are among the most complex patient populations in BC. All live with severe mental health disorders, most often a psychotic disorder, such as schizophrenia. For many, this is combined with a mood disorder (e.g., depression, post-traumatic stress disorder) and/or a personality disorder that makes them anxious, paranoid, fearful, and/or difficult to treat. For the majority of patients, mental illness is exacerbated by a concurrent substance use disorder. It is not uncommon for patients to come from disadvantaged backgrounds, sometimes characterized by victimization, violence, and trauma across the lifespan, which can be reflected in behavioural challenges (e.g., poor frustration tolerance, undeveloped coping skills, and harm to self or others). These characteristics also mean that many patients face associated socio-economic hardships (e.g., poverty, homelessness), structural violence (e.g., stigma, discrimination) and marginalization (e.g., poor social support).

Although all FPH patients must share critical characteristics of mental illness and referral by the criminal justice system to be admitted, they are a heterogeneous group. Patients are diverse in sex/gender, age, diagnosis, legal status, and severity of index offence. This heterogeneity makes it challenging to implement a standardized treatment approach for all. There are also sub-populations of patients at FPH who require special consideration in the planning and delivery of care (e.g., women, long stay or frail/elderly patients).

First-time patients at FPH are hospitalized on average for over 4 years prior to their first conditional discharge. The average patient then spends an additional 17 months under the purview of the BC Review Board for Criminal Code Matters (BC Review Board) before receiving an absolute discharge. The average length of stay for patients at the hospital for an assessment is 28 days.

While at FPH, patients receive intensive recovery-oriented care, with a focus on stabilizing and treating mental illness, reducing problem behaviours and specifically, reducing the risk of criminal offending. The assessment and management of risk is integrated into all aspects of care through formalized, evidence-informed risk assessments and risk management/reduction plans that are regularly reviewed and revised. While at FPH, patients engage in a range of evidence-based treatments, therapies and activities designed to increase their opportunities for healthy, substance-free living.

Key principles guiding the delivery of services at all BCMHSUS programs including FPH include: (1) implementing evidence-based and data-driven practices, (2) person- and family-centered care and (3) team-based decision-making to provide integrated, high quality care for patients. In addition, care is provided with (4) sensitivity to the impacts of previous trauma(s), (4) in a culturally safe manner with humility and (5) a recovery-oriented focus. A recovery-oriented approach aims to support patients to live satisfying, hopeful lives where they can find meaning in the face of ongoing challenges caused by mental health and substance use issues. The importance of a positive therapeutic relationship between caregivers and patients is paramount in achieving positive outcomes.

The FPH clinical framework applies these guiding principles to a therapeutic framework in six overlapping domains: physical wellness (including self-care and activities of daily living), mental wellness, substance-free living, addressing problem behaviours, family and intimacy, and a meaningful life. Therapeutic programming is patient-centered, gender-specific, and focused on individual patient goals that support progress towards a meaningful life, with a central focus on managing and preventing crime and violence, in alignment with the mandate of forensic services, always foremost in treatment planning and execution.

FPH offers a range of evidence-informed treatments and supports for patients, including psychiatric, pharmacotherapy and psychological/psychosocial interventions. Given that FPH patients are more likely to have physical health concerns and experience early mortality in addition to mental health challenges, access to comprehensive primary health care is also a critical component of service delivery.

Care is provided by a specialized team that collaborates with community agencies to ensure an expedient and efficient recovery and reintegration into the community. Patients work with a multidisciplinary clinical team comprised of psychiatrists, family physicians, nurses, social workers, pharmacists, dietitians, psychologists, health care workers, spiritual care practitioners, occupational and physiotherapists, recreation therapists, counsellors and other support staff and coordinators.

Individualized patient care means that each patient will engage in different aspects of the FPH program; no two patient journeys are identical. Care pathways are based upon the legal status of the patient, and their risk, needs and responsivity and include the following:

- NCR/Fitness Assessment – Voluntary
- NCR/Fitness Assessment – Certified
- Not Criminally Responsible Due to Mental Disorder/Unfit
- Returns from Community – Direct Back
- Returns from Community – Breach Return
- Temporary Absence – admissions from BC Corrections

There may be additional patient pathways in rare situations where a unique legal determination that necessitates a different

approach; however, the above pathways are the most common for FPH patients.

The decision to release a patient into the community is made exclusively by the BC Review Board. The BC Review Board also determines what conditions, if any, the patient must follow upon discharge. These conditions can involve the characteristics of their residence, level of supervision, and abstinence from drugs and alcohol. When a patient is discharged with conditions like these, they are supervised by the nearest Forensic Regional Community Clinic. The clinic monitors the patient's progress and ensures that they adhere to the conditions specified by the BC Review Board. The clinic can refer patients back to FPH when they are concerned about mental status or behaviour, either voluntarily (a "direct back") or involuntarily (a "breach"). Breach proceedings (requiring a court order) are normally only initiated if clinically required, usually in situations where voluntary re-admission is not possible.

The BC Review Board also grants absolute discharges, releasing patients from the Board's jurisdiction and transferring their care to a community mental health team and/or family physician.
The ultimate goal of treatment is to assist patients to achieve successful reintegration into the community. This includes reducing the risk of recidivism as much as possible. Preparation for this process begins at admission; it is important for the treatment team to ensure adequate discharge planning and community preparedness throughout the individual's stay at FPH.

Research, education and teaching are formally embedded within FPH and are considered integral to achieving organizational excellence and supporting translational science. FPH intends to assume a provincial leadership role in the creation of new knowledge, identification of evolving and emerging research, and translation and integration of evidence into practice.

Successful partnerships are essential to the success of each patient's journey of recovery. Key stakeholders influence and integrate care and ensure smooth transitions that include family and friends, regional health authorities, BC courts, the BC Review Board, BC Corrections, BC Housing and Forensic Regional Community Clinics.

In summary, FPH provides forensic inpatient care, including assessment and treatment, to residents of BC under the authority of the Forensic Psychiatry Act, the Mental Health Act, and the Criminal Code of Canada. FPH leadership, operations, and clinical care are guided by a philosophy of providing is evidence-informed, individualized, patient-centred, recovery-oriented, interdisciplinary, trauma-informed, and culturally inclusive care.

FPH focuses upon innovation, evidence-based practice, and excellence in capacity-building, all of which allow for effectively addressing the diverse needs of the BC forensic inpatient population. A separate, complimentary Model of Care is available for the FPS Clinics.

INTRODUCTION

The BC Mental Health and Substance Use Services (BCMHSUS) is a program of the Provincial Health Services Authority (PHSA) that provides a range of specialized services for people with complex needs in British Columbia. The service continuum includes the Forensic Psychiatric Hospital, Forensic Regional Community Clinics, and Red Fish Healing Centre for Mental Health and Addiction, Heartwood Centre for Women, Correctional Health Services and provincial contracted services. Programs and services are accredited by Accreditation Canada and are guided by a Directional Plan outlining the approach to care, scope of services, core principles and values, and directional priorities. As an academic program, BCMHSUS also conducts research, participates in student teaching programs, leads provincial planning initiatives, and partners with not-for-profit organizations to address mental health promotion, prevention, and stigma.

POPULATION

The individuals referred to BCMHSUS programs each have their own history, personality, and preferences; however, they share certain characteristics including:

- Complex physical health, mental health, and substance use needs
- Vulnerability to homelessness, poverty, incarceration, and social isolation.
- Adverse childhood experiences (ACEs) and other forms of victimization and trauma (e.g., intimate partner violence; and other forms of property, sexual, and/or violent crime)
- Shorter life expectancy than that of the general population, mostly due to preventable causes
- Repeat emergency department visits and hospitalization

In the conceptual model below (Figure 1), BCMHSUS programs fall into the upper tiers providing highly specialized services to a small number of people with complex and often severe and persistent needs.

TIERS OF SERVICE

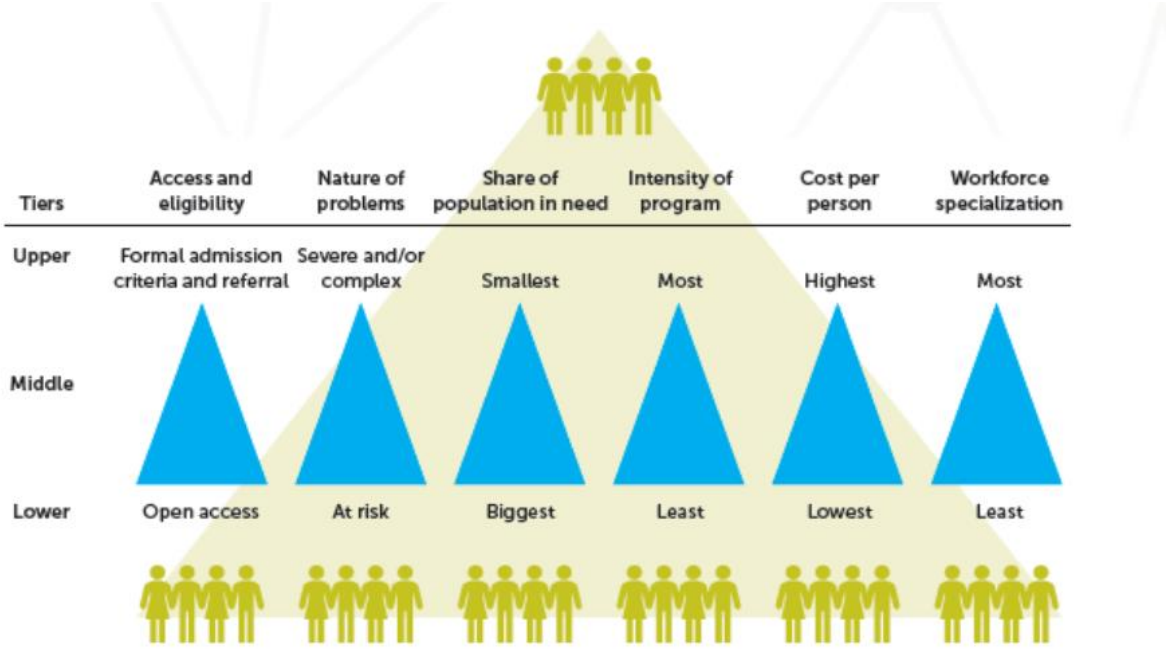


Figure 1: Tiers of Service

MODELS OF CARE

BCMHSUS programs are underpinned by a set of core values and principles and operate in accordance with an evidence-informed Model of Care (MOC) that articulates the target population, legislative framework, core services and clinical program components, interventions, admission and discharge criteria and expected outcomes. The MOC is informed by the research literature, clinical guidelines, expert opinion, and consultation with stakeholders including people with lived experience. The following document outlines the Model of Care for the Forensic Psychiatric Hospital (FPH).

PROVINCIAL QUATERNARY INPATIENT SERVICES – FORENSIC PSYCHIATRIC HOSPITAL (FPH)

Within BCMHSUS, FPH delivers specialized quaternary[1] inpatient services for people who have been found not criminally responsible on account of mental disorder (NCRMD) or are found unfit to stand trial (UST), as well as correctional inmates who are transferred temporarily for treatment under BC's Mental Health Act. To be deemed NCRMD, the individual must have committed a crime but deemed incapable of appreciating the nature and quality of their actions or of knowing their actions were wrong as a result of a mental disorder.[2] To be found UST the person, due to their mental illness, is deemed unable to participate meaningfully in their trial. That is, they are unable to understand the nature or object of proceedings, understand the possible consequences of the proceedings or communicate with counsel.[3]

FORENSIC LEGISLATIVE FRAMEWORK

In Canada, each province and territory has a Review Board, an independent tribunal established under the *Criminal Code of Canada*.[4] A key role of the Review Board is to make one of the following dispositions for NCRMD patients while taking into account the safety of the public, the mental condition of the accused, the reintegration of the accused into society and other needs of the accused:"[5]

a) by order, direct that the accused be discharged absolutely;
b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

The Review Board consists of no fewer than five members appointed by the lieutenant governor in council of the province. It is chaired by a current or retired judge and "must have at least one member who is entitled under the laws of a province to practise psychiatry and, where only one member is so entitled, at least one other member must have training and experience in the field of mental health, and be entitled under the laws of a province to practise medicine or psychology."[6]

Decisions about dispositions and conditions for individuals found to be NCRMD or UST are made at Review Board hearings that are legally required to occur at least annually, except under exceptional circumstances.

For more information on these legal routes/definitions, please refer to Appendix A.

HOSPITAL POPULATION

FPH averages approximately 350 admissions per year, including approximately 65% for assessment and 35% for treatment. Of the assessment admissions, 65% are referred for a fitness assessment, 30% for an NCRMD assessment, and 5% for a dual fitness/NCRMD assessment. Of the treatment admissions, just over half are Temporary Absences (TAs) from correctional facilities, a third are NCRMD patients, and the remainder are people found UST or remanded and awaiting trial. Although assessment admissions account for the majority of admissions to the hospital each year, these people generally have short lengths of stay and account for a minority of the population at any given point in time. Similarly, TA admissions have much shorter lengths of stay than people found NCRMD receiving treatment.[7]

[1] Quaternary Care = Highly specialized care and treatment for the most complex cases provided by a team of specialists, often in purpose-built facilities and often involving a one-of-a-kind program in the province. The progression is typically linear, with secondary care being provided to patients for whom primary care is insufficient, tertiary care being provided to patients for whom secondary care is insufficient and quaternary care being provided to patients for whom tertiary care is insufficient.
[2] Canadian Criminal Code. *R.S.C. 1985, c. C-46, s. 672.1*. Available at https://laws-lois.justice.gc.ca/eng/acts/c-46/page-1.html#h-115011. Accessed July 2020.
[3] Canadian Criminal Code. *R.S.C. 1985, c. C-46, s. 1.* Available at https://laws-lois.justice.gc.ca/eng/acts/c-46/page-1.html#h-115011. Accessed July 2020.
[4] Canadian Criminal Code. *R.S.C. 1985, c. C-46, s. 672.38.* Available at https://laws-lois.justice.gc.ca/eng/acts/c-46/page-1.html#h-115011. Accessed October 2020.
[5] Canadian Criminal Code. *R.S.C. 1985, c. C-46, s. 672.54*. Available at https://laws-lois.justice.gc.ca/eng/acts/c-46/page-167.html. Accessed July 2020.
[6] Canadian Criminal Code. *R.S.C. 1985, c. C-46, s. 672.38.* Available at https://laws-lois.justice.gc.ca/eng/acts/c-46/page-1.html#h-115011. Accessed October 2020.
[7] Ibid.

The average patient at FPH is a Caucasian man in their 30s or 40s who has a history of violent offending prior to the index admission.[8] The most common psychiatric diagnoses among patients admitted to FPH are schizophrenia spectrum disorders (61-77%) and substance use disorders (39%-63%) with the majority of patients diagnosed with concurrent disorders.[9,10]

Many patients additionally have extensive histories of involvement with civil mental health services (78% of assessment patients and 91% of treatment patients).[11] Lastly, histories of trauma and victimization are common among forensic patients,[12] with many reporting adverse childhood experiences (ACEs), such as psychological, physical or sexual abuse.[13,14, 15] Exposure to ACEs results in increased risk for mental and physical disorders, including substance use disorders,[16,17] depression,[18] psychotic disorders, attempted suicide[19] and increased use of prescribed psychotropic medications[20] as an adult.

Heterogeneity

Given the wide-ranging legal and legislative mandate of FPH, the patient population is heterogeneous. Although all FPH patients share critical characteristics of mental illness and involvement with the criminal justice system, patients are diverse in sex/gender, age, diagnosis, mental health, and criminal history, as well as present legal status and severity of index offense.[21,22] This heterogeneity makes it challenging to implement a standardized treatment approach for all patients.[23,24]

Ultimately, patient legal status and the management/reduction of risk are key drivers of any patient's treatment plan. FPH, however, also places an emphasis on the patients' general well-being and recovery, including stabilization of illness, rehabilitation and community reintegration, and use of individualized treatment plans to support each person's progression towards their goals.[25,26,27] The specific needs of indigenous and female patients,[28,29,30] and neurological, developmental, age-related, and genetic vulnerabilities and their impacts upon patient responsivity are carefully considered.[31,32,33,34]

Sub-Populations

A consideration of forensic sub-populations may help inform the planning and delivery of care. These include long stay patients, patients with neuropsychiatric needs, frail and/or elderly patients, and women. The unique needs of these groups should inform treatment, care and discharge planning, with a focus on evidence-based interventions and supports. Please see Appendix B for additional details

---

[8] Crocker A, Nicholls T, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 2: The people behind the label. *The Canadian Journal of Psychiatry*. 2015; 60(3): 106-116.
[9] Crocker A, Charette Y, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 3: Trajectories and outcomes through the forensic system. *The Canadian Journal of Psychiatry*. 2015; 60(3): 117-26.
[10] Nicholls T, Brink J, Greaves C et al. Forensic psychiatric inpatients and aggression: An exploration of incidence, prevalence, severity, and interventions by gender. *International Journal of Law and Psychiatry.* 2009; 32(1): 23-30.
[11] Nicholls T and Petersen K. *BC Forensic Psychiatric Hospital Patient Needs Assessment: Series on Physical Health, Mental Health, Substance Use, Trauma, Risk, Programming, and Pathways*. 2019. BC Mental Health & Substance Use Services. Internal Reports.
[12] McKenna G, Jackson N and Browne C. Trauma history in a high secure male forensic inpatient population. *International Journal of Law and Psychiatry.* 2019; 66: 101475.
[13] Felitti V, Koss M and Marks J. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventative Medicine*. 1998; 14(4): 245-58.
[14] Felitti V. Origins of the ACE Study. *American Journal of Preventive Medicine.* 2019; 56(6): 787-9.
[15] Nicholls T and Petersen K. *BC Forensic Psychiatric Hospital Patient Needs Assessment: Series on Physical Health, Mental Health, Substance Use, Trauma, Risk, Programming, and Pathways*. 2019. BC Mental Health & Substance Use Services. Internal Reports.
[16] Dube S, Anda R, Felitti V et al. Adverse childhood experiences and personal alcohol abuse as an adult. *Addictive Behaviors.* 2002; 27(5): 713-25.
[17] Dube S, Felitti V, Dong M et al. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics*. 2003; 111(3): 564-72.
[18] Chapman D, Whitfield C, Felitti V et al. Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders.* 2004; 82(2): 217-25.
[19] Dube S, Anda R, Felitti V et al. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association.* 2001; 286(24): 3089-96.
[20] Anda R, Brown D, Felitti V et al. Adverse childhood experiences and prescribed psychotropic medications in adults. *American Journal of Preventive Medicine.* 2007; 32(5): 389-94.
[21] Crocker A, Nicholls T, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 2: The people behind the label. *The Canadian Journal of Psychiatry*. 2015; 60(3): 106-116.
[22] Nicholls T, Brink J, Greaves C et al. Forensic psychiatric inpatients and aggression: An exploration of incidence, prevalence, severity, and interventions by gender. *International Journal of Law and Psychiatry.* 2009; 32(1): 23-30.
[23] Crocker A, Nicholls T, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 2: The people behind the label. *The Canadian Journal of Psychiatry*. 2015; 60(3): 106-116.
[24] Nicholls T, Brink J, Greaves C et al. Forensic psychiatric inpatients and aggression: An exploration of incidence, prevalence, severity, and interventions by gender. *International Journal of Law and Psychiatry.* 2009; 32(1): 23-30.
[25] Adshead G and Sarkar S. Justice and welfare: Two ethical paradigms in forensic psychiatry. *Australian & New Zealand Journal of Psychiatry*. 2005; 39(11-12): 1011-7.
[26] Birmingham L, Wilson S and Adshead G. Prison medicine: ethics and equivalence. *The British Journal of Psychiatry*. 2006; 188(1): 4-6.
[27] Exworthy T, Samele C, Urquía N et al. Asserting prisoners' right to health: Progressing beyond equivalence. *Psychiatric Services*. 2012; 63(3): 270-5.
[28] Covington SS. *Beyond Violence: A Prevention Program for Criminal Justice-involved Women Participant Workbook.* John Wiley & Sons; 2015.
[29] Nicholls T, Crocker A, Seto M et al. The national trajectory project of individuals found not criminally responsible on account of mental disorder. Part 5: How essential are gender-specific forensic psychiatric services? *The Canadian Journal of Psychiatry*. 2015; 60(3): 135-45.
[30] Van Voorhis P, Wright E, Salisbury E et al. Women's risk factors and their contributions to existing risk/needs assessment: The current status of a gender-responsive supplement. *Criminal Justice and Behavior*. 2010; 37(3): 261-88.
[31] Chudley A, Kilgour A, Cranston M et al. Challenges of diagnosis in fetal alcohol syndrome and fetal alcohol spectrum disorder in the adult. *American Journal of Medical Genetics Part C: Seminars in Medical Genetics*. 2007; 145(3): 261-72.
[32] Colantonio A, Stamenova V, Abramowitz C et al. Brain injury in a forensic psychiatry population. *Brain Injury.* 2007; 21(13-14): 1353-60.
[33] Curtice M, Parker J, Schembri Wismayer F et al. The elderly offender: an 11-year survey of referrals to a regional forensic psychiatric service. *Journal of Forensic Psychiatry & Psychology*. 2003; 14(2): 253-65.
[34] Shiroma E, Ferguson P and Pickelsimer E. Prevalence of traumatic brain injury in an offender population: A meta-analysis. *Journal of Correctional Health Care*. 2010; 16(2): 147-59.

THE HOSPITAL

FPH is a 190-bed secure facility that provides assessment, stabilization and treatment for individuals found NCRMD or UST as well as psychiatric assessment and treatment for people referred temporarily to the hospital from BC Corrections. The hospital is located in the beautiful Colony Farms Regional Park, in Coquitlam, BC.

CORE VALUES AND GUIDING PRINCIPLES

The following core values and guiding principles underpin all BCMHSUS programs and services including the FPH.

Core Values

How we show up

- Genuine and genuinely care
- Seeing the best in people
- Relentlessly dedicated

What we believe

- Health is a human right
- There is no health without mental health
- Every person is important
- Recovery is possible
- Quality care makes a difference

Guiding Principles

Evidence Based and Data Driven

We advance knowledge and practice through research, evaluation, and continuous quality improvement. We use data and evidence from a range of sources – research, clinical expertise, and lived experience – to inform our work, while remaining open to innovation and new ideas.

Person and Family Centred

We focus on the person in our care and seek to meet them where they are, not where we think they should be. We provide personalized, holistic care to meet the needs, values and preferences of patients, their families and loved ones. We engage people with lived experience in the planning and co-design of our programs, research, and services.

Team Based

We work in teams to provide integrated, high quality care for patients and families. With the patient at the centre, we collaborate across disciplines to address their needs and support them on their road to recovery.

Seamless and Integrated

We communicate and coordinate with health authorities, community providers, BC Housing and other partners to ensure seamless transitions and continuity of care for our patients. We share information, collaborate between agencies to

streamline the pathway of care from admission to discharge and through transitions in care.

Trauma Informed

We recognize that trauma has played a part in the lives of many of our patients and families and endeavour to interact with them considering the contexts and narratives of their lives. We are sensitive to the impacts of trauma and focus on healing-centred care.

Culturally Safe and Humble

We ensure that all people, regardless of age, gender, sexual orientation, occupation and socio-economic status, ethnic origin, migrant experience, religious or spiritual beliefs, and disability feel respected and safe when they interact with our system. We foster a climate where the unique history of Indigenous peoples is recognized and respected in order to provide appropriate care and services in an equitable and safe way, without discrimination.

Recovery Oriented

Recovery oriented care emphasizes patient participation, choice, and engagement in their treatment and recovery planning. We recognize that recovery is a personal, non-linear journey guided by accountability, informed be each patient's wellness goals, the pace they desire to go, the relationship they have with their illness, the agency they exercise, and the opportunity they are offered to lead their most satisfying and meaningful lives.

CLINICAL FRAMEWORK

The following clinical framework highlights how the seven guiding principles of BCMHSUS fit with six important overlapping domains of care to inform the therapeutic approach at the FPH. The six overlapping domains -- physical wellness, mental wellness, substance-free living, addressing problem behaviours, family and intimacy and a meaningful life -- capture the inter-relatedness between patient needs and the range of therapeutic programs, services and activities required to support them on their journey of recovery.

Figure 2: Clinical Framework

The following section provides an overview of the six domains of care. Before doing so, however, we discuss what may be the single most important component of effective treatment, the therapeutic relationship.

The Therapeutic Relationship

An overarching theme in the literature, particularly with respect to the effectiveness of interventions, is the importance of the therapeutic relationship.

The US Substance Abuse and Mental Health Services Administration (SAMHSA) notes that "successful pharmacologic interventions are most likely to occur in the context of a relationship in which the prescriber positions himself or herself as a collaborator in the recovery process, with the goal of helping the individual achieve his or her life goals. The relationship should be empathic, hopeful, and strength-based, and the prescribing clinician should be prepared to work with the individual in a continuing process of assessment and reassessment."[35] Similarly, the first recommendation of the Canadian Schizophrenia Guidelines is that the clinician "take time to engage the person from the start and build a respectful, trusting, nonjudgmental relationship in an atmosphere of hope and optimism."[36]

The evidence suggests that the psychotherapeutic relationship, in particular the working alliance and empathy, have a greater effect size on therapeutic outcomes than treatment methods or technical interventions.[37,38] The working alliance should include an agreement on therapeutic goals, consensus on tasks that make up therapy and a bond between the patient and therapist.[39,40] Empathy, by one definition, involves "the therapist's sensitive ability and willingness to understand the patient's thoughts, feelings and struggles from the patient's point of view."[41,42] The initial interaction between therapist and patient is also critical as more patients prematurely terminate from therapy after the first session than at any other point.[43]

Domains of Care

Physical Wellness

Co-morbid physical illnesses and health problems are significant for individuals at FPH. Physical wellness is a critical focus of care, given that challenges within this domain often need to be addressed before work on other domains can be effectively initiated.

Metabolic illness is a serious condition impacting many patients due in part to the weight-gain side effects of antipsychotic medications and lifestyle factors.[44] Patients may also have challenges with self-care, including physical inactivity, sleep, and nutrition.[45] Proper nutrition is an important aspect of physical wellness, particularly in individuals with concurrent mental illness and substance use disorders. Nutritional psychiatry is a new discipline with intriguing evidence of the relationship between psychiatric illnesses and diet type and quality beginning to emerge. [46,47,48,49] The importance of diet and, in particular, malnutrition and micronutrient imbalances among individuals with substance use disorders has been known for some time.[50,51,52,53]

---

[35] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders*. 2012. Available online at https://store.samhsa.gov/system/files/sma12-4689.pdf. Accessed May 2019.
[36] Crockford D, Addington D. Canadian Schizophrenia Guidelines: Schizophrenia and other psychotic disorders with coexisting substance use disorders. *The Canadian Journal of Psychiatry*. 2017; 62(9): 624-34.
[37] Wampold B. How important are the common factors in psychotherapy? An update. *World Psychiatry*. 2015; 14(3): 270-7.
[38] Norcross J and Lambert M. Psychotherapy relationships that work III. *Psychotherapy*. 2018; 55(4): 303-15.
[39] Horvath A, Del Re A, Fluckiger C et al. Alliance in individual psychotherapy. *Psychotherapy*. 2011; 48(1): 9-16.
[40] Horvath A. The psychotherapy relationship: Where does the alliance fit? In *Developing the Therapeutic Relationship: Integrating Case Studies, Research and Practice*. 2018. The American Psychological Association.
[41] Elliot R, Bohart A, Watson J et al. Empathy. *Psychotherapy*. 2011; 48(1): 43-49.
[42] Elliot R, Bohart A, Watson J et al. Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy*. 2018; 55(4): 399-410.
[43] Connell J, Grant S and Mullin T. Client initiated termination of therapy at NHS primary care counselling services. *Counselling and Psychotherapy Research*. 2006; 6(1): 60-67.
[44] von Hausswolff-Juhlin Y, Bjartveit M, Lindström E et al. Schizophrenia and physical health problems. *Acta Psychiatrica Scandinavica*. 2009; 119: 15-21.
[45] Samele C, Patel M, Boydell J et al. Physical illness and lifestyle risk factors in people with their first presentation of psychosis. *Social Psychiatry and Psychiatric Epidemiology.* 2007; 42(2): 117-24.
[46] Sarris J, Logan A, Akbaraly T et al. International Society for Nutritional Psychiatry Research consensus position statement: Nutritional medicine in modern psychiatry. *World Psychiatry*. 2015; 14(3): 370-1.
[47] Sarris J, Logan A, Akbaraly T et al. Nutrition medicine as mainstream in psychiatry. *Lancet Psychiatry*. 2015; 2: 271-3.
[48] Carnegie R, Zheng J, Sallis et al. Mendelian randomisation for nutritional psychiatry. *Lancet Psychiatry*. 2020; 7: 208-16.
[49] Taylor A and Holscher H. A review of dietary and microbial connections to depression, anxiety, and stress. *Nutritional Neuroscience*. 2020; 23(3): 237-50.
[50] American Dietetic Association. Position of the American Dietetic Association: Nutrition intervention in treatment and recovery from chemical dependency. *Journal of the American Dietetic Association*. 1990; 90(9): 1274-7.
[51] Kaiser S, Prendergast K and Ruter T. Nutritional links to substance abuse recovery. *Journal of Addictions Nursing*. 2008; 19: 125-9.
[52] Schroeder R and Higgins G. You are what you eat: The impact of nutrition on alcohol and drug use. *Substance Use & Misuse*. 2017; 52(1): 10-24.
[53] Jeynes K and Gibson L. The importance of nutrition in aiding recovery from substance use disorders: A review. *Drug and Alcohol Dependence*. 2017; 179: 229-39.

Another important health concern among forensic patients is the high rate of blood-borne viruses, in particular HIV and hepatitis B and C, with incidence rates 5-10 times that of the general population.[54,55,56] These higher rates are largely attributable to high-risk behaviours such as unprotected intercourse, having multiple sexual partners, and injection drug use.[57]

Individuals with severe mental illness also have a higher risk of coronary heart disease,[58] diabetes[59] and venous thromboembolism[60] than the general population. Rates of alcohol misuse and tobacco smoking are particularly high in this cohort, resulting in a disproportionate rate of alcohol- and tobacco-related harms.[61,62,63] These physical health challenges contribute to a substantial lowering of life expectancy.[64,65,66]

The coronavirus 2019 (COVID-19) pandemic has also highlighted a number of additional health risks in this context. Individuals who smoke, vape or use certain drugs (e.g., methamphetamines) are at increased risk for infection and more severe consequences due to compromised cardiac and respiratory systems.[67,68] In addition, they may experience challenges understanding and adhering to public health safety measures.[69] Finally, individuals in recovery may face an increased risk of relapse due to the isolation and stress caused by the public health response to the pandemic. In an inpatient environment such as FPH, increased vigilance is required for suspected COVID-19 symptoms to minimize the risk of outbreak in the facility.

Mental Wellness

The majority of patients at FPH have severe concurrent mental illness and substance use disorders. By definition, forensic patients have a combination of mental health problems and criminal justice involvement. The best outcomes are achieved when these problem areas are addressed in a coordinated way.[70]

Research on integrated treatment approaches "qualitatively and quantitatively demonstrate improved social and clinical outcomes, with comparable costs to standard care, consistent across a variety of outcomes and populations."[71] FPH provides an integrated, unified and comprehensive treatment program, recognizing that an individual's psychiatric illness, substance use disorder and criminogenic factors are equally important.[72,73,74]

Treatment for mental illness and criminogenic factors generally involves a combination of medications and psychosocial interventions. Common categories of medication include antidepressants, anti-anxiety medications, mood stabilizers and antipsychotic medications.[75] Common psychosocial treatments include cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), motivational interviewing (MI), psycho education, self-help groups, and social skills training. The individual's mental state is one of the criteria required when the BC Review Board considers patient discharge from the hospital. [76] Stabilizing the patient's mental illness is an essential requirement for discharge.

---

[54] Cournos F, McKinnon K. Substance use and HIV risk among people with severe mental illness. In Onken L et al. *Treatment of Drug-Dependent Individuals with Co-morbid Mental Disorders*. 1997. U.S. Department of Health and Human Services: National Institutes of Health.
[55] Rosenberg S, Goodman L, Osher F, et al. Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. *American Journal of Public Health*. 2001; 91(1): 31-7.
[56] Sanger C, Hayward J, Patel G, et al. Acceptability and necessity of HIV and other blood-borne virus testing in a psychiatric setting. *The British Journal of Psychiatry*. 2013; 202: 307-8.
[57] Meade C, Sikkema K. HIV risk behaviour among adults with severe mental illness: A systematic review. *Clinical Psychology Review*. 2005; 25(4): 433-457.
[58] Hemingway H, Marmot M. Evidence-based cardiology: Psychosocial factors in the aetiology and prognosis of coronary heart disease: Systematic review of prospective cohort studies. *British Medical Journal*. 1999; 318: 1460-7.
[59] Fenton W, Stover E. Mood disorders: Cardiovascular and diabetes co-morbidity. *Current Opinion in Psychiatry*. 2006; 19: 421-7.
[60] Zhang R, Dong L, Shao F, et al. Antipsychotics and thromboembolism risk: A meta-analysis. *Pharmacopsychiatry*. 2011; 44: 183-8.
[61] Dom G and Moggi F. Toward a New Model of Care: Integrating Mental Health, Substance Use, and Somatic Care. In: Dom G and Moggi F, eds. *Co-occurring Addictive and Psychiatric Disorders: A Practice-Based Handbook from a European Perspective*. Berlin, Germany: Springer; 2015.
[62] National Institute on Drug Abuse. *Do people with mental illness and substance use disorders use tobacco more often?* Available online at https://www.drugabuse.gov/publications/research-reports/tobacco-nicotine-e-cigarettes/do-people-mental-illness-substance-use-disorders-use-tobacco-more-often. Accessed August 2019.
[63] Bandiera F, Anteneh B, Le T, et al. Tobacco-related mortality among persons with mental health and substance abuse problems. *PLoS One*. 2015; 10(3): e0120581.
[64] Royal College of Psychiatrists. *Whole-Person Care: From rhetoric to reality. Achieving parity between mental and physical health.* Occasional paper OP88, March 2013.
[65] Wahlbeck K, Westman J, Nordentoft M et al. Outcomes of Nordic mental health systems: Life expectancy of patients with mental disorders. *The British Journal of Psychiatry*. 2011; 199(6): 453-8.
[66] Thornicroft G. Physical disparities and mental illness: The scandal of premature mortality. *The British Journal of Psychiatry*. 2011; 199(6): 441-2.
[67] Volkow N. Collison of the COVID-19 and addiction epidemics. *Annals of Internal Medicine*. 2020; 173(1): 61-2.
[68] Wu Z, and McGoogan J. Characteristics of and important lessons from the coronavirus disease 2019 (COVID-19) outbreak in China: Summary of a report of 72,314 cases from the Chinese Centre for Diseases Control and Prevention. *JAMA*. 2020; 323(13):1239-1242
[69] D'Agostino A, Demartini B, Cavallotti S et al. Mental health services in Italy during the COVID-19 outbreak. *The Lancet Psychiatry*. 2020; 7: 385-7.
[70] Andrews D. The Risk-Need-Responsivity (RNR) Model of correctional assessment and treatment. In Dvoskin J, Skeem J, Novaco R and Douglas K (Eds.), *Using Social Science to Reduce Violent Offending*. 2012. New York: Oxford University Press.
[71] Karapareddy V. A review of integrated care and concurrent disorders: Cost effectiveness and clinical outcomes. *Journal of Dual Diagnosis.* 2019; 15(1): 56-66.
[72] Essock S, Mueser K, Drake R et al. Comparison of ACT and standard case management for delivering integrated treatment for co-occurring disorders. *Psychiatric Services*. 2006; 57(2): 185-96.
[73] McKee S, Harris G and Cormier C. Implementing residential integrated treatment for co-occurring disorders. *Journal of Dual Diagnosis.* 2013; 9(3): 249-59.
[74] Urbanoski K, Rush B, Wild T et al. Use of mental health care services by Canadians with co-occurring substance dependence and mental disorders. *Psychiatric Services*. 2007; 58(7): 962-9.
[75] Skinner W, O'Grady C, Bartha C et al. *Concurrent substance use and mental health disorders: An information guide*. Centre for Addiction and Mental Health. 2010. Available online at https://www.camh.ca/-/media/files/guides-and-publications/concurrent-disorders-guide-en.pdf?la=en&hash=C32D7F0277A97650BEEE37DB0B2822ED1103EF46. Accessed May 2020.
[76] Canadian Criminal Code. *R.S.C. 1985, c. C-46, s. 672.54*. Available at https://laws-lois.justice.gc.ca/eng/acts/c-46/page-167.html. Accessed July 2020.

Substance-Free Living

Comorbidity in forensic psychiatry is the norm, not the exception. Accordingly, it is essential to provide concurrent disorders treatment and evidence-based interventions that support community integration.[77]

The term "abstinence-based" is used frequently in substance use treatment and may have different definitions and meanings for different people and organizations.[78] At FPH, the term "abstinence-focused" is preferred to reflect the expectation that a patient's ultimate goal is to cease the use of substances that negatively impact their life. It is recognized, however, that overcoming substance use disorders can be a cyclical journey, not a straight line, especially when substance dependency is accompanied by one or more psychiatric problems.[79,80,81,82] Therefore, FPH works with patients through relapse and uses harm reduction practices to reduce the negative consequences of drug use. According to Harm Reduction International, harm reduction refers to "policies, programs and projects that aim primarily to reduce the health, social and economic harms associated with the use of psychoactive substances."[83] FPH adopts a harm reduction approach while maintaining a focus on abstinence. Levels of care and programs are designed to reflect a non-linear recovery process.

Abstinence-focused care at FPH includes substitution treatment and other medications supporting control of substance use and reduction of relapse.[84,85,86] Use of non-prescribed medications, non-medical drugs, tobacco, marijuana, and alcohol are not considered compatible with a goal of healthy living.[87,88] Moreover, abstinence from alcohol and non-prescribed medications is generally a condition of most patient's Review Board dispositions.

Given the link between substance use and offending for forensic psychiatric patients,[89] it is important to reduce or eliminate substance use in order to reduce the risk of offending upon release. For example, there is a modest, yet statistically significant, relationship between severe mental illness and violence but when substance use is also included, the risk of violence increases by 4 to 8 fold.[90,91,92,93]

Addressing Problem Behaviours

A problem behaviour is a "behaviour that, because of its intensity, frequency or duration, poses a threat to the quality of life and/or physical safety of the individual or others and is likely to lead to restrictive or aversive responses or exclusion."[94] Problem behaviours include self-injuring behaviour, aggression and violence towards others, destruction of property, and inappropriate social and/or sexual conduct. Approximately 10-15% of individuals with a serious mental illness and developmental disabilities exhibit problem behaviours.[95,96,97,98,99]

---

[77] Cleary M, Hunt G, Matheson S et al. Psychosocial treatments for people with co-occurring severe mental illness and substance misuse: systematic review. *Journal of Advanced Nursing.* 2009; 65(2): 238-58.

[78] Dupont R. *Creating a New Standard for Addiction Treatment Outcomes: A Report from the Institute for Behavior and Health, Inc.* 2014. Available online at http://www.williamwhitepapers.com/pr/IBH%20Creating%20a%20New%20Standard%20for%20Addiction%20Treatment%20Outcomes%202014.pdf. Accessed June 2020.

[79] Anglin M, Hser Y and Grella C. Drug addiction and treatment careers among clients in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*. 1997; 11(4): 308–323.

[80] McKay J, Alterman A, Cacciola J et al. Group counseling versus individualized relapse prevention aftercare following intensive outpatient treatment for cocaine dependence: Initial results. *Journal of Consulting and Clinical Psychology*. 1997; 65(5): 778-88.

[81] Scott C, Foss M and Dennis M. Pathways in the relapse—treatment—recovery cycle over 3 years. *Journal of Substance Abuse Treatment*. 2005; 28(2): S63-S72.

[82] White W. *Pathways: From the Culture of Addiction to the Culture of Recovery: A Travel Guide for Addiction Professionals*. 1996. Hazelden Publishing.

[83] Harm Reduction International. *What is Harm Reduction*? Available online at https://www.hri.global/what-is-harm-reduction. Accessed June 2020.

[84] Bell J, Dru A, Fischer B et al. Substitution therapy for heroin addiction. *Substance Use & Misuse*. 2002; 37(8-10): 1149-78.

[85] Benowitz N. Cigarette smoking and nicotine addiction. *The Medical Clinics of North America*. 1992; 76(2): 415-37.

[86] Nutt D and Lingford-Hughes A. Addiction: the clinical interface. *British Journal of Pharmacology*. 2008; 154(2): 397-405.

[87] Ceste J, Kamarulzaman A, Kazatchkine M et al. Public health and international drug policy. *The Lancet*. 2016; 387(10026): 1427-80.

[88] Jane-Llopis E and Matytsina I. Mental health and alcohol, drugs and tobacco: A review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs. *Drug and Alcohol Review*. 2006; 25(6): 515-36.

[89] Pickard H and Fazel S. Substance abuse as a risk factor for violence in mental illness: some implications for forensic psychiatric practice and clinical ethics. *Current Opinion in Psychiatry.* 2013; 26(4): 349.

[90] Räsänen P, Tähonen J, Isohanni M et al. Schizophrenia, alcohol abuse, and violent behavior: a 26-year followup study of an unselected birth cohort. *Schizophrenia Bulletin*. 1998; 24(3): 437-41.

[91] Fazel S, Gulati G, Linsell L et al. Schizophrenia and violence: systematic review and meta-analysis. *PLoS Medicine*. 2009; 6(8): 1-15.

[92] Elbogen E and Johnson S. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry*. 2009; 66(2): 152-61.

[93] Volavka J and Swanson J. Violent behavior in mental illness: the role of substance abuse. *Journal of American Medical Association*. 2010; 304(5): 563-4.

[94] Devapriam J, Rosenbach A, Alexander R. In-patient services for people with intellectual disability and mental health or behavioural difficulties. *BJPsych Advances.* 2015; 21: 116-23.

[95] Emerson E, Kiernan C, Alborz A et al. The prevalence of challenging behaviors: a total population study. *Research in Developmental Disabilities*. 2001; 22(1): 77-93.

[96] Moss S, Emerson E, Kiernan C et al. Psychiatric symptoms in adults with learning disability and challenging behaviour. *The British Journal of Psychiatry*. 2000; 177(5): 452-6.

[97] Deb S, Thomas M and Bright C. Mental disorder in adults with intellectual disability. 2: the rate of behaviour disorders among a community-based population aged between 16 and 64 years. *Journal of Intellectual Disability Research*. 2001; 45(6): 506-14.

[98] Holden B and Gitlesen J. Prevalence of psychiatric symptoms in adults with mental retardation and challenging behaviour. *Research in Developmental Disabilities*. 2003; 24(5): 323-32.

[99] Hemmings C, Gravestock S, Pickard M et al. Psychiatric symptoms and problem behaviours in people with intellectual disabilities. *Journal of Intellectual Disability Research*. 2006; 50(4): 269-76.

Research shows that patients in forensic psychiatric hospitals have considerable idle time,[100,101] which may increase the rates of problematic behaviours.[102] Involvement in therapeutic programming and activities reduces boredom and provides a sense of accomplishment that may lessen the likelihood of engaging in problematic behaviours.[103] Reducing the occurrence of adverse events is essential for staff and patient safety and can impact the amount of time patients spend in seclusion, given that seclusion is a common response to behavioural concerns[104] despite being recommended as a last resort.[105] Reducing the time individuals spend in seclusion limits the negative consequences associated with seclusion,[106] and provides opportunities for patients to spend more time in programs that may benefit their recovery.

Problematic behaviours may in some instances be the result of personality disorder characteristics or other factors, such as trauma histories or traumatic brain injuries. As such, the care team should consider these factors when examining incidents of problematic behaviours, as they may help explain why patients engage in such behaviour and may help in the development of improved healthy coping strategies. A useful resource for addressing problematic thoughts and attitudes for patients (and ultimately behaviour) can be found in Module 3 of Changing Lives, Changing Outcomes, a guide for working with populations involved with the criminal justice system and have a mental illness.[107] Other strategies involve the use of therapeutic communities (see Appendix D for an overview of the effectiveness of therapeutic communities) or the Risk-Need-Responsivity Model, which involves tailoring interventions according to:

- risk (higher intervention for higher risk patients);
- need (targeting interventions to meet an individual's dynamic criminogenic needs); and
- responsivity (tailoring interventions to an individual's learning style/motivation).[108]

Family and Intimacy

Disconnection from family and friends is a challenge for many individuals found NCRMD or UST. Social networks are often defined by size (number of individuals in the network), frequency of contact, and quality of interactions.[109] Individuals with severe mental illness tend to have smaller and poorer quality social networks than the general population.[110,111] High levels of unemployment, periodic institutionalization and homelessness further reduce opportunities to engage in reciprocal social activities.[112,113]

Social relationships are not always positive and may involve conflict and stress, potentially resulting from emotional over-involvement, hostile interactions and unstable family situations, all of which are associated with reduced treatment initiation and poorer treatment outcomes.[114,115] For example, the number of substance users within one's social network is associated with poor treatment outcomes among people who use substances.[116] Similarly, socializing with people who engage in crime and violence can serve to destabilize the recovery of the individual.[117]

Affirmative social connections have a positive influence on the course of mental illness and recovery from substance use

[100] Vuk M and Doležal D. Idleness and Inmate Misconduct: A New Perspective on Time Use and Behavior in Local Jails. *Deviant Behavior*. 2019: 1-23.
[101] Zhong S, Guo H, Wang Y et al. The experience of long-stay patients in a forensic psychiatric hospital in China: a qualitative study. *BMC Health Services Research.* 2019; 19(1): 617.
[102] Nijdam-Jones A, Livingston JD, Verdun-Jones S et al. Using social bonding theory to examine 'recovery' in a forensic mental health hospital: A qualitative study. *Criminal Behaviour and Mental Health*. 2015; 25(3): 157-68.
[103] Ibid.
[104] Exworthy T, Mohan D, Hindley N et al. Seclusion: punitive or protective? *Journal of Forensic Psychiatry*. 2001; 12(2): 423-33.
[105] Goulet M, Larue C and Dumais A. Evaluation of seclusion and restraint reduction programs in mental health: A systematic review. *Aggression and Violent Behaviour*. 2017; 34: 139-146.
[106] Holmes D, Murray SJ and Knack N. Experiencing seclusion in a forensic psychiatric setting: A phenomenological study. *Journal of Forensic Nursing.* 2015; 11(4): 200-13.
[107] Morgan R, Kroner D and Mills J. *A Treatment Manual for Justice Involved Persons with Mental Illness: Changing Lives and Changing Outcomes*. 2018. Routledge.
[108] Andrews D and Bonta J. Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*. 2010; 16(1): 39-55.
[109] Degnan A, Berry K, Sweet D et al. Social networks and symptomatic and functional outcomes in schizophrenia: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*. 2018; 53: 873-88.
[110] Macdonald E, Hayes R, Baglioni A. The quantity and quality of the social networks of young people with early psychosis compared with matched controls. *Schizophrenia Research*. 2000; 46(1): 25-30.
[111] Padgett D, Henwood B, Abrams C et al. Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. *American Journal of Orthopsychiatry*. 2008; 78: 333-9.
[112] Schutz C, Choi F, Song M et al. Living with dual diagnosis and homelessness: Marginalized within a marginalized group. *Journal of Dual Diagnosis*. 2019; 15(2): 88-94.
[113] Padgett D, Henwood B, Abrams C et al. Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. *American Journal of Orthopsychiatry*. 2008; 78: 333-9.
[114] Saunders E, McLeman B, McGovern M et al. The influence of family and social problems on treatment outcomes of persons with co-occurring substance use disorders and PTSD. *Journal of Substance Use.* 2016; 21(3): 237-243.
[115] Degnan A, Berry K, Sweet D et al. Social networks and symptomatic and functional outcomes in schizophrenia: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*. 2018; 53: 873-88.
[116] Mowbray O. Can social networks inform treatment use for persons with co-occurring substance use and mental health problems? *Journal of Addiction Research & Therapy*. 2012; 3(5):
[117] Olver M, Stockdale K and Wormith J. Thirty years of research on the Level of Service Scales: A meta-analytic examination of predictive accuracy and sources of variability. *Psychological Assessment.* 2014; 26(1): 156-76.

disorders,[118,119] while reducing the risk of recidivism.[120] Ensuring that patients have strong, positive supports in the community helps increase their chance to succeed upon discharge.[121]
At FPH patients are reconnected to healthy support systems. The social work team engages with family members early in a patient's journey. We invite family members to participate in their loved one's care by attending Patient Care Meetings where they become valued partners with the treatment team. Family members are supported in building strong bonds with their loved one, by attending weekly visits at FPH, taking their loved one on outings into the community, and having regular phone and video conference contact. The Health and Wellness team support patients in developing the skills to foster and maintain health relationships in learning about communication styles and boundary setting through a trauma informed lens. We are also available to provide education to families regarding concurrent disorders recovery. If a patient's family wishes to take a more active role at FPH, there are opportunities to share their voice at the Patient and Family Advisory Council and the Family Advisory Council.

We know recovery happens in a context of a caring community, such as peers, community members, care providers, and family. Patients are supported in expanding their networks and creating connections within the community. The rehabilitation team supports patients in finding community recreation opportunities that include group fitness, spiritual gatherings, volunteer opportunities, culinary and library programs and more. These connections allow patients to practice healthy communication skills, while increasing their quality of life, and instilling hope for future community reintegration.

A Meaningful Life

Recovery-oriented care at FPH aims to equip and support patients in living satisfying, hopeful, and productive lives, despite the challenges of mental illness and substance use.[122,123] According to the Mental Health Commission of Canada's *Guidelines for Recovery-Oriented Practice*, being recovery-oriented means extending beyond a traditional clinical definition of pathology and helping people reach optimal mental health, not just reducing or managing symptoms.[124]

Research provides guidance on what a meaningful life might look like for individuals with a history of criminal justice involvement who are also living with major mental disorders. Livingston notes, for instance, that patients have conceptualized success as a "dynamic process materializing across six different domains, including normal life, independent life, compliant life, healthy life, meaningful life, and progressing life."[125]

Of the six domains, a meaningful life is one in which the individual "has a sense of contentment and enjoyment in life, and feels as though life has meaning or purpose." Markers of success include engaging in enjoyable activities, experiencing happiness, having personal interests, feeling fulfilled or satisfied, believing that life has purpose, seeing a broad range of possibilities and having a reason to get out of bed each day.[126]

A progressing life is one in which the individual "works toward realizing positive change in their life and improving their life circumstances." Markers of success include working toward personal goals, wanting to improve life, overcoming adversity, and achieving small successes, learning to solve problems, learning from mistakes, curbing slips and relapses and internalizing new learnings.[127]

In summary, a recovery-oriented approach to care aims to support patients to live satisfying, hopeful lives where they can contribute to society even when facing ongoing limitations caused by mental illness and substance use disorders.

---

[118] Palumbo C, Volpe U, Matanov A et al. Social networks of patients with psychosis: A systematic review. *BMC Research Notes*. 2015; 8 (560):
[119] Pahwa R, Smith M, Yuan Y et al. The ties that bind and unbound ties: Experiences of formerly homeless individuals in recovery from serious mental health and substance use. *Qualitative Health Research*. 2019; 29(9): 1313-23.
[120] Taylor CJ. The family's role in the reintegration of formerly incarcerated individuals: The direct effects of emotional support. *The Prison Journal*. 2016; 96(3): 331-54.
[121] Mowen T and Boman J. The duality of the peer effect: The interplay between peer support and peer criminality on offending and substance use during re-entry. *Crime & Delinquency*. 2018; 64(8): 1094–1116.
[122] Davidson L. The recovery movement: implications for mental health care and enabling people to participate fully in life. *Health Affairs*. 2016; 35(6): 1091-7.
[123] Chester P, Ehrlich C, Warburton L et al. What is the work of recovery oriented practice? A systematic literature review. *International Journal of Mental Health Nursing.* 2016; 25(4): 270-85.
[124] Mental Health Commission of Canada. *Guidelines for Recovery-Oriented Practice.* 2015. Available at https://www.mentalhealthcommission.ca/sites/default/files/MHCC_RecoveryGuidelines_ENG_0.pdf. Accessed May 2019.
[125] Livingston J. What does success look like in the forensic mental health system? Perspectives of service users and service providers. *International Journal of Offender Therapy and Comparative Criminology*. 2018; 62(1): 208-228.
[126] Ibid.
[127] Ibid.

EVIDENCE-INFORMED TREATMENTS AND SUPPORTS

FPH offers a range of evidence-informed treatments and supports, including psychiatric, pharmacological and psychological/psychosocial interventions provided by allied health care providers (psychologists, counsellors, occupational and rehabilitation therapists, spiritual care providers). Given that FPH patients are more likely to have physical health concerns and experience early mortality in addition to mental health challenges, access to all aspects of health care, including primary care is critical.

Primary Health Care

Family physicians and nurses provide specialized assessments and treatments to address the primary care and physical health needs of patients with mental illness and substance use disorders.[128] Individuals with mental illness have high rates of physical health problems,[129] so timely access to primary health care is critical. Moreover, given concerns about obesity among persons with schizophrenia[130] and specifically among FPH patients,[131] dietary support and regular tracking of patients' height, weight and BMI is undertaken.

Psychiatry

Forensic psychiatrists lead the care team in assessing, treating and preparing patients for community reintegration. Psychiatrists conduct risk assessments, and are responsible for NCRMD and Fitness reports to the courts for individuals admitted for assessment. They additionally provide expert evidence to the courts if needed on the reports that they write. Psychiatrists provide Review Board reports and evidence in person to the review boards at FPH. Along with forensic work, they treat patients for their mental disorder by prescribing pharmacotherapy and in some instances providing therapy.

Psychology

Highly specialized assessments and treatments are provided by registered psychologists. Assessments focus on personality (personality disorders, psychopathy), major mental illness (diagnostic clarification, malingering), risk (violence, sexual violence, stalking, intimate partner violence, etc.), and cognitive function (general cognitive ability, neuropsychological screening). Psychologists provide individual and group interventions, including evidence-based treatments such as CBT,[132] DBT,[133] interpersonal therapies (e.g., Changing Lives and Changing Outcomes program[134]) and mindfulness.[135] Psychologists additionally serve as consultants to care teams on the management of complex patient behaviours and unit milieu within the hospital.

Health and Wellness

A range of assessments and treatments are provided for the promotion of psychological health and physical/mental wellness. Evidence-based CBT oriented programs target changeable risk factors, such as problematic substance use and

[128] Ibid.
[129] Connolly M and Kelly C. Lifestyle and physical health in schizophrenia. *BJPsych Advances.* 2005; 11(2): 125-32.
[130] Von Hausswolff-Juhlin Y, Bjartveit M, Lindström E et al. Schizophrenia and physical health problems. *Acta Psychiatrica Scandinavica*. 2009; 119(s438): 15-21.
[131] Nicholls T and Petersen K. *BC Forensic Psychiatric Hospital Patient Needs Assessment: Series on Physical Health, Mental Health, Substance Use, Trauma, Risk, Programming, and Pathways*. 2019. BC Mental Health & Substance Use Services. Internal Reports.
[132] Yoon I, Slade K and Fazel S. Outcomes of psychological therapies for prisoners with mental health problems: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology.* 2017; 85(8): 783-802.
[133] Panos P, Jackson J, Hasan O et al. Meta-analysis and systematic review assessing the efficacy of dialectical behavior therapy (DBT). *Research on Social Work Practice*. 2014; 24(2): 213-23.
[134] Morgan D, Kroner R and Mills F. *A Treatment Manual for Justice Involved Persons with Mental Illness: Changing Lives and Changing Outcomes*. New York, US: Routledge, 2017.
[135] Day A. Mindfulness and forensic mental health. In Shonin E, Van Gordon W and Griffiths M (Eds.), *Mindfulness and Buddhist-Derived Approaches in Mental Health and Addiction*, pp. 299-311. 2016. Springer International Publishing.

other criminogenic needs, with a goal of reducing the likelihood of offending upon release.[136,137] In addition, health and wellness programs assist patients in improving their quality of life through helping manage mental illness symptoms, improving emotional regulation, developing coping skills, and setting realistic goals. Examples of interventions include MATRIX, Seeking Safety and Changing Lives and Changing Outcomes, as well as mindfulness and motivational interviewing.

A 2017 systematic review and meta-analysis of psychological therapies for prisoners with mental health problems provides guidance on the use of interventions.[138] CBT and mindfulness-based therapies are modestly effective in treating depression and anxiety symptoms in prisoners, though the effects are not sustained 3-6 months after release. Trauma-based therapies demonstrate limited effect on trauma symptomology, suggesting the need to improve upon these therapies. In addition, there is limited evidence on the effectiveness of action-oriented approaches such as art and music therapy. Finally, results do not differ if the therapy is provided individually or in groups.

Rehabilitation

Assessment and treatment services and programs are provided for patients. Assessments are generally conducted to evaluate suitability for a treatment program, to assess functional skills (cooking, cleaning, etc.) or to determine the need for physiotherapy. Staff Supported Community Outings (SSCOs) are used to prepare patients for community reintegration. Through SSCOs, individuals visit the community to participate in social outings (bowling, movies, etc.), volunteer opportunities, work placements and other activities. Research in correctional settings suggest that opportunities to enter the community prior to release contribute to reduced recidivism and improved employment opportunities upon release.[139] A study of forensic patients also found community access prior to discharge reduced the likelihood of later re-arrest.[140]

Occupational Skills Programming

Occupational therapy in forensic settings is under-researched, however evidence supporting its use is increasing.141 Extensive programming is offered with a focus on occupational rehabilitation including teaching community living skills such as cooking or grocery shopping and preparing patients for independent living. The goal is to facilitate patient engagement in prosocial activities prior to and upon release, rather than returning to antisocial habits.[142]

Patients have opportunities to meet individually with a qualified teacher to advance their individual learning needs. Research on corrections populations highlights the importance of providing educational opportunities for offenders to reduce recidivism and support rehabilitation.[143,144] Many forensic patients have educational deficits,[145,146] and models of care for forensic services (Risk-Need-Responsivity Model[147]; Good Lives Model[148]) highlight the importance of access to education. Many forensic patients describe educational programs as being meaningful to their recovery[149] and the UK Royal College of Psychiatrists recommends providing patients with these opportunities.[150]

---

[136] Andrews D and Bonta J. Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*. 2010; 16(1): 39-55.
[137] Polaschek D and Wong S. Risk-reducing treatment in high-risk psychopathic and violent offenders. (pp. 367- 384). In Wormith J, Craig L and Hogue T (Eds.), *The Wiley Handbook of What Works in Violence Risk Management: Theory, Research and Practice.* John Wiley & Sons Ltd, 2020.
[138] Yoon I, Slade K and Fazel S. Outcomes of psychological therapies for prisoners with mental health problems: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology.* 2017; 85(8): 783-802.
[139] Helmus L and Ternes M. Temporary absences from prison in Canada reduce unemployment and reoffending: Evidence for dosage effects from an exploratory study. *Psychology, Public Policy, and Law*. 2017; 23(1): 23-38.
[140] Norko M, Wasser T, Magro H et al. Assessing insanity acquittee recidivism in Connecticut. *Behavioral Sciences & the Law*. 2016; 34(2-3): 423-43.
[141] Hitch D, Hii Q and Davey I. Occupational therapy in forensic psychiatry: Recent developments in our understandings (2007-2013). *British Journal of Occupational Therapy*, 2016; 79(4): 197-205.
[142] Connell, C. (2016). Forensic occupational therapy to reduce risk of reoffending: A survey of practice in the United Kingdom. *The Journal of Forensic Psychiatry & Psychology*, 2016; 27(6): 907-928.
[143] Andrews D and Bonta J. Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*. 2010; 16(1): 39-55.
[144] Wilson D. (2016). Correctional programs. In D. Weisburd, D. P. Farrington, & C. Gill (Eds.), *What Works in Crime Prevention and Rehabilitation: Lessons from Systematic Reviews*, pp. 193-217. 2016. Springer Science + Business Media.
[145] Nicholls T, Brink J, Greaves C et al. Forensic psychiatric inpatients and aggression: An exploration of incidence, prevalence, severity, and interventions by gender. *International Journal of Law and Psychiatry*. 2009; 32(1): 23-30.
[146] Nicholls T and Petersen K. *BC Forensic Psychiatric Hospital Patient Needs Assessment: Series on Physical Health, Mental Health, Substance Use, Trauma, Risk, Programming, and Pathways*. 2019. BC Mental Health & Substance Use Services. Internal Reports.
[147] Andrews D and Bonta J. Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*. 2010; 16(1): 39-55.
[148] Ward T and Stewart C. Criminogenic needs and human needs: A theoretical model. *Psychology, Crime & Law*. 2003; 9(2): 125-43.
[149] Aga N, Laenen F, Vandevelde S et al. Recovery of offenders formerly labeled as not criminally responsible: Uncovering the ambiguity from first-person narratives. *International Journal of Offender Therapy and Comparative Criminology.* 2017; 1-21.
[150] Reeves-Hoyland, n.d., as cited in Nicholls T and Goossens I. Guidelines for improving forensic mental health in inpatient psychiatric settings. (pp. 496 - 542). In Roesch R and Cook A (Eds.), *Handbook of Forensic Mental Health Services*. New York, US: Routledge, 2017.

Recreational Programming

Recreational and dietary programs support patients to engage in healthy lifestyle behaviours through regular physical activity and healthy eating.[151,152,153] Individuals with concurrent mental health and substance use disorders are at high risk for physical health problems, and there are many positive benefits, including the reduction anxiety and stress and providing structure to the patient's day, that can be achieved through focused recreational programming.[154]

Vocational Skills Programming

Vocational programs support patients to develop skills designed to help with access to employment upon discharge, through activities like woodshop, horticulture and recycling. Problems with employment are one of eight factors that contribute to increased risk for re-offending; providing employment these opportunities has been found to reduce recidivism rates among people involved with the criminal justice system. [155,156] Helping patients develop employability skills while in hospital will ultimately help to ensure public safety while improving patient's lives.[157]

Gender-Informed Care

Research suggests that gender-informed interventions can be effective in reducing recidivism among female patients.[158] FPH endeavors to ensure that treatment for female patients are adapted to their unique needs.
Female-only groups are provided, particularly at the beginning of an individual's stay in hospital. Patients are supported to begin their healing in a safe environment prior to being introduced to mixed-gender groups.[159] Although most programs for women are based on evidence based interventions for both males and females (e.g., Matrix, Seeking Safety), specific art adapted trauma therapy is utilized to address the needs of women with high rates of trauma.[160]

Trauma informed treatments are key to care delivery at BCMHSUS, and it is emphasized in female focused programs due to high rates of previous trauma and victimization.[161,162] Staff aim to create a safe and respectful environment where women feel comfortable participating in treatment,[163] and where the focus of treatment is on the development of coping skills and recognizing women's strengths, ultimately promoting independence and resilience.[164] Not all women have the same histories or needs, so care is individualized while adhering to these broad principles.[165]

Therapeutic Community

A pilot therapeutic community is currently underway at FPH. Patients can apply to live in the unit if they are interested in residing with others who are dedicated to recovery. In choosing to live in the therapeutic community, patients agree to follow a specific set of rules (e.g., remaining sober, no violence, fully attendance at unit programs/meetings).

---

[151] Fogarty M and Happell B. Exploring the benefits of an exercise program for people with schizophrenia: A qualitative study. *Issues in Mental Health Nursing.* 2005; 26(3): 341-51.
[152] Lassenius O, Arman M, Söderlund A et al. Moving toward reclaiming life: Lived experiences of being physically active among persons with psychiatric disabilities. *Issues in Mental Health Nursing.* 2013; 34(10): 739-46.
[153] Wynaden D, Barr L, Omari O et al. Evaluation of service users' experiences of participating in an exercise programme at the Western Australian State Forensic Mental Health Services. *International Journal of Mental Health Nursing*. 2012; 21(3): 229-35.
[154] Ibid.
[155] Andrews D and Bonta J. Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*. 2010; 16(1): 39-55.
[156] Uggen C. Work as a turning point in the life course of criminals: A duration model of age, employment, and recidivism. *American Sociological Review*. 2000; 65(4): 529-46.
[157] MacKenzie D and Farrington D. Preventing future offending of delinquents and offenders: What have we learned from experiments and meta-analyses? *Journal of Experimental Criminology*. 2015; 11: 565-95.
[158] Gobeil R, Blanchette K and Stewart L. A meta-analytic review of correctional interventions for women offenders: Gender-neutral versus gender-informed approaches. *Criminal Justice and Behavior*. 2016; 43(3): 301-22.
[159] Covington S and Bloom B. Gender responsive treatment and services in correctional settings. *Women & Therapy*. 2007; 29(3-4): 9-33.
[160] Schouten K, de Niet G, Knipscheer J et al. The effectiveness of art therapy in the treatment of traumatized adults: A systematic review on art therapy and trauma. *Trauma, Violence, & Abuse*. 2015; 16(2): 220-8.
[161] de Vogel V, Stam J, Bouman Y et al. Violent women: A multicentre study into gender differences in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*. 2016; 27(2): 145-68.
[162] Nicholls T, Petersen K, Brink J et al. A clinical and risk profile of forensic psychiatric patients: Treatment team STARTs in a Canadian service. *International Journal of Forensic Mental Health.* 2011; 10(3): 187-99.
[163] Covington S and Bloom B. Gender responsive treatment and services in correctional settings. *Women & Therapy*. 2007; 29(3-4): 9-33.
[164] Ibid.
[165] Ibid.

The focus of the therapeutic community is to encourage patients to engage in opportunities for autonomy and mentorship and provide increased community access and reintegration opportunities. Research supports the use of therapeutic communities, particularly among individuals with criminal justice involvement and/or substance use disorders and other mental illnesses as a means of reducing recidivism.[166,167,168]

See Appendix D for an overview of the effectiveness of therapeutic communities.

PROGRAM COMPONENTS AND CLINICAL PATHWAYS

While at FPH, patients receive intensive, long-term, recovery-oriented care, with a focus on stabilizing and treating mental illness and substance use disorders, reducing problem behaviours and reducing the risk for criminal offending. The assessment and management of risk is integrated into all aspects of care through formalized, evidence-informed risk assessments and risk management/reduction plans that are regularly reviewed and updated. Patients engage in a range of evidence-based treatments, therapies and activities designed to increase their chances for healthy, substance-free living. Programming is patient-centered, gender-specific, and focused on individual goals in alignment with a meaningful and progressing life.

Patients work with a multidisciplinary care team based on their legal status and risk, needs and responsivity. The team includes psychiatrists, family physicians, nurses, social workers, pharmacists, dietitians, psychologists, health care workers, spiritual care practitioners, occupational and physiotherapists, recreation therapists, counsellors and other support staff and coordinators.

Referral and Admission

Referrals

There are three legal routes by which a BC adult (19 years of age or older) can be referred to FPH:

1. Court-ordered assessments and/or treatment for criminal responsibility
2. Court-ordered assessments and/or treatment for fitness to stand trial
3. Court-ordered treatments (e.g., fit but fragile, treatment order)

Psychiatric assessment, stabilization and treatment is also provided for individuals referred temporarily from BC Corrections, under the BC Mental Health Act.

Patients may also be directed or ordered back through legal breach to FPH from the Forensic Regional Community Clinics in instances when clinic staff feel that an individual may pose a risk of harm to themselves or others.

Screening and Triage

A referral package is prepared for each referral. Each package is reviewed by FPH Access and Transitions Coordinator to ensure completeness and prepare the care team for patient admission. Referrals are screened for appropriateness and to determine risk for violence at admission. Detailed plans are made to ensure safe and trauma-informed admissions for every individual.

---

[166] Perry A, Martyn-St James M, Burns L et al. Interventions for drug-using offenders with co-occurring mental health problems (Review). *Cochrane Database of Systematic Reviews*. 2019; 10.
[167] Sacks J, McKendrick K and Hamilton Z. A randomized clinical trial of a therapeutic community treatment for female inmates: Outcomes at 6 and 12 months after prison release. *Journal of Addictive Diseases*. 2012; 31(3), 258–269.
[168] Sullivan C, McKendrick K, Sacks S et al. Modified therapeutic community treatment for offenders with MICA disorders: Substance use outcomes. *The American Journal of Drug and Alcohol Abuse*. 2007; 33(6): 823–832.

The Access and Transitions Committee meets daily (5 days per week) to prioritize and plan all admissions. Referrals are considered in the context of the total number of individuals waiting to determine appropriateness and priority based on collateral information, including legal status and clinical presentation. Risk is a key determinant in all decision-making. A "health snap shot" is developed and maintained by the Access and Transitions Coordinator to guide decision-making and includes current mental and physical status, legal dates (i.e., release, certification, impending court dates) and clinical updates from referral sources.

Risk Assessment and Care Planning

Research evidence suggests that over-intervening with criminally involved individuals with major mental disorders may be detrimental to the recovery and well-being of the individual.[169,170] Thus, it is essential that thorough assessments inform the development of individualized care plans (see Appendix C).

At admission, males are stabilized and assessed in one of the high secure units, depending upon legal status. The majority of males are admitted to the Remand Unit, A1. Patients may proceed to lower-secure units, including a unit for geriatric and medically frail males, once their team determines they can be managed in a less secure environment. All females, including Trans women, are admitted and cared for in the single female unit, Dogwood East. In some instances, females may progress to a low secure unit if they are assessed as ready to live semi-independently. Patients who are directed back or breached (from community mental health programs/services) can be assigned to any unit after re-assessment on A1, depending on their risk level/presentation.

Patients should be discharged as soon as they are medically stable and ready for reintegration into the community, for the benefit of both the individual and forensic services.[171] FPH aims to implement least restrictive practices in providing care, as this practice contributes to reducing recidivism risk and improving community reintegration.[172] Patients are encouraged to move forward in treatment via motivational interviewing and use of incentives. FPH focuses on achieving high-quality transitions between units, ensuring that patients are placed in the appropriate level of secure care (high, medium, low) while providing a clear path from admission to discharge.[173]

Although most individuals are admitted for index offences against a person such as assault and uttering threats,[174]only 20-30% are considered high risk.[175] Using risk assessment measures[176] [177] upon admission can help accurately place patients in appropriate units based on their security needs.

Risk level continues to be assessed every three months using the Short-Term Assessment of Risk and Treatability (START).[178] The START considers a patient's vulnerabilities and strengths to help inform their individualized care plan. Additionally, risk is considered for each of seven outcomes: violence, self-harm, suicide, unauthorized leave, substance abuse, self-neglect, and victimization. Comprehensive assessments that consider patient risk across a variety of domains, rather than just violence to others, are particularly important.[179] Clinicians and treatment teams will encounter clinical issues in multiple areas (e.g., concerns of suicide, self-harm, absconding) outside of violence risk; therefore, it is important to address all of these issues using a comprehensive risk assessment tool such as the START.[180]

---

[169] Andrews D. The Risk-Need-Responsivity model of correctional assessment and treatment. In Dvoskin, J, Skeem J, Novaco R, & Douglas K (Eds.), *Using Social Science to Reduce Violent Offending*. 2012. New York, NY: Oxford University Press.
[170] Latessa, E. What works and what doesn't in reducing recidivism: Some lessons learned from evaluating correctional programs. Paper presented at the American Psychology Law Society conference, New Orleans, LA. 2014.
[171] Sampson S, Edworthy R, Völlm B et al. Long-term forensic mental health services: an exploratory comparison of 18 European countries. *International Journal of Forensic Mental Health*. 2016; 15(4): 333-51.
[172] Seppänen A, Törmänen I, Shaw C et al. Modern forensic psychiatric hospital design: clinical, legal and structural aspects. *International Journal of Mental Health Systems.* 2018; 12(1): 58.
[173] Joint Commissioning Panel for Mental Health. *Guidance for commissioners of forensic mental health services: Practical mental health commissioning.* 2013. Available at https://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf. Accessed July 2020.
[174] Nicholls T, Petersen K, Almond M et al. Short-Term Assessment of Risk and Treatability (START): Rationale, Application, and Empirical Overview. Chapter in K. Douglas & R. Otto *Handbook of Violence Risk Assessment* (2nd Ed) in press/2020.
[175] Nicholls T and Petersen K. *BC Forensic Psychiatric Hospital Patient Needs Assessment: Series on Physical Health, Mental Health, Substance Use, Trauma, Risk, Programming, and Pathways*. 2019. BC Mental Health & Substance Use Services. Internal Reports.
[176] Kennedy H, O'Neill C, Flynn G et al. *Dangerousness Understanding, Recovery and Urgency Manual (the DUNDRUM Quartet), V1.0.26: Four Structured Professional Judgement Instruments for Admission Triage, Urgency, Treatment Completion and Recovery Assessments.* 2013. Available online at http://www.tara.tcd.ie/bitstream/handle/2262/67375/?sequence=1. Accessed August 2020.
[177] Webster CD, Martin ML, Brink J et al. *Short-Term Assessment of Risk and Treatability (START).* BC Mental Health & Addiction Services and St. Joseph's Healthcare, Hamilton; 2009.
[178] Webster CD, Martin ML, Brink J et al. *Short-Term Assessment of Risk and Treatability (START).* BC Mental Health & Addiction Services and St. Joseph's Healthcare, Hamilton; 2009.
[179] Ibid.
[180] Ibid.

Forensic Psychiatric Hospital Units

There are three levels of care – **high, medium and low risk** – delivered across nine (9) units to assist patients with a progressive approach to the reduction of risk, recovery and eventual transition to their home communities and regional community or tertiary mental health supports.

- High secure units include Ashworth 1, 2, 3 and 4.
- Medium secure units include Dog Wood West, Elm North, Elm South
- Low secure unit is Hawthorne House
- Women's continuum of care (including Transwomen) includes Dog Wood East and in some instances Hawthorne House

A description of each of the units can be found in Appendix E, and Figure 3 below shows the configuration of units, levels of care and flow through the hospital.

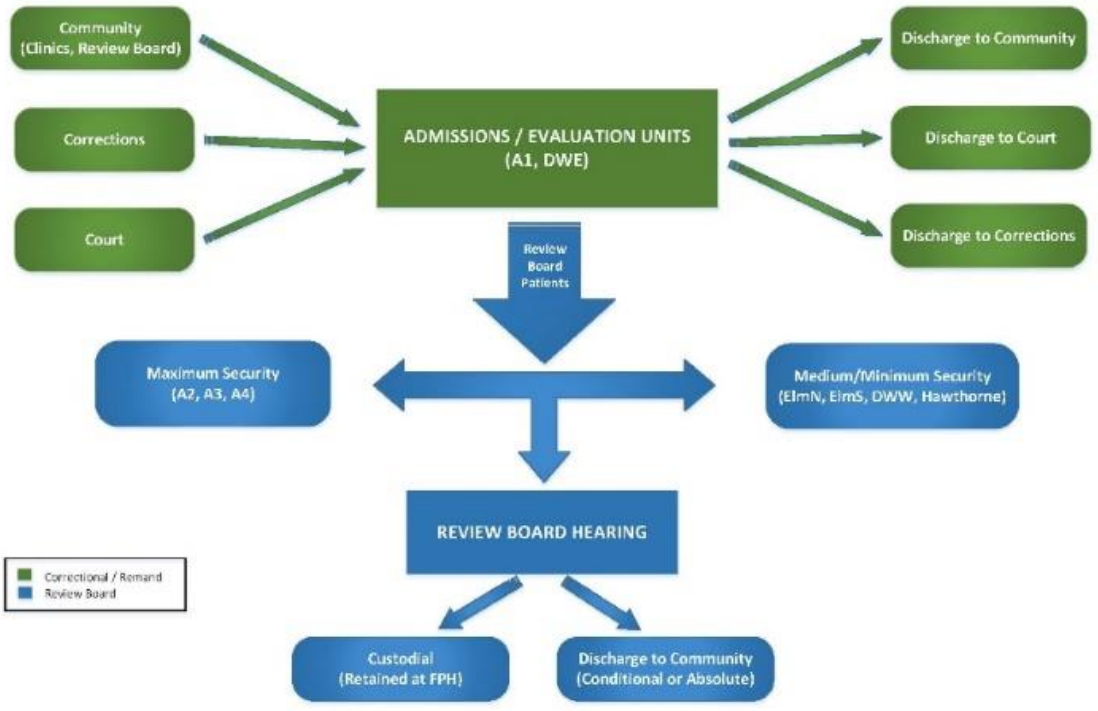


Figure 3: Overview of FPH Patient Flow and Units

Clinical Pathways

Individualized patient care means that each individual will engage in different aspects of the FPH program; no two patient journeys are identical. There are six care pathways, based upon legal status of the patient, including:

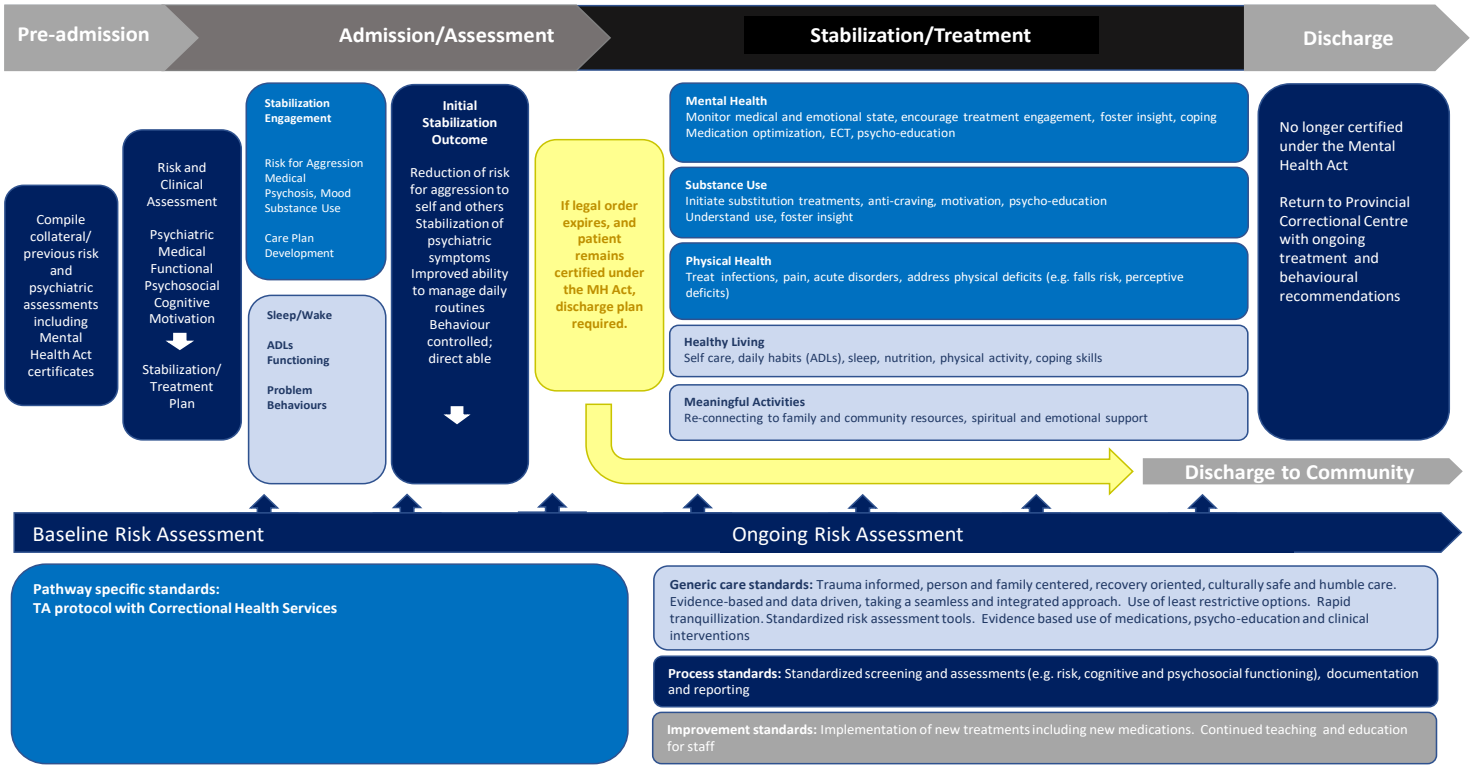
- Temporary Absence
- NCR/Fitness Assessment – Voluntary
- NCR/Fitness Assessment – Certified
- Not Criminally Responsible Due to Mental Disorder/Unfit
- Returns from Community – Direct Back
- Returns from Community – Breach Return

There may be additional unique care pathways, rare situations where there is a different legal determination, however the above are those most frequently followed by FPH patients.

Temporary Absence

This patient was referred to FPH because he had been refusing treatment at Surrey Pretrial Services Centre. He has an extensive history of criminal charges and is serving a sentence in provincial corrections. He was transferred to FPH after being certified by two physicians who assessed him at the correctional facility. While there, he was described as acutely paranoid with delusions of grandeur and persecution. Collateral information indicated that he was disruptive, agitated and making threats. On admission to FPH, he was diagnosed with personality disorder, underlying psychosis and substance use disorder. He has shown some improvement in his mental state after treatment using a long-acting injection of antipsychotic medication and divalproex to stabilize his mood. For the duration of his stay at FPH, he developed tolerance to engage with the FPH care team for prolonged periods of time and to receive ongoing psychopharmacological treatment. Although at times he continues to express delusional content, the patient was returned to Surrey Pretrial Services Centre to continue treatment while serving his provincial sentence.

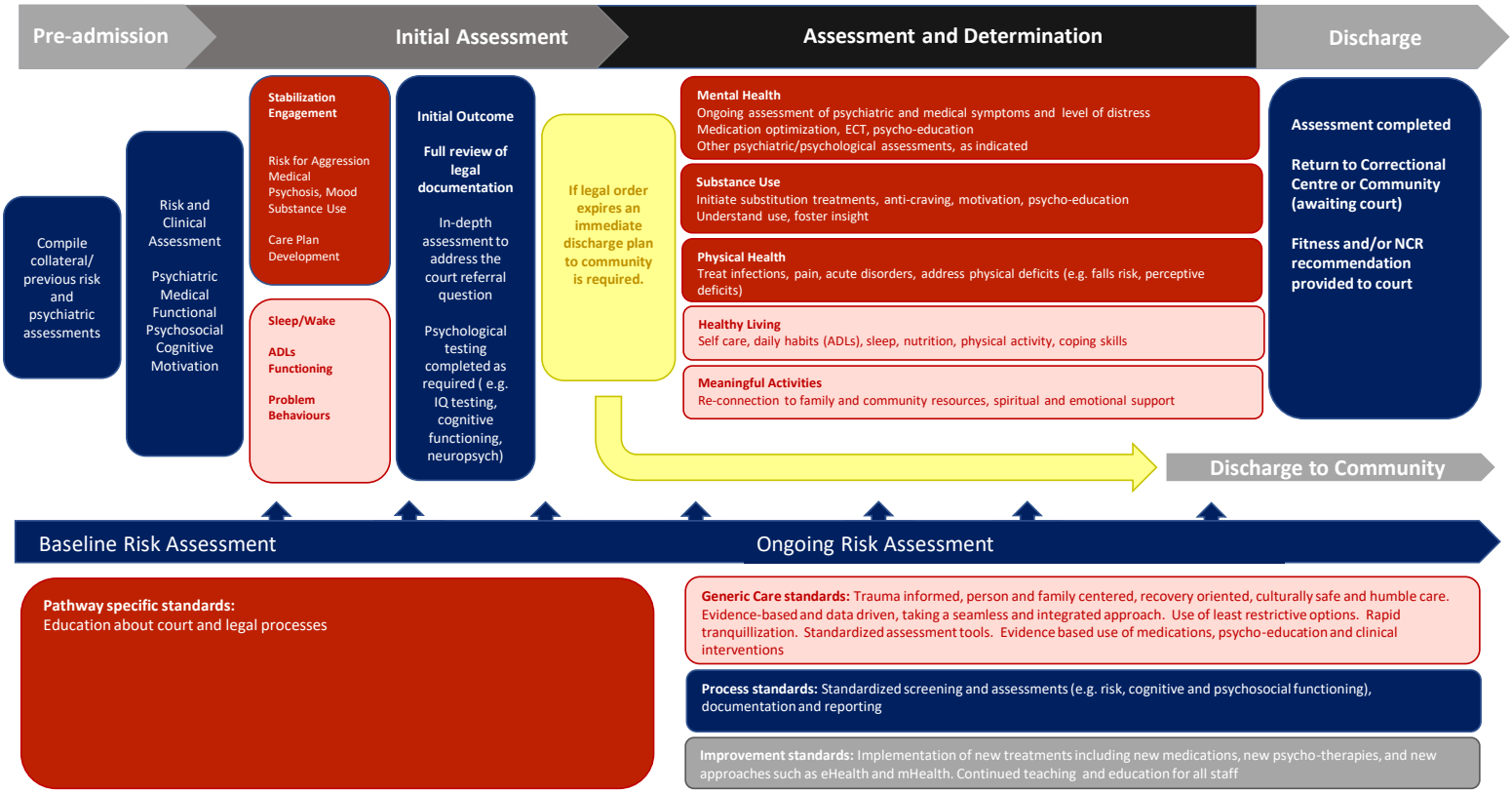
Figure 4: Clinical Pathway –Temporary Absence



NCR/Fitness Assessment - Voluntary

This patient was referred to FPH by a judge of the Provincial Court in Vancouver to make a determination on fitness to stand trial on various criminal charges. He has a history of schizophrenia and substance use disorder including use of heroin and stimulants. Further, he demonstrates impulsive, spontaneous violence in the context of his treatment-resistant mental illness characterized by command auditory hallucinations. The patient was treated with olanzapine and methadone, and loxapine as needed. He cooperated with a psychological assessment at FPH and demonstrated insight into the need for opioid agonist therapy. He did not meet the criteria for certification under the BC Mental Health Act and was admitted as a voluntary patient. He was able to answer questions posed to him by his treating psychiatrist regarding the nature and the outcome of court proceedings. He was similarly able to demonstrate an ability to communicate with his counsel. As a result, on a balance of probabilities the patient's psychiatrist recommended to the judge at the Provincial Court in Vancouver that he was fit to stand trial and he was discharged to North Fraser Pre-Trial Services Centre to await his court appearance.

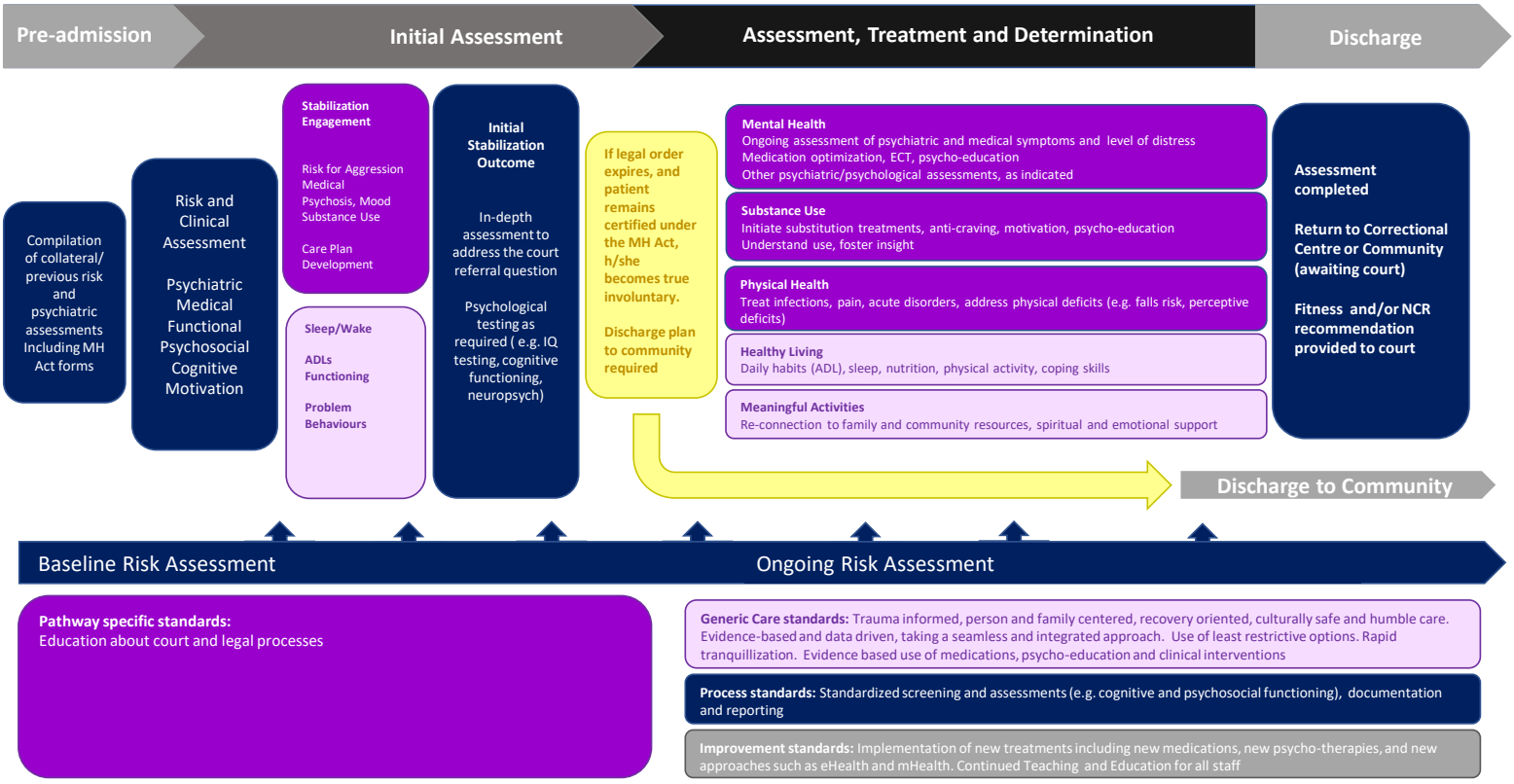
Figure 5: Clinical Pathway – Fitness and/or NCR Assessments (Not Certified under the Mental Health Act)



NCR/Fitness Assessment – Certified

This patient was referred by a correctional facility to FPH for a fitness assessment. During the admission, the patient was stabilized and received treatment, and education about the legal system. When the patient appeared before the BC Review Board, he was deemed Fit to Stand Trial. However, due to his certification under the BC Mental Health Act, he was required to remain at FPH to await his hearing date and to continue receiving treatment.

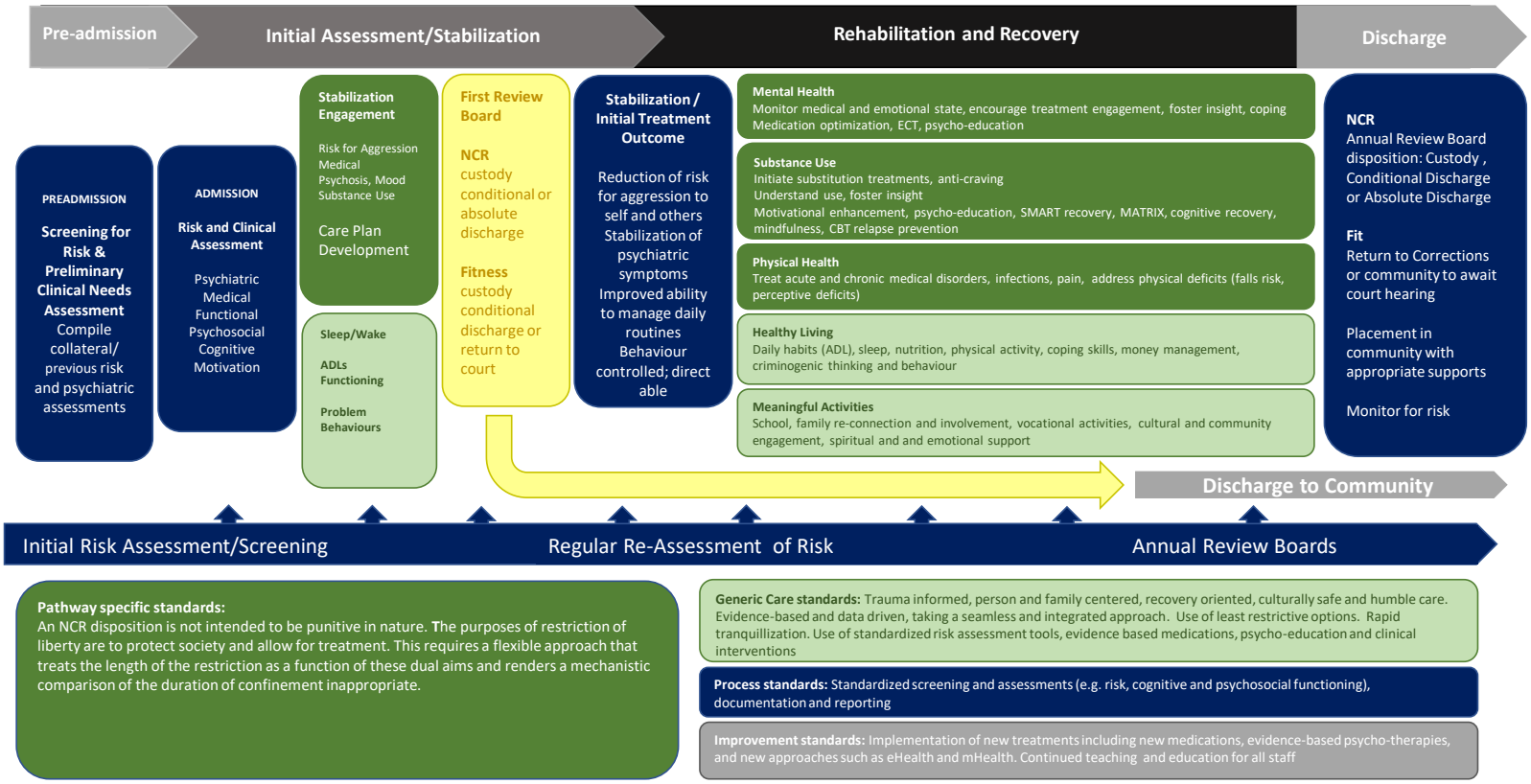
Figure 6: Clinical Pathway – Fitness and/or NCR Assessments (Certified under the MHA)



Not Criminally Responsible Due to Mental Disorder / Unfit

This patient was found NCRMD by the court, and sent to FPH under the Review Board's jurisdiction, who ordered a custodial disposition reviewable in 12 months. Throughout the patient's first year at FPH, he participated well in programs and progressed from a high secure to a lower secure unit. At his next review board meeting, he was granted community access with 28-day visit leave in order to progress to the next step of his reintegration into the community. Once a discharge plan was in place, and the patient was trialed in the community using 28-day visit leaves, his team deemed it appropriate to request a conditional discharge. The BC Review Board granted him a conditional discharge and the patient went to a community placement permanently. Once there, he connected with a forensic community clinic with whom he checked in regularly to make sure he continued to abide by his conditions.

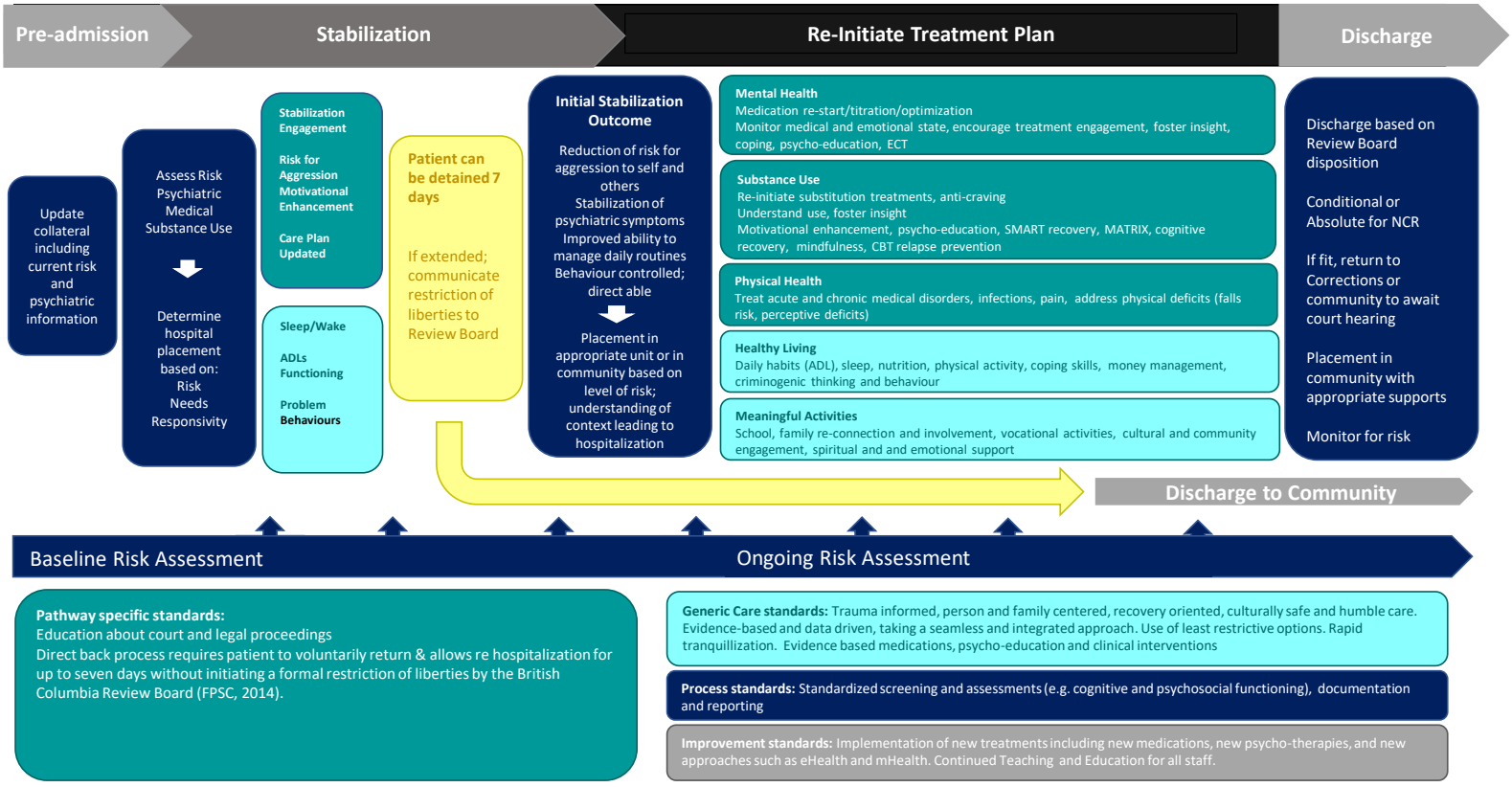
Figure 7: Clinical Pathway – Not Criminally Responsible on Account of Mental Disorder/Unfit to Stand Trial



Returns from Community – Direct Back

This patient was on conditional discharge, residing in an independent house at CTC. He was directed back to FPH by the Forensic Regional Clinic, who cited substance use as the primary reason for the decision. He was in agreement and cooperative with the transfer. A BC Review Board was held to address the restriction of liberties and it was decided that, while he was psychiatrically stable, further substance use treatment was required before he could safely return to live independently in the community. The patient was given a custody disposition, with a condition that he attend a daytox program. He was cooperative with his care at FPH, and quickly moved to a low secure unit from which he could attend the daytox program. Upon completing the daytox program, the patient was gradually reintegrated to independent living with 28-day visit leaves. After several consecutive uneventful months in the community, his team applied for and secured a conditional discharge.

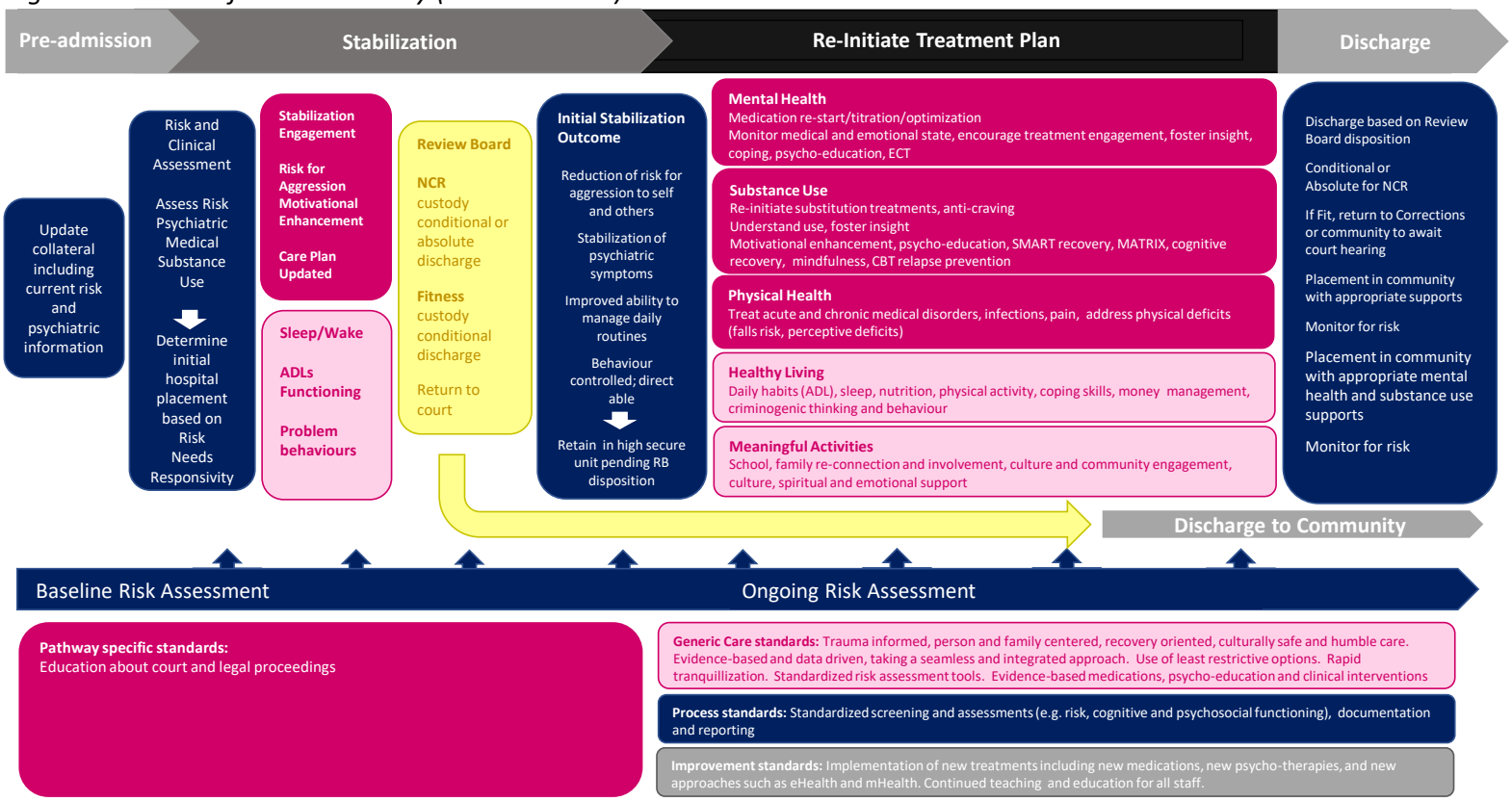
Figure 8: Clinical Pathway – Returns from Community (Direct Back)



Returns from Community – Breach Return

This patient was admitted to a high secure unit at FPH as a result of an enforcement order issued by a Judicial Justice at a Port Coquitlam court registry. He was previously found not criminally responsible on account of mental disorder (NCRMD) on a criminal charge. He was diagnosed with bipolar affective disorder and substance use disorder. He was detained at FPH after the NCRMD verdict but was granted a conditional discharge pursuant to sustained progress in treatment. He resided in the community for some time, adhered to a self-medication regimen and was followed by the Forensic Regional Clinic. The enforcement order occurred as a result of the patient refusing to come into the clinic to meet with his team. He demonstrated a significant deterioration in his mental state, admitted to excessive substance use and to not taking his medications as prescribed. In so doing, he wilfully failed to comply with the disposition issued by the BC Review Board at the time of his conditional discharge. Once his mental state stabilized he was transferred to a medium secure unit and referred to substance use treatment and counselling groups. Additional psychological testing will be provided to explore a personality disorder and the potential for alternate medication options. Pursuant to this, the treatment team will seek placement at a residential alcohol and drug treatment facility outside the hospital.

Figure 9 – Returns from Community (Breach Return)



Discharge and Community Reintegration

The decision to release a patient into the community is made by the BC Review Board. The Review Board also determines what conditions, if any, the patient must follow. These conditions can involve the characteristics of their residence, level of supervision, and abstinence from drugs and alcohol. When a patient is discharged with conditions like these, they are supervised by the nearest Forensic Regional Community Clinic. The clinic monitors the patient's progress and ensures that they adhere to the specified conditions. The clinic can refer patients back to FPH when they are concerned about their mental status or behaviour, either voluntarily (a "direct back") or involuntarily (a "breach"). Breach proceedings (which require a court order) are normally only initiated when clinically required, usually in situations where voluntary re-admission is no longer possible.

The BC Review Board also grants absolute discharges, which release patients from the Board's jurisdiction and transfers their care to a community mental health team or family physician.

The ultimate goal of treatment is to assist patients with successful reintegration into the community. Preparation for this process begins at admission; it is important for the clinical team to ensure adequate discharge planning and community preparedness throughout the individual's stay at FPH.

Once the clinical team has determined that a patient is ready to be considered for discharge, the patient is referred to the Forensic Regional Community Clinic that is closest to their anticipated discharge location. The clinic works with the FPH team to develop an appropriate discharge plan. Prior to being granted a discharge from the BC Review Board, the patient may be given access to the community in increasing amounts: first short staff escorted leaves, then unescorted day leaves, then extended visit leaves (for up to 60 days). Allowing access to the community prior to discharge has been shown to reduce recidivism among correctional patients.[181]

Social workers play a significant role in a patient's transition to community living. This includes keeping family members informed of the patient's progress (with the patient's approval), and sharing important information regarding extraordinary family events and/or behavioural concerns from the patient's family members with the rest of the treatment team. This is vital to providing context when considering how the patient's known risk factors will factor into community living. Patients may be discharged or transferred to:

- The community with access to an appropriate level of housing and with follow up support (e.g., Forensic Clinic, ACT Team, or Mental Health Team).
- Community Transition Program
- Other specialized provincial programs
- Regional tertiary mental health program (Timber Creek, Willow Pavilion, Hillside, Seven Oaks)
- Correctional Centres, in instances where legal status changes

VIRTUAL CARE

There has been a dramatic increase in the number of patients seen virtually through the use of online platforms.[182] Recent meta-analyses synthesizing evidence from quantitative and qualitative research in rural and remote areas demonstrates consistent evidence that telehealth has an overall positive impact on patient and caregivers' satisfaction.[183] Similarly, generally positive results have been found from a systematic review and meta-analysis examining patients with criminal justice and substance use needs.[184] Despite many recognized advantages (flexibility of timing, reduced travel and costs)

[181] Helmus L and Ternes M. Temporary absences from prison in Canada reduce unemployment and reoffending: Evidence for dosage effects from an exploratory study. *Psychology, Public Policy, and Law*. 2017; 23(1): 23-28.
[182] Calton B, Abedini N and Fratkin M. Telemedicine in the time of coronavirus. *Journal of Pain and Symptom Management*. 2020; 60(1): e12-e14.
[183] Orlando J, Beard M and Kumar S. Systematic review of patient and caregivers' satisfaction with telehealth videoconferencing as a mode of service delivery in managing patients' health. *PLoS ONE*. 2019; 14(8): e0221848.
[184] Batastini A, King C, Morgan R et al. Telepsychological services with criminal justice and substance abuse clients: A systematic review and meta-analysis. *Psychological Services*. 2016; 13(1): 20-30.

virtual health is not without acknowledged challenges (e.g., "whether the inevitable loss of nuance and depth influences the delivery of justice in any way is an unanswered question"[185]). Sustainment of virtual health capacity is crucial given the recent public health order, and the need to minimize our footprint within clinical facilities in order to effectively control the spread of COVID-19.

During the COVID-19 pandemic, a virtual health infrastructure was introduced at FPH to enable the provision of psychiatric and medical care for patients by providers remotely. This virtual health infrastructure allowed for robust provision of services during pandemic conditions while minimizing the risk of infection to both patients and providers. It also allowed patients to remain virtually connected to family and loved ones through the use of videoconference-enabled tablets during a time when visitation to the site was significantly restricted to limit potential transmission of COVID-19.

Virtual health introduces unparalleled flexibility for providers to care for patients when they are unable to attend the hospital. Moreover, many of the providers have different schedules and virtual health will allow prescribers to join case conferences such as patient care meetings and rounds on days where they are not scheduled to be at the facility. This would provide for greater input and participation from members of the patient's care team, ultimately enhancing patient care.

FPH will utilize virtual care to extend the provision of health care beyond its walls. According to Elrod and Fortenberry, the hub and spoke organization of health care "arranges service delivery assets into a network consisting of an anchor establishment (hub) which offers a full array of services, complemented by secondary establishments (spokes) which offer more limited service arrays."[186] FPH can be conceptualized as the hub in this model and community teams would be the spokes. Community teams often do not have the same expertise in evaluation and provision of care that is available at FPH and patients may start to decompensate while on leave or following discharge. Increased utilization of virtual care by FPH for outpatient follow-up of discharged patients can assist outpatient teams stabilize these patients and prevent readmission. As part of the PHSA, FPH can leverage the virtual health resources to provide expert consultation to patients in rural, remote, and otherwise underserved areas enhancing FPH as a truly provincial resource.

Furthermore, in alignment with BCMHSUS' *Virtual and Digital Health Strategy*, there is an opportunity to undertake innovative demonstration projects, and engage in research and evaluation related to the use of new and emerging virtual health modalities (e.g., virtual reality, socially-assistive robots, etc.). In collaboration with its research partners, FPH would be uniquely positioned to contribute to the current body of evidence in this very specialized area, while also providing patients with access to some of the most technologically-advanced treatment options available.

PATIENT MEASUREMENT AND OUTCOMES

Measurement

The qualitative and quantitative measurement of patient and program outcomes plays a critical role in assessing progress and readiness for discharge at the patient-level, and the operationalization of FPH at the site-level, respectively. BCMHSUS is continuously evolving its suite of scorecards, indicators, and management reports that capture the key operational- and patient-centered performance indicators necessary to support the management of services provided by the organization. The metrics to be used to track patient outcomes are used for baseline quantification and ongoing tracking. Examples of measures obtained and reported on include:

Clinical

- Patient changes in mental status
- Patient changes in substance use
- Patient subjective ratings of the program, including satisfaction and complaints/concerns

[185] Carroll, A. Forensic mental-health assessments after coronavirus disease 2019: Will telehealth lead us to trade psychological depth for convenience? *Medicine, Science and the Law*. 2020; 60(3): 169–171.
[186] Elrod J and Fortenberry J. The hub-and-spoke organization design: An avenue for serving patients well. *BMC Health Services Research*. 2017; 17(1): 25-33.

- Continuity of care after discharge, with connection to appropriate services
- Staff education on best practices

Safety

- Seclusion room use
- Patient aggression events, suicide attempts, overdoses
- Medication errors
- Staff injuries

Outcomes

A 2017 internal report described the FPH patient length-of-stay at the hospital. Individuals returning to the hospital from a conditional discharge (i.e., via breach or direct-back) stayed at FPH an average of 20.8 weeks before being discharged. For first-time discharges, individuals were hospitalized for over 4 years on average before their first conditional discharge. The average patient then spent another 1.4 years under the Review Board before becoming absolutely discharged.[187]
The National Trajectory Project (NTP) examined longitudinal data from 1,800 cases of individuals found NCRMD between May 2000 and April 2005 who were followed-up until December 2008 across British Columbia (N=222), Ontario (N=1,094), and Quebec (N=484).[188] Based on three years of follow-up, criminal recidivism was relatively low at an average of 16.7%, while the recidivism rate for a severe violent offence was just 0.6% (9 of 1,611). The rate of criminal recidivism in BC at 9.5% was similar to the rate in Ontario (9.3%) but significantly lower than the rate in Quebec (21.5%).[189]
The 3-year recidivism rates in BC are much lower than rates of recidivism found among a general offender population (23% over a 2-year period[190] and 34% over a 7-year period[191]) and much lower than rates found among an inmate population treated for mental disorder (78% over a 7.7-year period).[192]

[187] Chu K and Brink J. *FPH clinical program redesign evaluation: 9-month analysis (January to September 2017) Version 1.0.* 2017. BC Mental Health & Substance Use Services, Forensic Psychiatric Services Commission.
[188] Crocker A, Nicholls T, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 1: context and methods. *The Canadian Journal of Psychiatry*. 2015; 60(3): 98-105.
[189] Charette Y, Crocker A, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 4: Criminal recidivism. *The Canadian Journal of Psychiatry*. 2015; 60(3): 127-134.
[190] Stewart L, Wilton G, Baglole S et al. *A Comprehensive Study of Recidivism Rates among Canadian Federal Offenders.* Correctional Service of Canada. August 2019. Available online at https://www.csc-scc.gc.ca/005/008/092/005008-r426-en.pdf. Accessed August 2020.
[191] Johnson S, Grant B. Release outcomes of long-term offenders. *FORUM on Corrections Research*. 2000; 12(3): 16–20. Available online at https://www.csc-scc.gc.ca/research/forum/e123/123e_e.pdf. Accessed August 2020.
[192] Villeneuve D, Quinsey V. Predictors of general and violent recidivism among mentally disordered inmates. *Criminal Justice and Behaviour.*1995; 22(4): 387–410.

ACADEMIC AND PROVINCIAL CAPACITY BUILDING MANDATE

Research, education and teaching are formally embedded within FPH and considered integral to achieving organizational excellence and supporting translational science. FPH intends to assume a provincial leadership role in the creation of new knowledge, identification of evolving and emerging research, and translation and integration of evidence into practice.

TEACHING

FPH is an academic treatment facility that offers on-site experience and mentorship to students and trainees studying to become psychologists, medical doctors, social workers, occupational therapists, psychiatrists and a variety of other health care disciplines through practicum and internship opportunities. These experiences give students and trainees the chance to connect with staff and community partners, apply classroom knowledge to clinical practice, and expand their awareness, knowledge, and understanding of forensic mental health care.

RESEARCH

Research and evidence-based clinical practice are constantly evolving. Recognizing that significant gaps in knowledge about individuals with major mental disorders and criminal justice involvement, FPH uses the best available evidence to guide practice, and also constantly monitor the state of the literature and contribute to research to advance practice. This means that FPH strives to be both *evidence-informed* and *evidence-informing*.

Being *evidence-informed* refers to the utilization of a systematic approach ensuring the integration of evidence-based interventions into a treatment plan, while incorporating the unique values, preferences and circumstances of the patient in a person-centered manner. Evidence-informed practice brings together local experience and expertise with the best available evidence from research.[193]

FPH is also uniquely positioned to contribute to the knowledge base about individuals with criminal justice involvement and major mental disorders. As a result, FPH is committed to being *evidence-informing* by improving outcomes through embedding systematic quality improvement, program evaluation, and research into the model of care. An overarching knowledge exchange strategy promotes synergies and alignment of research and clinical practice across the BCMHSUS continuum of care. Ongoing research and evaluation assesses the effectiveness of leading practices for the FPH unique and complex population. The adoption and creation of best-available evidence includes assessment tools, interventions, goals, and philosophies.

Research at FPH focuses on studies intended to examine the characteristics and needs of the population and projects evaluating clinical interventions, the primary objective is to improve patient outcomes. The findings are also disseminated through publication in peer-reviewed scientific journals and presentation of the results at scientific conferences.

One excellent example of this philosophy is FPH's role in the National Trajectory Project (NTP). Initially, the NTP examined longitudinal data from 1,800 cases of individuals found NCRMD between May 2000 and April 2005 who were followed-up until December 2008 across British Columbia, Ontario, and Quebec. The purpose of the NTP was to "assess the presence of provincial differences in the application of the law (to people found NCRMD, to examine the characteristics of people with serious mental illness who come into conflict with the law and receive this verdict, and to investigate the trajectories of NCRMD–accused people as they traverse

[193] Tasmanian Government. Department of Health. *Evidence Informed Practice*. Available online at https://www.dhhs.tas.gov.au/wihpw/principles/evidence_informed_practice. Accessed June 2020.

the mental health and criminal justice systems."[194]

The results illustrated that severe index offenses such as murder, attempted murder or sexual offences represent a small portion of NCRMD patients (<10%) and that there is a heterogeneous population of NCRMD patients with regards to mental health/criminogenic characteristics.[195] Moreover, the study found "considerable discrepancies in the application of NCRMD legislation and the processing of NCRMD cases through the forensic system across the provinces, suggest(ing) that fair and equitable treatment under the law could be enhanced by increased national integration and collaboration."[196] Based on three years of follow-up, criminal recidivism was relatively low at an average of 17%, with similar rates in BC and Ontario (10% and 9%) with a higher rate in Quebec (22%).[197] Finally, the study found that NCRMD-accused women have a distinct psychosocial, clinical, and criminological profile from their male counterparts.[198]
These research results have been used to guide national policies and practices.[199,200]

Due to the success of the initial NTP, data collection for a second phase of research has begun in eight provinces. Data of individuals found NCRMD who were discharged between 2010 and 2015 is being collected and analyzed from official administrative, medical, and legal documents in eight provinces. This research will focus on achieving a better understanding of the needs and outcomes of individuals found NCRMD, as well as extending the examination of patient trajectories after they leave the hospital.

PROVINCIAL CAPACITY BUILDING AND PARTNERSHIPS

Successful partnerships are integral to the success of each complex individual's overall journey of recovery. The key stakeholders that influence and integrate with care and ensure smooth transitions include:

Regional Health Authorities

RHAs are key stakeholders responsible for patient's health care and long-term outcomes once they are discharged to the community.

Family and Friends

Family members, loved ones and friends are highly encouraged to connect with patients and to become involved with care at the FPH as they provide instrumental support to patients. Patients cite family and friends as being essential to their recovery.[201] FPH provides time for friends and family to visit their loved ones at the hospital. A focus is placed on patient-centered care that integrates family participation at all levels, including informing programming and care.

BC Courts

The BC Courts are a key stakeholder. They can order a fitness to stand trial or NCRMD assessment when criminal charges are laid against an individual and mental illness may be a factor in the individual's alleged offence. Individuals are given a verdict of Unfit to Stand Trial (UST) or NCRMD by the BC Court system; the judge also has the power to order the

[194] Crocker A, Nicholls T, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 1: Context and methods. *The Canadian Journal of Psychiatry*. 2015; 60(3): 98-105.
[195] Crocker A, Nicholls T, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 2: The people behind the label. *The Canadian Journal of Psychiatry*. 2015; 60(3): 106-116.
[196] Crocker A, Charrette Y, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 3: Trajectories and outcomes through the Forensic System. *The Canadian Journal of Psychiatry*. 2015; 60(3): 117-126.
[197] Charette Y, Crocker A, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 4: Criminal recidivism. *The Canadian Journal of Psychiatry*. 2015; 60(3): 127-134.
[198] Nicholls T, Crocker A, Seto M et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 5: How essential are gender-specific forensic psychiatric services? *The Canadian Journal of Psychiatry*. 2015; 60(3): 135-45.
[199] Crocker A, Seto M, Nicholls T et al. *Implementing Evidence-based Policies for Persons Found Not Criminally Responsible on account of Mental Disorder (NCRMD)*. June 2013. Available online at http://ntp-ptn.ntpmb.ca/media/documents/2018/06/04/NCRMD-SVO-NTPteam_March_2013.pdf. Accessed September 2021.
[200] Crocker A, Seto M, Nicholls T et al. *Description and Processing of Individuals Found Not Criminally Responsible on Account of Mental Disorder Accused of "Serious Violent Offences"*. March 2013. Available online at http://ntp-ptn.ntpmb.ca/media/documents/2018/06/04/NCRMD-SVO-NTPteam_March_2013.pdf. Accessed September 2021.
[201] Nijdam-Jones A, Livingston JD, Verdun-Jones S et al. Using social bonding theory to examine 'recovery'in a forensic mental health hospital: A qualitative study. *Criminal Behaviour and Mental Health*. 2015; 25(3): 157-68.

first disposition for an NCRMD accused (custodial disposition, conditional discharge or absolute discharge) or can choose to defer the disposition to the BC Review Board. In addition, the Court has the authority to breach individuals on a conditional discharge and send them back to the hospital when they violate a condition on their disposition.

BC Review Board

The British Columbia Review Board is a specialized tribunal established under the Criminal Code of Canada. When an individual is given a verdict of UST or NCRMD, they must appear before the Review Board. Individuals continue to have Review Board hearings annually while in hospital. Moreover, when patients are conditionally discharged, they are obligated to attend annual hearings to re-assess their risk and to see how they are managing in the community. The Review Board can also impose conditions that help aid in community success such as making it mandatory to attend appointments at a Forensic Regional Community Clinic or abstaining from substance use.

Corrections

When an individual committed to provincial corrections suffers from a mental illness and is unwilling to accept psychiatric treatment, they can be certified under the Mental Health Act. Subsequently, they are transferred to FPH as a temporary absence patient to be treated for their mental illness. Once they are mentally stable, they are transferred back to their correctional facility

BC Housing

FPH helps their patients find suitable housing to meet their needs and help them transition smoothly back to society. One BCMHSUS program is the Coast Transitional Cottages (CTC) Program. CTC offers psychosocial rehabilitation, clinical assessments, treatment, counselling, and support.[202] Individuals with a custodial disposition are at times directed to CTC as the next step towards community reintegration under a visit leave to determine their readiness for release.

Forensic Regional Community Clinics

When patients at FPH are granted a conditional discharge by the BC Review Board, they are connected with a team of health care professionals from a Forensic Regional Community Clinic. Care teams include psychiatrists, psychologists, nurses, counsellors, social workers, and physicians. The community clinics monitor patients and provide psychiatric assessments and counselling for mental illness, substance use, and concurrent disorders. Like FPH, they provide evidence-based and trauma-informed care. Care teams are responsible for assessing how well patients are managing in the community as well as assessing for future risk. When they feel that an individual may pose a risk to themselves or to others, they can direct the individual back to FPH to be treated. [203]

[202] Coast Mental Health. *Housing*. Available at https://www.coastmentalhealth.com/what-we-do/pillar-housing/ Accessed July 2020.
[203] BC Mental Health & Substance Use Services. *Forensic regional community clinics.* Available at http://www.bcmhsus.ca/our-services/court-referred-mental-health-assessment-treatment/regional-community-clinics. Accessed July 2020.

SUMMARY

FPH provides forensic inpatient care, including assessment and treatment, to residents of BC under the authority of the Forensic Psychiatry Act, the Mental Health Act, and the Criminal Code of Canada. FPH leadership, operations, and clinical care are driven by a philosophy of providing care that is evidence-informed, individualized, patient-centred, recovery-oriented, interdisciplinary, trauma-informed, and culturally inclusive.

FPH services provide a comprehensive program that addresses physical health, mental health, drugs and alcohol, problem behaviours, family and intimacy, and a meaningful life. This care is provided by a specialized team that collaborates with community agencies to ensure an expedient and efficient recovery and reintegration into the community.

FPH focuses upon innovation, evidence-based practice, and excellence in capacity-building, all of which allow for effectively addressing the diverse needs of the BC forensic inpatient population.

APPENDIX A: LEGAL DEFINITIONS

NOT CRIMINALLY RESPONSIBLE ON ACCOUNT OF MENTAL DISORDER

Individuals can be referred to FPH for NCRMD assessments (to provide judges with information to help determine if an NCRMD verdict is appropriate) or after being found NCRMD in order to receive treatment. An NCRMD finding is based upon the person's mental state at the time of the offence. A person found NCRMD is not convicted in the traditional sense; however, it is also not the same as being found not guilty. The individual is diverted to the forensic system and comes under the authority of the BC Review Board, which is accountable to the Supreme Court of BC.

FITNESS TO STAND TRIAL

Individuals can be referred to FPH for questions surrounding their fitness to stand trial. Unlike a finding of NCMRD, this references a person's mental state at the time of the trial, rather than at the time of the offence. Moreover, people who are found UST, if their fitness is restored (i.e., their mental illness is stabilized), will proceed through a criminal trial and may be found guilty of a crime; people found NCRMD are deemed to not have had the intent necessary to receive a guilty verdict.[204] If someone is found UST, they fall under the jurisdiction of the BC Review Board (see below) to determine whether they should continue to be detained or if they can be conditionally discharged. If the accused remains UST after 90 days, there will be an annual Review Board hearing to assess their fitness. They will remain under the jurisdiction of the Review Board until they are either found fit (and then will proceed to trial) or until the charges are stayed. Similar to an NCRMD finding, individuals can be referred for assessment (where they will be assessed by mental health professionals to help judges determine whether a UST finding is applicable) or they can be referred to FPH after being found UST to receive treatment to restore their fitness and prepare them to return to trial.

NCRMD and UST verdicts are quite rare. According to the 2017/18 Annual Report of the BC Review Board, an average of 53 (ranging from 42 to 61) new patients received this verdict each year during the five years from 2013/14 to 2017/18. In 2017/18. From this group of 53 patients, 41 were NCRMD and 12 were UST.[205] These patients represent less than 1% of the total number of new adult criminal cases heard in BC courts that same year.[206]

ADMISSIONS UNDER THE BC MENTAL HEALTH ACT

FPH is also designated as a provincial mental health facility under Schedule A of the BC Mental Health Act (MHA) which articulates the rules and regulations for admission and detention of "persons with a mental disorder".[207] As such, psychiatric assessment and treatment is provided for people referred temporarily to FPH from BC Corrections (Temporary Absence or TA).

[204] Canadian Criminal Code. *R.S.C. 1985, c. C-46, s. 672.22.* Available at https://laws-lois.justice.gc.ca/eng/acts/c-46/page-1.html#h-115011. Accessed October 2020.
[205] British Columbia Review Board. *Annual Report Fiscal Year: April 2017 – March 2018.* Available at http://www.bcrb.bc.ca/BCRB%20Annual%20Report%202017%202018.pdf. Accessed October 2020.
[206] Ibid.
[207] BC Mental Health Act. Available online at http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01. Accessed February 2020.

APPENDIX B: SUB-POPULATIONS

EARLY STARTERS

The term “Early starters” refers to individuals whose criminal offending and/or other forms of antisocial behavior preceded the onset of their mental illness.[208] Early starters have generally experienced early behavioural problems (e.g., a diagnosis of conduct disorder, serious substance use, or delinquency during adolescence)[209] and although mental illness contributes to their criminal behaviour, the expectation is that they may be involved in crime even if they were not mentally ill.[210,211] Although treatment must focus on the stabilization of mental illness, targeting of criminogenic needs[212,213] is critical to overall treatment success, particularly for individuals who present with these characteristics.[214]

LATE STARTERS

The term “Late starters” refers to individuals who have no, or very minimal, histories of antisocial behaviour or criminal offending prior to the onset of their mental illness and are likely to exhibit few(er) criminogenic needs compared to early starters.[215,216,217] Although the person may also have criminogenic needs that need to be addressed, tor people whose involvement in crime post-dates their mental health symptoms, the priority is to treat and stabilize their mental health, through medications and evidence-based therapeutic interventions.

LONG STAY PATIENTS

The average length of stay within forensic hospitals has been increasing.[218] Duke et al found that 23.5% of patients in high security units and 18.1% in medium security units were long stay patients, defined as a minimum stay of 5 years in medium, 10 years in high or 15 years in a mix of medium and high secure settings.[219]
When compared to the general forensic patient population, long stay patients have higher rates of intellectual disabilities, self-harm or serious suicide attempts, violent index offenses and inpatient admissions. In addition, they are more likely to have been admitted from a medium or high security setting.[220,221,222,223]

Forensic long stay patients have unique needs for medical/psychosocial treatment and quality of life maintenance, including structured activities to address social skills, self-esteem, physical health and communication challenges.[224,225]

NEUROPSYCHOLOGICAL IMPAIRMENTS

In addition to psychiatric disorders, a subset of forensic patients have neuropsychological impairments, including cognitive impairments such as dementia. Individuals with neuropsychological impairments are typically characterized by inadequate

[208] Hodgins S. Violent behaviour among people with schizophrenia: a framework for investigations of causes, and effective treatment, and prevention. *Philosophical Transactions of the Royal Society B: Biological Sciences*. 2008; 363(1503): 2505-18.
[209] Ibid.
[210] Crocker A, Martin M, Leclair M et al. Expanding the early and late starter model of criminal justice involvement for forensic mental health clients. *Law and Human Behavior*. 2018; 42(1): 83-93.
[211] Hodgins S. Violent behaviour among people with schizophrenia: a framework for investigations of causes, and effective treatment, and prevention. *Philosophical Transactions of the Royal Society B: Biological Sciences*. 2008; 363(1503): 2505-18.
[212] Bonta J, Blais J and Wilson H. A theoretically informed meta-analysis of the risk for general and violent recidivism for mentally disordered offenders. *Aggression and Violent Behavior.* 2014; 19(3): 278-87.
[213] Nicholls T and Goossens I. Guidelines for improving forensic mental health in inpatient psychiatric settings. In: Roesch R and Cook A, eds. *Handbook of Forensic Mental Health Services*. 2017.
[214] Morgan R, Kroner D and Mills J. *A Treatment Manual for Justice Involved Persons with Mental Illness: Changing Lives and Changing Outcomes.* Routledge; 2017.
[215] Crocker A, Martin M, Leclair M et al. Expanding the early and late starter model of criminal justice involvement for forensic mental health clients. *Law and Human Behavior.* 2018; 42(1): 83-93.
[216] Hodgins S. Violent behaviour among people with schizophrenia: a framework for investigations of causes, and effective treatment, and prevention. *Philosophical Transactions of the Royal Society B: Biological Sciences*. 2008; 363(1503): 2505-18.
[217] Crocker A, Martin M, Leclair M et al. Expanding the early and late starter model of criminal justice involvement for forensic mental health clients. *Law and Human Behavior.* 2018; 42(1): 83-93.
[218] Shah A, Waldron G, Boast N et al. Factors associated with length of admission at a medium secure forensic psychiatric unit. *The Journal of Forensic Psychiatry & Psychology*. 2011; 22(4): 496–512.
[219] Ibid.
[220] Ibid.
[221] Duke L, Furtado V, Guo B et al. Long-stay in forensic-psychiatric care in the UK. *Social Psychiatry and Psychiatric Epidemiology*. 2018; 53(3): 313-321.
[222] Riordan S, Smith H and Humphreys M. Conditionally discharged restricted patients and the need for long-term medium security. *Medicine, Science and the Law*. 2002; 42(4): 339-343.
[223] Hofvander B. Predictors of length of stay in forensic psychiatry: The influence of perceived risk of violence. *International Journal of Law and Psychiatry*. 2014; 37(6): 635-642.
[224] Glorney E, Perkins D, Adshead G et al. Domains of need in a high secure hospital setting: A model for streamlining care and reducing length of stay. *International Journal of Forensic Mental Health*. 2010; 9(2): 138-148. https://doi.org/10.1080/14999013.2010.499552
[225] Cormac I, Ferriter M, Benning R et al. Physical health and health risk factors in a population of long-stay psychiatric patients. *Psychiatric Bulletin*. 2005; 29(1): 18-20.

functional outcomes, which include general life satisfaction, the maintenance of healthy social relationships, and personal care/daily activities.[226,227,228,229]

FRAIL ELDERLY PATIENTS

In the forensic mental health context, geriatric patients defined as those aged 50 and older.[230] Individuals within forensic psychiatric facilities tend to experience the challenges of aging earlier than the general population, and have life expectancies that are on average 15-20 years lower, mainly related to histories of poor health management and substance use.[231]

Older patients have unique characteristics and needs in the forensic environment and are at high risk for comorbid physical health issues[232] such as sensory impairment (visual and auditory),[233] mobility problems,[234] heart disease, hypertension, diabetes, dementia and Alzheimer's disease.[235]

It is vitally important to support older adults with severe mental illness, as poor functional outcomes and quality of life are strongly associated with social isolation, depression, cognitive impairment, and chronic physical illness.[236]

WOMEN

Women comprise 12-15% of the FPH population at any given time. Research demonstrates that the impact of mental illness on women including the risk of violence is more pronounced than in men.[237,238]

Studies also demonstrate that a higher proportion of women with mental health problems, substance use and/or justice involvement have significant histories of victimization when compared to males.[239]

Gender-sensitive, trauma-informed approaches are integral to care. A priority of treatment is to prepare women for community re-entry, including improving self-esteem and autonomy, fostering the development of coping skills for encountering uncomfortable situations and empowering help seeking.

[226] Fujii D, Wylie A and Nathan J. Neurocognition and long-term prediction of quality of life in outpatients with severe and persistent mental illness. *Schizophrenia Research*. 2004; 69(1): 67-73.
[227] Green M, Kern R, Braff D et al. Neurocognitive deficits and functional outcome in schizophrenia: Are we measuring the "right stuff"? *Schizophrenia Bulletin.* 2000; 26(1): 119-36.
[228] Jaeger J, Berns S, Uzelac S et al. Neurocognitive deficits and disability in major depressive disorder. *Psychiatry Research.* 2006; 145(1): 39-48.
[229] Nishinaka H, Nakane J, Nagata T et al. Neuropsychological impairment and its association with violence risk in Japanese forensic psychiatric patients: A case-control study. *PLoS One.* 2016; 11(1): e0148354.
[230] Walker K, Griffiths C, Yates J et al. Service provision for older forensic mental health patients: A scoping review of the literature. *The Journal of Forensic Psychiatry & Psychology.* 2020; DOI: 10.1080/14789949.2020.1817525.
[231] Chesney E, Goodwin G and Fazel S. Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry*. 2014; 13(2): 153–160.
[232] Di Lorito C, Castelletti L, Tripi G et al. The individual experience of aging patients and the current service provision in the context of Italian forensic psychiatry: A case study. *Journal of Forensic Nursing*. 2017; 13(3): 118–125.
[233] Lightbody E, Gow R and Gibb R. A survey of older adult patients in special secure psychiatric care in Scotland from 1998 to 2007. *Journal of Forensic Psychiatry & Psychology*. 2010; 21(6): 966–974.
[234] Coid J, Fazel S and Kahtan N. Elderly patients admitted to secure forensic psychiatry services. *The Journal of Forensic Psychiatry*. 2002; 13: 416–427.
[235] Paradis C, Broner N, Maher L et al. Mentally ill elderly jail detainees. *Journal of Offender Rehabilitation*. 2000; 31(1–2): 77–86.
[236] Bartels S and Pratt S. Psychosocial rehabilitation and quality of life for older adults with serious mental illness: Recent findings and future research direction. *Current Opinion in Psychiatry*. 2009; 22(4): 381-385.
[237] Fazel F, Gulati G, Linsell L et al. Schizophrenia and violence: Systematic review and meta-analysis. *PLOS Medicine*. 2009; 6(8): e1000120.
[238] Stevens H, Laursen T, Mortensen P et al. Post-illness-onset risk of offending across the full spectrum of psychiatric disorders. *Psychological Medicine*. 2015; 45(11): 2447-57.
[239] Nicholls T, Petersen K, Brink J et al. A clinical and risk profile of forensic psychiatric patients: Treatment team STARTs in a Canadian service. *International Journal of Forensic Mental Health*. 2011; 10(3): 187-99.

APPENDIX C: RISK ASSESSMENT AND CARE PLANNING

INTRODUCTION

FPH relies on the Risk-Need-Responsivity (RNR) model and empirically validated structured professional judgment (SPJ) measures to inform our understanding of a patient's level of risk of violence, to identify what their criminogenic needs are to reduce that risk, and to treat them in a manner that is consistent with evidence and best practices.

GUIDING THEORY: THE RISK-NEED-RESPONSIVITY MODEL

The RNR model has provided some of the most important and wide-spread guidance on contemporary risk assessment and the prevention of crime and violence.[240,241,242]

An individual's *Risk* of criminal recidivism can be reduced if the level of services is proportional to the individual's risk to re-offend. Higher-risk individuals require more intensive services and management. Similarly, over-intervening with low-risk individuals can have negative effects (e.g., disrupting employment and prosocial relationships).

Need refers to the importance of interventions that focus on meeting the needs of the individual. Unmet needs can lead to individuals attempting to meet those needs through *criminogenic* behaviours. Addressing needs by reducing deficits or risk factors and building strengths or protective factors can lead to a lower likelihood of recidivism.

Responsivity refers to the extent to which an individual is likely to respond to an intervention. The responsivity principle encompasses both general responsivity, including a preference for evidence based approaches that employ cognitive or social learning interventions, and specific responsivity, which focuses on individual factors (e.g., learning style, personality, motivation, strengths).

Research has validated the use of RNR principles among populations of individuals who have perpetrated criminal offences and people with mental illness.[243,244] Although Skeem and colleagues found there are presently no studies investigating the responsivity principle among forensic populations, mental illness has often been considered a specific responsivity concern.[245,246]

INTRODUCTION TO RISK ASSESSMENT

There are three primary approaches to risk assessment: unstructured clinical judgment, actuarial risk assessment and SPJ. Evidence demonstrates that unstructured clinical judgment, or the decisions clinicians' make based solely their own clinical expertise, lacks validity (i.e., accuracy) and reliability (i.e., consistency).[247,248]

SPJs are designed to ensure the items considered are comprehensive and promote generalizability across populations and contexts. This approach helps evaluators and decision-makers identify risk factors that are present and relevant to the individual being evaluated, facilitates a determination of relative risk level and informs risk management and risk reduction strategies.

---

[240] Andrews D, Bonta J & Hoge R. Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior*. 1990; 17(1): 19–52.
[241] Andrews D, Bonta J & Wormith J. The recent past and near future of risk and/or need assessment. *Crime & Delinquency*. 2006; 52(1): 7–27.
[242] Bonta J & Andrews D. *The Psychology of Criminal Conduct*. 2017. Routledge.
[243] Eisenberg M, Van Horn J, Dekker J et al. Static and dynamic predictors of general and violent criminal offense recidivism in the forensic outpatient population: A meta-analysis. *Criminal Justice and Behaviour*. 2019; 46(5): 732-750.
[244] Skeem J, Steadman H & Manchak S. Applicability of the Risk-Need-Responsivity Model to persons with mental illness involved in the criminal justice system. *Psychiatric Services*. 2015; 66(9): 916–922.
[245] Osher F, D'Amora D, Plotkin M et al. *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*. 2012. Council of State Governments Justice Center. Available online at https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_Behavioral_Framework.pdf. Accessed January 2021.
[246] Skeem J, Steadman H & Manchak S. Applicability of the Risk-Need-Responsivity Model to persons with mental illness involved in the criminal justice system. *Psychiatric Services*. 2015; 66(9): 916–922.
[247] Heilbrun K, Yasuhara K & Shah S. Violence risk assessment tools: Overview and critical analysis. In R. Otto and K. Douglas (Eds.), *Handbook of Violence Risk Assessment* (pp. 1-17). 2010. Winnipeg, Manitoba: Routledge Taylor and Francis Group.
[248] Heilbrun K, Yasuhara K, Shah S & Locklair B. Approaches to violence risk assessment: Overview, critical analysis, and future directions. In K. Douglas & R. Otto (Eds.) *Handbook of Violence Risk Assessment.* 2021. Routledge Taylor and Francis Group.

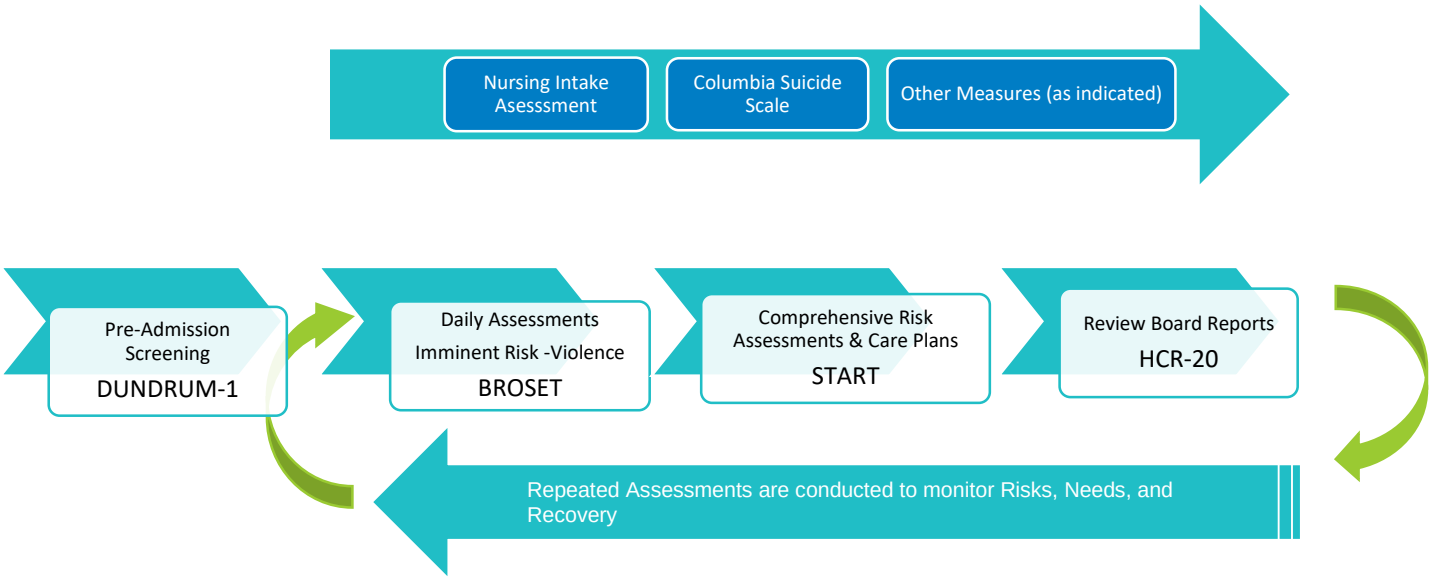
The actuarial approach dispenses with clinical judgment altogether in favour of an algorithmic model wherein quantitative values for a finite number of weighted variables computes a probabilistic decision about future risk (e.g., Violence Risk Appraisal Guide [VRAG]).[249] The estimates generated are referenced against group-based norms, and cannot be adapted for sub-populations (e.g., gender-specific risk factors).

SPJ measures adopt non-algorithmic, non-numeric decision processes and risk estimates. They do so to avoid the pitfalls inherent in actuarial approaches, such as sample dependence, exclusion of potentially important risk factors, instability of precise probability estimates across samples and the inherent difficulty in applying group-based probability estimates to individuals.[250]

Multiple meta-analyses demonstrate that actuarial and SPJ measures produce comparable effect sizes.[251]
The approach chosen should be based on the assessment question, the intent of the assessment and the context of the patient. Additional factors to consider include the timeframe of interest, location, identification of risk factors (i.e., indicative of increased risk of violence), promotive factors (i.e., indicative of a favorable outcome, such as responsible behavior) and protective factors (associated with a decrease in risk when protective factors are present).[252]

FPH has integrated evidence-based SPJ measures to inform each critical decision-making point in a patient's care pathway (see Figure A-1).

Figure A-1: Integrated Evidence-based SPJ measures at FPH



The primary objective of FPH is to support patient recovery and safe return to the community. It is therefore useful to distinguish two major objectives in risk assessment: prediction/classification and risk reduction.[253]

Actuarial risk assessments involve predicting violence by using an algorithmic approach, with static (unchanging) variables.[254] Experts agree it is important to conduct reassessments of risk that incorporate dynamic variables[255,256] and

[249] Harris G, Rice M & Quinsey V. Violent recidivism of mentally disordered offenders. *Criminal Justice and Behavior*. 1993; 20(4): 315–335.
[250] Douglas K, Hart S, Webster C et al. Historical-Clinical-Risk Management-20, Version 3 (HCR-20V3): Development and overview. *International Journal of Forensic Mental Health.* 2014 ; 13(2) : 93–108.
[251] Heilbrun K, Yasuhara K, Shah S & Locklair B. Approaches to violence risk assessment: Overview, critical analysis, and future directions. In K. Douglas & R. Otto (Eds.) *Handbook of Violence Risk Assessment.* 2021. Routledge Taylor and Francis Group.
[252] Ibid.
[253] Heilbrun K & Wiener R. Prediction versus management models relevant to risk assessment. *Law and Human Behavior. 1997; 21*(4): 347–59.
[254] Ogloff J & Davis M. From predicting dangerousness to assessing and managing risk for violence: A journey across four generations. (pp. 81-98). In J. S. Wormith, L. A. Craig, & T. E. Hogue (Eds.), *The Wiley Handbook of What Works in Violence Risk Management: Theory, Research, and Practice*. 2020. Wiley-Blackwell.
[255] Douglas K & Skeem J. Violence risk assessment: Getting specific about being dynamic. *Psychology, Public Policy, and Law*. 2005; 11(3): 347–83.
[256] Heilbrun K, Yasuhara K, Shah S & Locklair B. Approaches to violence risk assessment: Overview, critical analysis, and future directions. In K. Douglas & R. Otto (Eds.) *Handbook of Violence Risk Assessment.* 2021. Routledge Taylor and Francis Group.

research demonstrates dynamic risk factors significant predict institutional violence.[257] Further, it is important for evaluators to appraise and convey whether risk factors, and their relevance, have changed.

FPH considers SPJ measures best suited to inform patient care plans. Heilbrun and colleagues concluded that "promising directions for risk assessment include increased application of risk assessment to risk reduction planning and delivery…and the incorporation of influences of trauma and adverse experience into risk assessment and risk reduction."[258]

MENTAL ILLNESS AND VIOLENCE

Mental illness is not a good predictor of violence at a population level, and is not considered a prominent risk factor in the RNR model.[259] Within the forensic context, however, mental illness was determined by the courts to be central to the individual's risk. Despite an exaggerated public perception that people suffering from mental illness are violent and dangerous,[260] meta-analyses demonstrate that symptoms of mental illness represent only a modest increased risk of violence.[261]

Researchers have noted, however, that the comorbidity of mental illnesses with substance abuse does lead to a higher risk of crime and violence.[262] Additionally, people suffering from severe mental disorders such as schizophrenia and other psychotic disorders are more prone to committing violent criminal acts than the general population.[263,264]

RISK ASSESSMENT TOOLS AND CARE PLANNING INSTRUMENTS

FPH uses a variety of validated risk assessments during pre-admission, treatment and preparation for discharge. These are briefly discussed below.

Pre-Admission Screening: DUNDRUM - 1

When a patient is initially admitted to FPH, it is essential to have an understanding of the person's criminal history, their behavior in similar institutions, their mental health history, recent symptoms or substance use. This information guides decisions with respect to placement (e.g., medium vs. maximum secure unit) and initial treatment plan (e.g., knowing what medications and/or interventions have worked well in the past).

The DUNDRUM-1 (Dangerousness, Understanding, Recovery, and Urgency Manual, Element 1: Triage Security Items) assesses the level of therapeutic security needs in patients.[265] This instrument was designed to aid in decision-making for the appropriate security level of individuals transferring from the criminal justice system to a hospital.[266]

Although not intended as a violence risk assessment tool,[267] DUNDRUM-1 scores have been shown to be predictive of violence for patients in a secure forensic hospital.[268] Moreover, individuals who moved from higher security units to lower security units on average had lower mean scores on the DUNDRUM-1, supporting its use in informing security level.[269]

---

[257] Wilson C, Desmarais S, Nicholls T et al. Predictive validity of dynamic factors: Assessing violence risk in forensic psychiatric inpatients. *Law and Human Behavior*. 2013; 37: 377–388.
[258] Heilbrun K, Yasuhara K, Shah S & Locklair B. Approaches to violence risk assessment: Overview, critical analysis, and future directions. In K. Douglas & R. Otto (Eds.) *Handbook of Violence Risk Assessment.* 2021. Routledge Taylor and Francis Group.
[259] Bonta J, Blais J & Wilson H. A theoretically informed meta-analysis of the risk for general and violent recidivism for mentally disordered offenders. *Aggression and Violent Behavior*. 2014; 19(3): 278–287.
[260] Markowitz F. Mental illness, crime, and violence: Risk, context, and social control. *Aggression and Violent Behavior*. 2011; 16(1): 36–44.
[261] Douglas K, Guy L & Hart S. Psychosis as a Risk Factor for Violence to Others: A meta-analysis. *Psychological Bulletin*. 2009; *135*(5): 679–706.
[262] Ogloff J, Talevski D, Lemphers A et al. Co-occurring mental illness, substance use disorders, and antisocial personality disorder among clients of forensic mental health services. *Psychiatric Rehabilitation Journal*. 2015; 38(1): 16–23.
[263] Fazel S, Långström N, Hjern A et al. Schizophrenia, substance abuse, and violent crime. *JAMA*. 2009; 301(19): 2016-2023.
[264] Penney S, Morgan A & Simpson A. Assessing illness- and non-illness based motivations for violence in persons with major mental illness. *Journal of Law and Human Behavior*. 2016; 40(1): 42–49.
[265] Kennedy H O'Neill C, Flynn G et al. *Dangerousness, understanding, recovery, and urgency manual (the DUNDRUM quartet).* 2013. National Forensic Mental Health Service; Trinity College Dublin.
[266] Ibid.
[267] Ibid.
[268] Abidin Z, Davoren M, Naughton L et al. Susceptibility (risk and protective) factors for in-patient violence and self-harm: Prospective study of structured professional judgement instruments START and SAPROF, DUNDRUM-3 and DUNDRUM-4 in forensic mental health services. *BMC Psychiatry*. 2013; 13: 197.
[269] Davoren M, O'Dwyer S, Abidin Z et al. Prospective in-patient cohort study of moves between levels of therapeutic security: The DUNDRUM-1 triage security, DUNDRUM-3 programme completion and DUNDRUM-4 recovery scales and the HCR-20. *BMC Psychiatry*. 2012; 12: 80.

Nursing Intake and Initial Psychiatric Assessment

Upon admission to FPH, nursing staff complete a nursing intake form which identifies acute physical and mental health needs. Additionally, the patient's treating psychiatrist also assesses the patient upon admission to provide preliminary opinions on psychiatric diagnoses, current risk, and to inform the treatment plan for the patient.

Daily Assessments: Brøset Violence Checklist (Imminent Risk Assessment)

A person's risk for violence is dynamic and can change depending on their context (e.g., noise level on the unit), their symptoms (e.g., command hallucinations that they need to hurt someone), substance use, mood, and temporal events (e.g., an impending Review Board or anniversary of a prior trauma).
The Brøset Violence Checklist (BVC) is an actuarial violence risk assessment measure that evaluates the risk of imminent violence (next 24 hours).[270,271,272,273,274]

The BVC is considered to be the best violence risk assessment tool for patients in an acute mental health care setting.[275] In these settings, the BVC helps predict potential violence over the next 24 hours[276,277] and daily use leads to reduced incidents of violence and aggression.[278,279,280] The use of the BVC has also led to a reduction in the incidence and duration of seclusions.[281,282,283,284,285]

Comprehensive Risk Assessment and Treatment Planning: START

The complexity of the FPH's population requires comprehensive assessments and care plans.The Short-Term Assessment of Risk and Treatability (START) is an empirically and theoretically informed SPJ guide for the dynamic assessment of risks and treatability in patients with mental illness and/or criminal justice needs.[286,287]

The development of START was in response to a number of identified gaps within the forensic risk assessment mental health field, including the lack of measures to inform *comprehensive* assessments and treatment plans, a failure to consider the treatment relevant, *dynamic variables* necessary to inform management and interventions and a failure to integrate *protective factors* to ensure balanced assessments that consider both a person's deficits and their strengths.[288,289,290]

START is uniquely positioned to facilitate *case formulation and treatment planning* in diverse populations, including forensic psychiatric patients.[291,292]After assessing a patient's strengths and vulnerabilities, the START prompts the team to document management concerns, as well as the current management plan (which details how the patient's risk can be

[270] Almvik R & Woods P. The Brøset Violence Checklist (BVC) and the prediction of inpatient violence: Some preliminary results. *Psychiatric Care*; 1998; 5: 208-213.
[271] Almvik R & Woods P. (1999). Predicting inpatient violence using the Broset Violence Checklist (BVC). *The International Journal of Psychiatric Nursing Research*. 1999; 4(3): 498-505.
[272] Almvik R & Woods P. (2003). Short-term risk prediction: The Bröset Violence Checklist. *Journal of Psychiatric and Mental Health Nursing*. 2003; 10(2): 236-38.
[273] Almvik R, Woods P & Rasmussen K. The Brøset Violence Checklist: Sensitivity, specificity, and interrater reliability. *Journal of Interpersonal Violence.* 2000; 15(12): 1284-96.
[274] Woods P & Almvik R. The Brøset violence checklist (BVC). *Acta Psychiatrica Scandinavica*. 2002; 106: 103-5.
[275] Anderson K & Jenson C. Violence risk–assessment screening tools for acute care mental health settings: Literature review. *Archives of Psychiatric Nursing.* 2019; 33(1): 112-119.
[276] Abderhalden C, Needham I, Miserez B et al. (2004). Predicting inpatient violence in acute psychiatric wards using the Brøset-Violence-Checklist: A multicentre prospective cohort study. *Journal of Psychiatric and Mental Health Nursing*. 2004; 11(4): 422-427.
[277] Almvik R, Woods P & Rasmussen K. (2007). Assessing risk for imminent violence in the elderly: The Brøset Violence Checklist. *International Journal of Geriatric Psychiatry*. 2007; 22(9): 862-867.
[278] Abderhalden C, Needham I, Dassen T et al. Predicting inpatient violence using an extended version of the Brøset-Violence-Checklist: Instrument development and clinical application. *BMC Psychiatry*. 2006; 6(1): 17.
[279] Adberhalden C, Needham I, Dassen T et al. Structured risk assessment and violence in acute psychiatric wards: Randomised controlled trial. *British Journal of Psychiatry*. 2008; 193(1): 44-50.
[280] Van de Sande R, Nijman H, Noorthoorn E et al. Aggression and seclusion on acute psychiatric wards: effect of short-term risk assessment. *The British Journal of Psychiatry*. 2011; 199(6): 473-78.
[281] Abderhalden C, Needham I, Dassen T et al. Predicting inpatient violence using an extended version of the Brøset-Violence-Checklist: Instrument development and clinical application. *BMC Psychiatry*. 2006; 6(1): 17.
[282] Adberhalden C, Needham I, Dassen T et al. Structured risk assessment and violence in acute psychiatric wards: Randomised controlled trial. *British Journal of Psychiatry*. 2008; 193(1): 44-50.
[283] Blair E, Woolley S, Szarek B et al. Reduction of seclusion and restraint in an inpatient psychiatric setting: A pilot study. *Psychiatric Quarterly*. 2017; 88(1): 1-7.
[284] Clarke D, Brown A & Griffith P. The Brøset Violence Checklist: Clinical utility in a secure psychiatric intensive care setting. *Journal of Psychiatric and Mental Health Nursing*. 2010; 17(7): 614-620.
[285] Van de Sande R, Noorthoorn E, Wierdsma A et al. Association between short-term structured risk assessment outcomes and seclusion. *International Journal of Mental Health Nursing*. 2013; 22(6): 475-84.
[286] Webster C, Martin M, Brink J et al. *Short-term Assessment of Risk and Treatability (START)*. 2004. St. Joseph's Healthcare Hamilton, Ontario, and Forensic Psychiatric Services Commission.
[287] Webster C, Martin M, Brink J et al. *Short-term Assessment of Risk and Treatability (START)*. 2009. St. Joseph's Healthcare Hamilton, Ontario, and Forensic Psychiatric Services Commission.
[288] Webster C, Nicholls T, Martin M et al. Short-Term Assessment of Risk and Treatability (START): The case for a new structured professional judgment scheme. *Behavioral Sciences & the Law*. 2006; 24(6): 747–766.
[289] Heilbrun K, Yasuhara K, Shah S & Locklair B. Approaches to violence risk assessment: Overview, critical analysis, and future directions. In K. Douglas & R. Otto (Eds.) *Handbook of Violence Risk Assessment.* 2021. Routledge Taylor and Francis Group.
[290] Nicholls T, Petersen K, Almond M & Geddes C. Short-Term Assessment of Risk and Treatability. 2021 (in press). In K. Douglas & R. Otto (Eds.) *Handbook of Violence Risk Assessment*.
[291] Kroppan E, Nesset M, Nonstad K et al. Implementation of the Short Term Assessment of Risk and Treatability (START) in a forensic high secure unit. *International Journal of Forensic Mental Health*. 2011; 10(1): 7-12.
[292] Nicholls T, Petersen K, Almond M & Geddes C. Short-Term Assessment of Risk and Treatability. 2021 (in press). In K. Douglas & R. Otto (Eds.) *Handbook of Violence Risk Assessment*.

managed through monitoring, supervision, and treatment). for the START supports case formulation; this allows the team to consider what factors led the accused to engage in violence, as well as future scenarios of violence that could be likely given the accused's history. START is useful in assisting treatment teams with documenting and organizing information,[293] improving consensus in defining risks and communicating treatment needs,[294] leading to a broader, more nuanced understanding of the patient[295,296] and leading to more systematic and structured assessments and care plans.[297,298,299] Research at FPH indicates that START risk scores decrease significantly and strength scores increase significantly as patients move through the continuum of care, suggesting that START can be useful for informing patient placement and privilege decisions.[300]

START is predictive of a wide variety of general mental health outcomes including: self-neglect,[301, 302] suicide and self-harming behaviours,[303, 304] substance use,[305,306] property theft/damage and stalking/intimidation.[307] In addition, research has begun to find that the risk and strength factors assessed in START may predict violent recidivism.[308,309]

Annual Review Board Risk Assessment: HCR-20 V3

The Historical Clinical Risk Management-20, Version 3 (HCR-20 V3) is a SPJ risk assessment measure designed to assess an individual's violence risk and help practitioners develop strategies to reduce and manage violence risk.[310,311] Within forensic settings, a higher HCR-20 V3 total score is associated with violent offending following hospital discharge[312] while high risk scale scores increase the likelihood of withholding release from a forensic facility as well as returning to hospital post-discharge.[313] Predictive accuracy has been maintained for at least six years.[314,315] At the FPH, the HCR-20 V3 has been used to inform expert reports to the BC Review Board.[316]

Monitoring Aggressive Incidents: AIS

The Aggressive Incidents Scale (AIS) is a measure of number and severity of aggressive incidents.[317] Scores are collected and recorded on a daily basis by clinical staff. They are then reviewed and summed up at the following treatment case conference. It is designed so that staff can look at a list of AIS scores and understand what type of incidents occurred over the reporting period.

---

[293] Doyle M, Lewis G & Brisbane M. Implementing the Short-Term Assessment of Risk and Treatability (START) in a forensic mental health service. *Psychiatric Bulletin*. 2008; 32(11): 406-8.
[294] Levin S, Nilsen P, Bendtsen P & Bülow P. Staff perceptions of facilitators and barriers to the use of a short-term risk assessment instrument in forensic psychiatry. *Journal of Forensic Psychology Research and Practice*. 2018; 18(3): 199-228.
[295] Crocker A, Braithwaite E, Laferrière D et al. (2011). START changing practice: Implementing a risk assessment and management tool in a civil psychiatric setting. *International Journal of Forensic Mental Health*. 2011; 10(1): 13-28.
[296] Kroppan E, Nesset M, Nonstad K et al. Implementation of the Short Term Assessment of Risk and Treatability (START) in a forensic high secure unit. International Journal of Forensic Mental Health. 2011; 10(1): 7-12.
[297] Crocker A, Braithwaite E, Laferrière D et al. (2011). START changing practice: Implementing a risk assessment and management tool in a civil psychiatric setting. *International Journal of Forensic Mental Health*. 2011; 10(1): 13-28.
[298] Doyle M, Lewis G & Brisbane M. Implementing the Short-Term Assessment of Risk and Treatability (START) in a forensic mental health service. *Psychiatric Bulletin*. 2008; 32(11): 406-8.
[299] Kroppan E, Nesset M, Nonstad K et al. Implementation of the Short Term Assessment of Risk and Treatability (START) in a forensic high secure unit. International Journal of Forensic Mental Health. 2011; 10(1): 7-12.
[300] Nicholls T, Petersen K, Brink J & Webster C. A clinical and risk profile of forensic psychiatric patients: Treatment team STARTs in a Canadian service. *International Journal of Forensic Mental Health.* 2011; 10(3): 187-199.
[301] Dickens G & O'Shea L. How short should short-term risk assessment be? Determining the optimum interval for START reassessment in a secure mental health service. *Journal of Psychiatric and Mental Health Nursing*. 2015; 22(6): 397–406.
[302] Marriott R, O'Shea L, Picchioni & Dickens G. Predictive validity of the short-term assessment of risk and treatability (START) for multiple adverse outcomes: The effect of diagnosis. *Psychiatry Research*. 2017; 256: 435–443.
[303] Dickens G & O'Shea L. How short should short-term risk assessment be? Determining the optimum interval for START reassessment in a secure mental health service. *Journal of Psychiatric and Mental Health Nursing*. 2015; 22(6): 397–406
[304] Marriott R, O'Shea L, Picchioni & Dickens G. Predictive validity of the short-term assessment of risk and treatability (START) for multiple adverse outcomes: The effect of diagnosis. *Psychiatry Research*. 2017; 256: 435–443.
[305] Braithwaite E, Charette Y, Crocker A & Reyes A. The predictive validity of clinical ratings of the short-term assessment of risk and treatability (START). *The International Journal of Forensic Mental Health*. 2010; 9: 271–281.
[306] Dickens G & O'Shea L. How short should short-term risk assessment be? Determining the optimum interval for START reassessment in a secure mental health service. *Journal of Psychiatric and Mental Health Nursing*. 2015; 22(6): 397–406
[307] Inett A, Wright G, Roberts L & Sheeran A. Predictive validity of the START with intellectually disabled offenders. *Journal of Forensic Practice*. 2014; 16(1): 78–88.
[308] de Vries Robbé M, de Vogel V & de Spa E. Protective factors for violence risk in forensic psychiatric patients: A retrospective validation study of the SAPROF. *International Journal of Forensic Mental Health.* 2011; 10(3): 178–186.
[309] Kashiwagi H, Kikuchi A, Koyama M et al. Strength-based assessment for future violence risk: A retrospective validation study of the structured assessment of protective factors for violence risk (SAPROF) Japanese version in forensic psychiatric inpatients. *Annals of General Psychiatry*. 2018; 17(1): 5–8.
[310] Douglas K, Hart S, Webster C & Belfrage H. HCR-20: *Assessing Risk for Violence*, Version 3. 2013. Vancouver: Mental Health Law and Policy Institute, Simon Fraser University.
[311] Douglas K & Shafer C. The Science of and practice with the HCR-20 V3 (Historical-Clinical-Risk Management-20, Version 3). In K. Douglas & R. Otto (Eds.) *Handbook of Violence Risk Assessment*. 2021.
[312] Shepherd S, Campbell R & Ogloff J. The utility of the HCR-20 in an Australian sample of forensic psychiatric patients. *Psychiatry, Psychology, and Law*. 2018; 25(2): 273-282.
[313] Vitacco M, Tabernik H, Zavodny D et al. Projecting risk: The importance of the HCR-20 risk management scale in predicting outcomes with forensic patients. *Behavioral Sciences and the Law*. 2016; 34: 308-20
[314] Dolan M & Blattner R. The utility of the Historical Clinical Risk -20 Scale as a predictor of outcomes in decisions to transfer patients from high to lower levels of security – A UK perspective. *BMC Psychiatry*. 2010; 10(76): 1-8.
[315] Morrissey C, Beeley C & Milton J. Longitudinal HCR-20 scores in a high-secure psychiatric hospital. *Criminal Behaviour and Mental Health*. 2014; 24: 169-180.
[316] Douglas K, Hart S, Webster C & Belfrage H. HCR-20: *Assessing Risk for Violence*, Version 3. 2013. Vancouver: Mental Health Law and Policy Institute, Simon Fraser University.
[317] Chaimowitz G & Mamak M. *Companion Guide to the Aggressive Incidents Scale and the Hamilton Anatomy of Risk Management*. 2011. Hamilton, Ontario, Canada: St. Joseph's Healthcare Hamilton.

The AIS is a new measure with one published study. A study of forensic inpatients (*N*=39) under the jurisdiction of the Ontario Review Board (8% UST, 92% NCRMD) were evaluated with the AIS and aggressive outcomes were recorded over the following month. The AIS showed strong concurrent validity with another widely-used violence risk assessment measure, the modified Overt Aggression Scale. The authors concluded the results also provided support for the predictive validity of the AIS for inpatient aggression over one month.[318]

Monitoring Risk of Suicide: C-SSRS

The Columbia – Suicide Severity Rating Scale (C-SSRS) is a SPJ measure designed to aid in the assessment of the risk for suicidal ideation and behaviour.[319] The C-SSRS has been shown to be valid (with a high sensitivity) compared to other measures of suicide risk,[320] able to discriminate between suicidal ideation and behaviour,[321] and has demonstrated clinical utility.[322] No research appears to have yet examined the use of the C-SSRS among adult forensic psychiatric populations.

Case Specific Risk Assessment Measures

The FPH team of forensic psychologists are experts in assessing risk for diverse forms of (violent) offending. As required, this team provides additional risk assessments to inform risk evaluations and treatment planning and are also available to the treatment team to assess for specific mental health diagnoses and needs (e.g., neurological, fetal alcohol syndrome, impulsivity, and psychopathy). In addition Forensic Psychologists provide a range of assessments to inform treatment planning while patients are in the care of the hospital.

[318] Cook A, Moulden H, Mamak M et al. (2018). Validating the Hamilton Anatomy of Risk Management-Forensic Version and the Aggressive Incidents Scale. *Assessment*. 2018; 25(4): 432-445.
[319] Posner K, Brent D, Lucas C et al. *Columbia-Suicide Severity Rating Scale (C-SSRS)*. New York, NY: Columbia University Medical Center, 2008.
[320] Posner K, Brown G, Stanley B et al. The Columbia Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*. 2011; 168: 1266 – 77.
[321] Wilson, N. J. The Columbia-Suicide Severity Rating Scale: Validation for use as a screen for suicide risk in New Zealand prisons and probation settings. *Practice: The New Zealand Corrections Journal*. 2017; 5(2): 40-46.
[322] Madan A, Frueh C, Allen J et al. Psychometric re-evaluation of the Columbia-Suicide Severity Rating Scale: Findings from a prospective, inpatient cohort of severely mentally ill adults. *Journal of Clinical Psychiatry*. 2016; 77(7): e867-e873.

APPENDIX D: EFFECTIVENESS OF THERAPEUTIC COMMUNITIES

Prior to the COVID-19 Pandemic in 2019-2020 FPH had initiated a pilot project to implement a therapeutic community on one of the low-secure units (one of Hawthorne house).

Therapeutic communities (TCs) are residential treatment programs both within and outside of correctional facilities designed to provide a "highly immersive, highly structured, pro-social environment for the treatment of substance abuse and addiction."[323] TCs have a recovery orientation, focusing on the whole person and overall lifestyle changes, not simply abstinence from drug use. This orientation acknowledges the chronic, relapsing nature of substance use disorders and views lapses as opportunities for learning. Recovery is seen as a gradual, ongoing process of cognitive change through clinical interventions, and it is expected that it will take time for program participants to advance through the stages of treatment, setting personal objectives along the way.[324]

A key focus is on "right living" - considered to be based on honesty, taking responsibility, hard work, and willingness to learn. As program participants progress through the stages of recovery, they assume greater personal and social responsibilities in the TC. Individual participants also take on some of the responsibility for their peers' recovery as this is seen as an important part of changing oneself. The goal is for a TC participant to leave the program not only drug-free but also employed or in school or training.[325]

Acknowledging that personal change takes time, an essential element of a TC is drug-free, long-term, residential treatment lasting between 12 and 18 months. The TC's therapeutic model includes a hierarchical design of the community (i.e., levels of peer status and step-like treatment stages), emphasis on mutual responsibility for peers, the importance of work, and the TC's structured environment (i.e., daily seminars and groups, rules, privileges and disciplines, and a confrontational therapeutic milieu).[326]

During the first few months post-release, justice-involved individuals with substance use problems have a heightened risk of relapse, fatal and non-fatal overdose, death and recidivism. Given the chronic, relapsing nature of substance use disorders, a key component of the TC approach is to aid participants in connecting with formal aftercare and self-help groups in the community. [327,328]

The first randomized controlled trial of a TC was completed by Wexler and colleagues at the US-based Amity Prison TC.[329] The Amity Prison TC consisted of the following phases:

1. A 2 - 3 month initial phase involving orientation, clinical assessment of resident needs and problem areas, and planning interventions and treatment goals. Residents are given prison jobs but have limited responsibility for the maintenance of the TC.
2. A 5 - 6 month phase in which residents earn increased responsibility by showing greater involvement in the program and through hard emotional work. Encounter groups and counselling sessions focus on self-disciple, self-worth, self-awareness, respect for authority and acceptance of guidance for problem areas.
3. A 1 - 3 month reentry phase in which residents strengthen their planning and decision-making skills and work with program and parole staff to prepare for their return to the community.

[323] Schaefer D, Davidson K, Haynie D et al. Network integration within a prison-based therapeutic community. *Social Networks*. 2021; 64: 16-28.
[324] NIH National Institute on Drug Abuse. *Therapeutic Communities Research Report*. Available online at https://www.drugabuse.gov/publications/research-reports/therapeutic-communities/what-therapeutic-communitys-approach. Accessed January 2021.
[325] Ibid.
[326] De Leon, G. *The Therapeutic Community: Theory, Model, and Method*. Springer; New York: 2000.
[327] Moore K, Hacker R, Oberleitner L et al. Reentry interventions that address substance use: A systematic review. *Psychological Services.* 2020; 17(1): 93 - 101.
[328] Ibid.
[329] Wexler H, De Leon G, Thomas G et al. The Amity prison TC evaluation: Reincarceration outcomes. *Criminal Justice and Behaviour*. 1999; 26(2): 147-67.

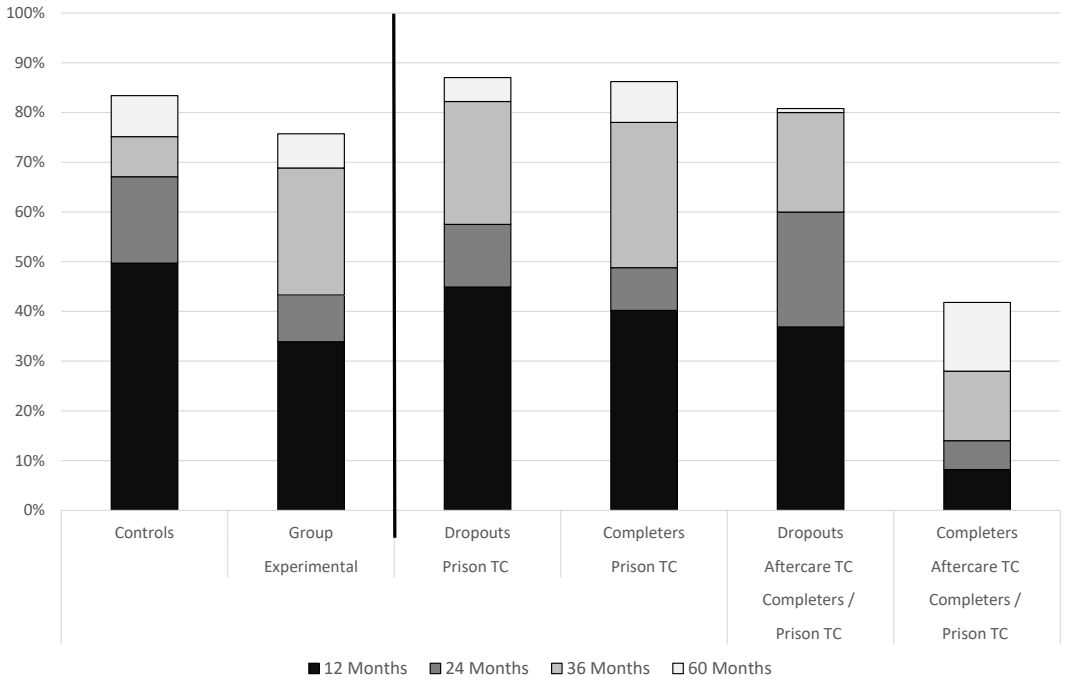
4. An aftercare component for up to 1 year in which the residents are given the opportunity of assisting in maintaining an Amity-operated facility while continuing the program curriculum they began in prison. The aftercare component also provides services for wives and children of residents.

To assess the effectiveness of the Amity Prison TC, Wexler and colleagues randomly assigned inmates to a treatment (*N*=425) or control group (*N*=290). At the conclusion of the study, the following five groups were identified:

1. Inmates who volunteered for the in-prison TC program but were not selected for participation (no-treatment control)
2. Inmates who entered the in-prison treatment program but who left prematurely for disciplinary or personal reasons (prison TC drop outs)
3. Inmates who completed the in-prison TC but did not choose to parole to the aftercare TC in the community (prison TC treatment completers)
4. Inmates who completed the in-prison TC and volunteered to attend the aftercare TC but dropped out in less than three months (aftercare TC treatment drop outs)
5. Inmates who completed the prison and aftercare TC programs (aftercare TC completers).

The initial results[330] and subsequent follow-up studies clearly indicate the value of the aftercare component.[331,332,333] After 12 months of follow-up, the reincarceration rate for those who completed both the prison and aftercare component of the TC was just 8.2%, compared with 49.7% in the control group (see Figure 1). After 60 months (5 years), those who completed both the prison and aftercare component of the TC had a reincarceration rate of 41.8%, less than half that of the control group (83.4%). All other subgroups had reincarceration rates at 5 years similar to that of the control group.

Figure 1: Amity Prison-Based Therapeutic Community
12, 24, 36 and 60 Month Reincarceration Rates



In 2019, Perry and colleagues reviewed high quality research evidence (in this case, randomized controlled clinical trials or RCTs) assessing the "effectiveness of interventions for drug-using offenders with co-occurring mental health problems in reducing criminal activity or drug use, or both." [334] The review includes the available RCT evidence (including the Amity results summarized above) comparing a therapeutic community with aftercare intervention to a number of alternative treatment scenarios.

Participants who received the TC with aftercare versus a treatment as usual intervention were 33% (risk ratio [RR] of 0.67, 95% CI of 0.53 to 0.84) less likely to be involved in a subsequent criminal activity and 60% (RR of 0.40, 95% CI of 0.24 to 0.67) less likely to return to prison, based on a one-

[330] Ibid.
[331] Wexler H, Melnick G, Lowe L and Peters J. Three-year reincarceration outcomes for Amity in-prison therapeutic community and aftercare in California. *The Prison Journal*. 1999; 79(3): 321-35.
[332] Prendergast M, Hall E and Wexler H. Multiple measures of outcome in assessing a prison-based drug treatment program. *Journal of Offender Rehabilitation*. 2003; 37 (3-4): 65-94.
[333] Prendergast M, Hall E, Wexler H et al. The Amity prison-based therapeutic community: 5-year outcomes. *The Prison Journal*. 2004; 84(1): 36-60.
[334] Perry A, Martyn-St James M, Burns L et al. Interventions for drug-using offenders with co-occurring mental health problems (Review). *Cochrane Database of Systematic Reviews*. 2019; 10.

year period of follow-up.[335,336] The Wexler et al. study compared participants who received the therapeutic community with aftercare intervention versus those on a waiting list and found a 40% (RR of 0.60, 95% CI of 0.46 to 0.79) reduction in recidivism over a three-year follow-up period.[337] The authors of the review note that they are "moderately confident in (these) effect estimates (meaning) the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different."[338]

When the TC with aftercare intervention is compared with cognitive behavioral therapy, however, there does not appear to be any further significant reduction in self-reported drug use (RR of 0.78, 95% CI of 0.46 to 1.32), re-arrest for any type of crime (RR of 0.69, 95% CI of 0.44 to 1.09), criminal activity (RR of 0.74, 95% CI of 0.52 to 1.05) or drug-related crime (RR of 0.87, 95% CI of 0.56 to 1.36) within six months after the intervention for drug-using women.[339]

In 2020, Moore and co-authors published a systematic review of re-entry interventions that address substance use.[340] They note that "justice-involved individuals with substance use problems have heightened risk of relapse and recidivism after release from incarceration, making re-entry a critical time to provide evidence-based treatments for substance use." They note two studies that assessed the effectiveness of therapeutic communities.[341,342]

The study by Robbins et al. assessed the effectiveness of a therapeutic community approach using "milieu therapy", meaning that "the entire environment, including routines of daily living, is intended to be therapeutic"[343] for drug-involved female offenders during a six-month work release period. Their analysis suggests that, if participants successfully complete the six-month program, then they are more likely to remain arrest-free, drug-free and/or use drugs less extensively one year after the program than female offenders not in the program.[344]

Sacks et al. report on the effectiveness of a re-entry modified TC for male offenders with co-occurring substance use and mental disorders.[345] A total of 127 men were randomly assigned to the re-entry modified TC (N=71, the experimental group) or parole supervision and case management (N=56, the control group). A combination of CBT and a psychoeducation curriculum was used in the re-entry modified TC. At one year post prison release, the men in the experimental group were significantly less likely to be reincarcerated (19%) than the men in the control group (38%).[346]

Importantly, not all research indicates that therapeutic communities have an advantage over alternative interventions.[347] This may in part, be due to limited fidelity to the core principles and methods of a TC in some settings.[348]

Indeed, the issue of appropriate aftercare is critical to the success of any prison-based TC. When this component is missing or utilized in a limited way, prison-based TCs tend to be no more effective at reducing recidivism than usual prison care.[349,350,351,352,353] As noted by Anglin and colleagues, "there is increased evidence that the prison-based component of treatment may serve primarily as an orientation or transitional phase for the community-based component."[354]

---

[335] Sacks S, Sacks J, McKendrick K et al. Modified TC for MICA offenders: Crime outcomes. *Behavioural Sciences and the Law*. 2004; 22(4): 477-501.
[336] Sacks S, Chaple M, Sacks J et al. Randomized trial of a re-entry modified therapeutic community for offenders with co-occurring disorders: Crime outcomes. *Journal of Substance Abuse Treatment*. 2011; 23(12): 1676-86.
[337] Wexler H, Melnick G, Lowe L et al. Three-year reincarceration outcomes for Amity in-prison therapeutic community and aftercare in California. *Prison Journal.* 1999; 79(3): 321-36.
[338] Perry A, Martyn-St James M, Burns L et al. Interventions for drug-using offenders with co-occurring mental health problems (Review). *Cochrane Database of Systematic Reviews*. 2019; 10.
[339] Sacks J, Sacks S, McKendrick K et al. Prison therapeutic community treatment for female offenders: Profiles and preliminary findings for mental health and other variables (crime, substance use and HIV risk). *Journal of Offender Rehabilitation*. 2008; 46(3-4): 233-61.
[340] Moore K, Hacker R, Oberleitner L et al. Reentry interventions that address substance use: A systematic review. *Psychological Services.* 2020; 17(1): 93 - 101.
[341] Robbins C, Martin S, Surratt H. Substance abuse treatment, anticipated maternal roles, and reentry success of drug-involved women prisoners. *Crime & Delinquency*. 2009; 55: 388-411.
[342] Sacks S, Chaple M, Sacks J et al. Randomized trial of a reentry modified therapeutic community for offenders with co-occurring disorders: Crime outcomes. *Journal of Substance Abuse Treatment*. 2012; 42: 247-59.
[343] Robbins C, Martin S, Surratt H. Substance abuse treatment, anticipated maternal roles, and reentry success of drug-involved women prisoners. *Crime & Delinquency*. 2009; 55: 388-411.
[344] Ibid.
[345] Sacks S, Chaple M, Sacks J et al. Randomized trial of a reentry modified therapeutic community for offenders with co-occurring disorders: Crime outcomes. *Journal of Substance Abuse Treatment*. 2012; 42: 247-59.
[346] Ibid.
[347] Welsh W, Zajac G, Bucklen K. For whom does prison-based drug treatment work? Results from a randomized experiment. *Journal of Experimental Criminology*. 2014; 10: 151-77.
[348] Schaefer D, Davidson K, Haynie D et al. Network integration within a prison-based therapeutic community. *Social Networks*. 2021; 64: 16-28.
[349] Prendergast M, Hall E, Wexler H et al. The Amity prison-based therapeutic community: 5-year outcomes. *The Prison Journal*. 2004; 84(1): 36-60.
[350] Zhang S, Roberts R and McCollister K. Therapeutic community in a California prison: Treatment outcomes after five years. *Crime & Delinquency*. 2011; 57(1): 82-101.
[351] Welsh W, Zajac G & Bucklen K. For whom does prison-based drug treatment work? Results from a randomized experiment. *Journal of Experimental Criminology*. 2014; 10(2): 151-77.
[352] Aslan L. *Doing time* on a TC: How effective are drug-free therapeutic communities in prison? A review of the literature. *Therapeutic Communities: The International Journal of Therapeutic Communities*. 2018; 39(1): 26-34.
[353] Anglin M, Prendergast M, Farabee D & Carter J. *Final Report on the California Substance Abuse Treatment Facility (SATF) and State Prison at Corcoran: A Report to the California Legislature*. Available online at https://web.archive.org/web/20100629213339/http://www.attc.ucsd.edu/pdfs/UCLA/FinalSATFLegislativeReport.pdf. Accessed January 2021.
[354] Ibid.

Even a TC with appropriate aftercare, however, is not effective for all inmates. The Amity Prison TC excluded individuals convicted of arson or a sexual crime[355] as well as those with a psychiatric disorder (psychosis, mood disorder).[356] Based on 10 years of follow-up of a TC implemented in an Ontario maximum security hospital, nonpsychopaths graduating from the TC program had a violent recidivism rate of 22%, compared to 39% for their prison counterparts. On the other hand, psychopaths graduating from the TC program had a violent recidivism rate of 77%, substantially higher than the 55% observed for their prison counterparts.[357]

Although the evidence base is of considerably lower quality than that for the key outcome of recidivism, a model TC may also improve the resident's quality of life,[358] lead to lower rates of suicide and self-harm,[359] lead to lower rates of institutional misconduct[360,361] and provide a more favourable working environment for staff.[362]

[355] Wexler H, De Leon G, Thomas G et al. The Amity prison TC evaluation: Reincarceration outcomes. *Criminal Justice and Behaviour*. 1999; 26(2): 147-67.
[356] McCollister K, French M, Prendergast M et al. Is in-prison treatment enough? A cost-effectiveness analysis of prison-based treatment and aftercare services for substance-abusing offenders. *Law & Policy*. 2003; 25(1): 63-83.
[357] Rice M, Harris G and C. Cormier. An evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders. *Law and Human Behavior*. 1992; 16(4): 399-412.
[358] Shefer G. The quality of life of prisoners and staff at HMP Grendon. In R. Shucker and E. Sullivan (Eds.), *Grendon and the Emergence of Forensic Therapeutic Communities: Developments in Research and Practice*. 2010. Chichester: Wiley Blackwell.
[359] Rivlen A. Suicide and self-harm at Grendon therapeutic community prison. *Prison Service Journal*. 2007; 173: 34-8. 2007
[360] Cullen E. Grendon: The therapeutic prison that works. *Therapeutic Communities*. 1994; 15(4): 301-11.
[361] Newton M. Changes in prison offending among residents of a prison-based therapeutic community. In R. Shucker and E. Sullivan (Eds.), *Grendon and the Emergence of Forensic Therapeutic Communities: Developments in Research and Practice*. 2010. Chichester: Wiley Blackwell.
[362] Tonkin M & Howells K. *Social climate in secure settings: A report for HMP Grendon* (unpublished report). As noted in Shuker R. Forensic therapeutic communities: A critique of treatment model and evidence base. *The Howard Journal*. 2010; 49(5): 463-77.

APPENDIX E: DESCRIPTION OF FPH UNITS

HIGH SECURE UNITS

Ashworth 1/2

Ashworth 1 is a high security unit for the assessment and stabilization of male patients transferred from a Provincial Correctional Centre. Remand patients are held in A1, and are not eligible for transfer within the hospital.

Complex assessments of male patients who have been directed from the courts or jail for treatment (i.e., new UST and new NCRMD patients awaiting initial Review Board hearings) are placed in either Ashworth 1 or 2.

Ashworth 2 is a high security unit for the stabilization and treatment of male patients who require intensive interventions and have had their first Review Board hearing or for the stabilization and treatment of male patients with acute psychosis or major mood disturbance from other FPH units or returning from the community.

Ashworth 3/4

Ashworth 3 and 4 are high security units for male patients providing intensive treatment for those with cognitive impairments, severe behavioural disturbances, refractory mood and psychotic disorder with or without cognitive impairment, or sexually inappropriate behaviours/aggression.

MEDIUM SECURE UNITS

Dogwood West

Dogwood West is a medium secure unit for medically frail/elderly or vulnerable males whose needs cannot be met in another unit. Individuals may have cognitive impairments, severe behavioural disturbances, refractory mood and psychotic disorder with or without cognitive impairment, or may have sexually inappropriate behaviours/aggression. These individuals often have multiple chronic medical conditions that co-occur with their psychiatric illnesses.

A focus is placed on specialized discharge planning for individuals who may no longer present a risk to the public or require long term tertiary care.

Elm North and South

Elm North and South are medium secure units with a focus on intensive rehabilitation for male patients with stable major psychiatric illnesses and/or concurrent psychiatric and severe substance use disorders and/or behavioural disturbances.

A continuum of care includes opportunities for step-down to an increasing level of independence with appropriate supports. Elm North and South are part of a continuum of increased independence in living, which includes Hawthorne House.

LOW SECURE UNIT

Hawthorne House

Hawthorne House is a low secure unit that offers independent living in a secure setting. Patients are responsible for house chores, weekly grocery shopping, and cooking; this is done in order to mirror community living and to prepare patients for

transition to the community where ever possible. Long stay patients can live in this environment if their risk is assessed as low.

Hawthorne House also has a dedicated female “house” where women can step down into more independent living when ready.

An emphasis is placed on community reintegration and dynamic risk assessment in this unit.

WOMEN’S CONTINUUM OF CARE

Dogwood East

Dogwood East is a unit dedicated for female and transwomen at all security levels. The unit provides comprehensive care, including:

- Assessment and stabilization of patients transferred from a Provincial Correctional Centre.
- Complex assessment of patients who have been directed from the courts or jail for treatment (i.e., new UST and new NCRMD patients awaiting an initial Review Board hearing).
- Stabilization and treatment of patients who require intensive interventions and have had their first Review Board hearing.
- Stabilization and treatment of patients with acute psychosis or major mood disturbance from other FPH units or returning from the community.
- Intensive rehabilitation and recovery for patients with stable major psychiatric illnesses and/or concurrent psychiatric and severe substance use disorders and/or behavioural disturbances that require intensive rehabilitation.

CONTACT
INFORMATION

bcmhsus.ca

BC Mental Health and Substance Use Services

4949 Heather Street

Vancouver, BC, V5Z 3L7

Canada

Follow us:

Provincial Health Services Authority
Province-wide solutions. Better health.

BC MENTAL HEALTH
& SUBSTANCE USE SERVICES
Provincial Health Services Authority

Appendix C

The National Trajectory Project

Who are the people found not criminally responsible on account of a mental illness?

The National Trajectory Project examined the path of people deemed not criminally responsible on account of mental disorder (NCR) in Canada.

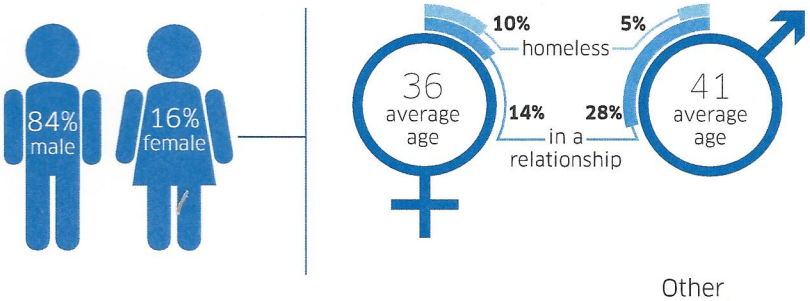
The study analyzed 1800 cases between May 2000 and April 2005 in the three most populous provinces: British Columbia, Ontario, and Quebec. It included a three-year, follow-up review of each case.

Here is a picture of what emerged:

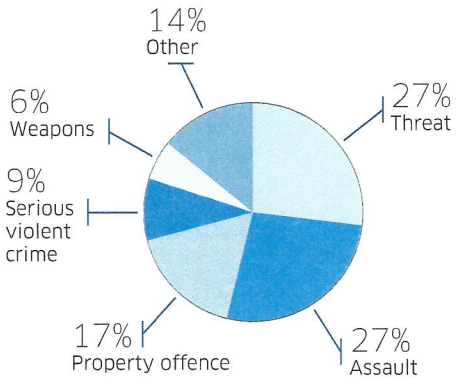
Who is typically found NCR?

94% are diagnosed with a severe mental illness

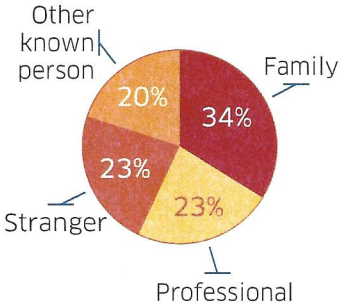
71% benefit from governmental income support



What is their offence?



Link to the victim



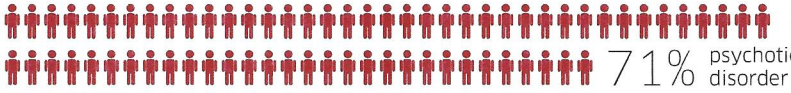
What is their mental illness?

Out of **100 individuals** found NCR have a:


11% personality disorder


23% mood disorder

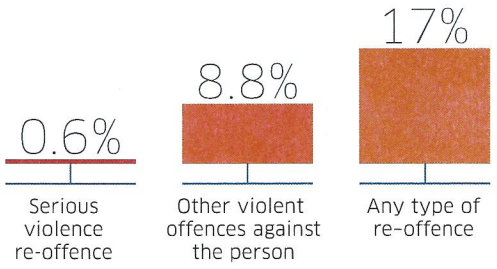

31% substance use disorder


71% psychotic disorder


⅓ have more than one illness

Recidivism of NCR

after three years of follow-up:



By comparison people released from the general prison population (non NCR population and did not receive forensic care) re-offend twice as often (at about **34%**).

IT
https://ntp-ptn.org for more information
mentalhealthcommission.ca

FUNDED IN PART BY:

Mental Health Commission of Canada / Commission de la santé mentale du Canada
The Royal
Douglas Institute
BC Mental Health & Substance Use Services
Forensic Psychiatric Services Commission

Provincial Health Services Authority
Province-wide solutions. Better health.

BC MENTAL HEALTH & SUBSTANCE USE SERVICES
Provincial Health Services Authority

Policy Number & Name	**CCR-712H**	**Program and Privilege Committee and Privilege Levels**	
Policy Section	Clinical Care: Guidelines for Care	**Date Approved**	October 8, 2019 (replaces June 19, 2019 version)
Approval Authority	Chief Operating Officer, Complex Mental Health & Substance Use Services (AMHSU and FPH) Medical Director, Forensic Psychiatric Services	**Effective Start Date**	October 8, 2019
Scope	☐ **Agency wide** (applies to all BCMHSUS programs) ☐ **Correctional Health Services** **Forensic Psychiatric Services** ☒ Forensic Psychiatric Hospital ☐ Forensic Regional Clinics **Adult Mental Health and Substance Use** ☐ BCMHA ☐ Heartwood		
Exceptions	No exceptions.		

1. PURPOSE

Access to therapeutic programs in the Forensic Psychiatric Hospital ("FPH") and access to the community are important aspects of the recovery and patient-centred model of care.

No patient shall be assigned a Privilege level unless approved by the Program & Privilege Committee.

To facilitate the safe integration of patients into the community and the rehabilitative pathway, privilege levels are applied for, assigned, reviewed, and updated in a manner that takes into account patients' clinical status, risk assessment and needs, as well as the safety of patients, staff, and the community.

To this end, all patients will be assigned a security or privilege level, which is based on a comprehensive assessment of risk to self and others, and that sets out access to programs, activities and the degree of freedom that patients enjoy while in the hospital.

The purpose of this policy is to:

(i) Define the seven privilege levels.

(ii) Describe the process for the application, review, approval, suspension and reinstatement of privilege levels.

2. POLICY

2.1. Privilege Levels

2.1.1. There are 7 levels of privileges. Patients will progress through Levels 0 to 6 as their individual clinical situation permits. On occasion, a patient may skip a level if appropriate and supported by extensive supporting information and approved by the P & P Committee.

2.2. Privilege Level 0

2.2.1. The patient may only access those off-unit activities that require all patients to participate (i.e. airing court, gym).

2.2.2. Only in exceptional cases, will patients awaiting trial or their first Review Board hearing have privileges higher than Level 0.

2.2.3. Remand assessment patients will have Level 0 privileges only.

2.3. Privilege Level 1

2.3.1. Patient may attend hospital-based programs in Ashworth and Birch buildings only (e.g., Act 1, Act 2, Power Hour, etc.) when escorted by two staff members.

2.3.2. Patients on Level 1 privileges will not have contact in programs with patients from closed or open units.

2.4. Privilege Level 2

2.4.1. The following privileges are available in addition to those within Level 1:

a) Attendance at programs within the Hospital when escorted by one staff member;
b) Fir Hall when escorted by one staff member (1:1 Fir Hall);
c) Escorted by one staff member from the unit to the hospital grounds for the purpose of Supervised Grounds;
d) 1:1 and Supervised grounds.

2.5. Privilege Level 3

2.5.1. The following privileges are available in addition to those within Level 2:

a) Staff Supported Community Outings (SSCO's) done in accordance with Policy CCR-705H (Staff Supported Community Outings);
b) Unescorted attendance at programs within the Hospital;
c) Unescorted Grounds Privileges;
d) Unescorted access to Fir Hall;
e) Accompanied Day Leaves with a designated person (family or volunteer) approved by the Treatment Team and the Program & Privilege Committee. This privilege must be applied for and cannot be granted by the Treatment Team without specific approval by the PROGRAM & PRIVILEGE Committee.

2.6. Privilege Level 4

2.6.1. The following privileges are available in addition to those within Levels 2 & 3:

a) Unescorted Day Leaves that are specified and structured. These include day leaves to a specific, verifiable location and for a specified purpose such as to a Community Centre for Narcotics or Alcoholic Anonymous meetings, or for other community based Drug and Alcohol treatment program.
b) Unescorted visits to verifiable locations such as Forensic Outpatient clinics or other community treatment centres.
c) Unescorted therapeutic day leaves intended to allow patients to participate in time limited community access such as walks in the local area where the patient's return to FPH will be within one hour of his / her departure.

2.7. Privilege Level 5

2.7.1. The following privileges are available in addition to those within Levels 2-4:

a) Unescorted Day Leaves for leisure purposes into the Community, (e.g., Coquitlam Centre mall or Colony Farm Road), but within a specified time frame.

2.8. Privilege Level 6

2.8.1. The following privileges are available in addition to those within all other Levels:

a) Overnight Leaves;

b) Visit Leaves.

3. PROCEDURES

3.1.1. Any patient may request that the Treatment Team consider an application for an increase in his/her privilege level.

3.1.2. If in agreement with the patient's request, the Treatment Team, in preparing the application for approval to the Program & Privilege Committee, must consult with the patient's unit nursing staff and the Rehabilitation Services department and record any dissenting opinion.

3.1.3. The Treatment Team completes the Program & Privilege Application Form. A START completed within the past 28 days or no more than four weeks must accompany all applications including transfer applications.

3.1.4. When applying for an increase in privilege level and/or transfer to a unit of lower security, the team must provide sufficient information, relevant to the application, for the Program & Privilege Committee to make an informed decision whether to approve the application.

3.1.5. When applying for any community access privileges, the Treatment Team must consider the potential impact on victims and the community to which the patient will have access if granted the requested privilege.

3.1.6. All applications for community access require an informational addendum describing any history of unauthorized absences, breaches, and direct-backs.

3.1.7. Per CCR-713H (Patient Leaves & Grounds Privileges), the Treatment Team must request permission from the Program & Privilege Committee to allow a patient to take debit/credit cards

or government-issued identification while accessing the community. This permission must be sought with each community access application.

3.1.8. The permission granted in (7) above is only for the patient to have access to financial cards and government-issued identification when they are accessing the community. When not on an SSCO or Day/Visit Leave, these items must be retained by the unit in appropriate storage, as noted in CCR-805H (Patient's Personal Effects and Valuables).

3.1.9. The Program & Privilege Committee may request additional information or clarification from the Treatment Team (in writing or in person).

3.1.10. The Program & Privilege Committee, in reviewing a request for increase or reinstatement of a privilege level, considers the following factors:

(i) Risk assessment and clinical risk management strategies,

(ii) Rationale for increased privileges,

(iii) The patient's clinical and legal status,

(iv) The potential impact of such privileges on victims and the community,

(v) The recommendations of the Treatment Team,

(vi) Any other relevant information

3.1.11. Generally, the Program & Privilege Committee assigns a privilege level to the patient, while the Treatment Team, in its discretion, determines which specific privileges within each Level the patient may have. However, in some cases, the Program & Privilege Committee will grant only specific privileges within a level.

3.1.12. When documenting privilege levels and individual privileges, the following points must be adhered to:

(i) Individual privilege levels (i.e. Level 1, Level 2, etc.) will be written on the Program & Privilege Activity Documentation sheet (FPS 2233) by the assigned clinical team member, as delegated by the unit's Clinical Services Manager or Psychiatrist.

(ii) Individual programs and privileges (i.e. Power Hour, Act I, Fir Hall, etc.) must be written by the assigned clinical team member, as delegated by the unit's Clinical Services Manager or Psychiatrist.

(iii) Once written on FPS 2233, a parallel entry must be made in the Patient Care Notes, noting the privilege that was granted, by the person writing on FPS 2233.

3.1.13. Once signed by the Program & Privilege Committee, unit staff will file all applications for Programs and Privileges on the clinical file under the "Status/Privileges" tab.

3.1.14. Where the Treatment Team is in disagreement with a decision of the Program & Privilege Committee, they may request to meet with the Program & Privilege Committee to discuss the reasons for the decision.

3.2. Applications for Community Access Privileges

3.2.1. For all community access privileges, the following shall apply:

(i) A current Short Term Assessment of Risk and Treatability (START) form, completed as per policy CCR-721H (START), must accompany the application. For the purposes of this policy, "current START form" refers to a START assessment that was completed within the past 28 days or no more than four weeks..

(ii) The Program & Privilege Committee may request additional information, including submission of the current Integrated Treatment Plan (ITP), and/or attendance in person by a member(s) of the Treatment Team at the Program & Privilege Committee meeting.

3.3. Withholding of Community-Access Privileges

3.3.1. Physicians, nurses and/or the social worker, in consultation with the Nurse-in-Charge, may withhold a privilege for clinical reasons.

3.3.2. If this is done, an entry in ink is made on the Privilege and Program Activity Documentation (FPS 2233) with a corresponding note on the clinical chart. The unit's Clinical Services Manager and Psychiatrist must be notified as soon as practicable.

3.3.3. Where community access privileges within a particular level have been withheld for less than 14 days, they may be re-instated by the Treatment Team without the approval of the Program & Privilege Committee. If this is done, an entry in ink is made on the Program & Privilege Documentation Sheet (FPS 2233) with a corresponding note on the clinical chart. This documentation will be completed by a staff member as delegated by the unit's Clinical Services Manager or Psychiatrist.

3.3.4. When community access privileges within a particular level have been withheld for 14 days or more, those privileges will remain withheld until a new application is made to, reviewed, and approved by the Program & Privilege Committee.

3.3.5. An application to reinstate community access will be supported by a current START assessment completed within the past 28 days or no more than four weeks (i.e. completed within the past 2 weeks).

3.4. Escapes and/or Unauthorized Absences

3.4.1. If a patient escapes or has been placed on Unauthorized Absence (UA) from FPH, the patient's privileges which allow access to the community (escorted or unescorted) will be withheld upon the patient's return to FPH until they are reinstated, through application to and approval by, the Program & Privilege Committee.

3.4.2. A current START (completed within the past 28 days or no more than four weeks) must be appended to this application, as UAs represent a significant clinical event.

4. REFERENCES, RELATED DOCUMENTS AND RELATED POLICIES

CCR-705H Staff Supported Community Outings

CCR-713H Patient Leaves and Grounds Privileges

CCR-721H START

CCR-723 Staff Supported Community Outings to Regional Clinic Events

HAS-050 Code Yellow (In Custody Patients)

TOR-204 Program & Privilege Committee

Program & Privilege Committee Application Form (FPS 2127)

Program & Privilege Activity Documentation Sheet (FPS 2233)

Paper versions may not reference the most up to date version of this policy, please refer to the POD/SHOP for current version of this policy.

Policy Update History

Revision and Review Version History (to be posted with document)			
Version	**Approved and Effective Date**	**Key Changes**	**Approved By**
1.0	October 8, 2019	Added two new points ('b' and 'c') under '2.6.Privilege level 4' section heading.	Chief Operating Officer, Complex Mental Health & Substance Use Services (AMHSU and FPH) Medical Director, Forensic Psychiatric Services
n/a	June 17, 2019	Revision to clarify the timing of STARTs	n/a
n/a	October 24, 2018: Revision	(Template update)	n/a
n/a	May 27th, 2016: Revision	n/a	n/a
n/a	August 21, 2014: Revision	n/a	n/a
n/a	March 20, 2013: Revision	n/a	n/a
n/a	June 27, 2012: Revision	n/a	n/a
n/a	Nov. 27, 2012: Revision	n/a	n/a
n/a	December 14, 2009: Revision	n/a	n/a
n/a	May 5, 2008: Revision	n/a	n/a
n/a	February 26, 2005: Original Policy Approval	n/a	n/a

Appendix D - Part 2

THE PROGRAM AND PRIVILEGE COMMITTEE INTERIM POLICY

24.04.08

A. PURPOSE

The Forensic Psychiatric Hospital ("FPH") is committed to providing therapeutic care, including the use of rehabilitation and reintegration programs, to assist patients to recover from their illness and be able to live in the community.

The principle of therapeutic care exists in tension with the need to manage the risk that flows from the illness each patient is striving to overcome. The Program and Privilege Committee (the "Committee") has the critical role of advising the Director of FPH on how best to balance each patient's rehabilitation needs while still managing that risk.

The following principles apply:

a. No patient shall be assigned a new Privilege level unless an application has been made to the Committee and the Director has approved the application.

b. To facilitate the safe integration of patients into the community and the rehabilitative pathway, privilege levels are applied for, assigned, reviewed, and updated in a manner that takes into account patients' clinical status, risk assessment and needs, as well as the safety of patients, staff, and the community.

c. To this end, all patients will be assigned a security or privilege level, which is based on a comprehensive assessment of risk to self and others, and that sets out access to programs, activities and the degree of freedom that patients enjoy while in the hospital, and the patient's access (if any) to absences from FPH.

d. If a patient is determined to be a high-risk patient as per the High-Risk Patient Protocol, the additional risk management procedures in this Policy must be adhered to in granting a patient unescorted or additional unescorted access outside of the FPH.

B. PARTICIPANTS

The Director:

The Director is the Person in Charge of the Hospital as defined in section 672.1 of the *Criminal Code* and the Review Board Rules (December 2023). The Director has the

responsibility for the risk management of all patients under the authority of the Review Board.
Only the Director has the authority to grant privileges under this Policy. The Director can tailor any privilege listed below to meet the needs of the patient and manage the risk of granting the privilege.

The Director includes any person the Director delegates to perform the Director's duties under this Policy.

Some patients are not under the authority of the RB or a court order and are being pursuant to the Mental Health Act (MHA). For MHA patients, the Director means the Medical Director of the FPH. Privileges for MHA patients held at FPH are also granted pursuant to this policy.

The Committee:

The mandate of the Committee is to make recommendations to the Director when applications are made by a patient care team (PCT) to grant a higher level of privileges to a patient. The Committee considers an application, reviews the relevant documentation, including the recent START and risk management plan, elicits any further needed information from the PCT and provides a recommendation to the Director on whether to grant the application.

The recommendation will include any recommendations for tailoring the privilege to the patient's particular circumstances and any additional precautionary steps or specific restrictions that the Committee believes are necessary.

Committee Quorum:

a. The Director, or delegate;
b. Second Psychiatrist;
c. The Executive Director; or delegate
d. The Director of Clinical Forensic Risk and Access; or delegate
e. Clinical Services Manager of Review Board Department; or delegate
f. The Medical Director, when available

Treating Psychiatrist:

If the application is to allow unescorted access or increased unescorted access outside of FPH, the treating psychiatrist shall attend the Committee meeting to explain their evaluation of the risk management concerns and provide any further information requested by the Committee. These applications will be deferred if necessary to a time when the treating psychiatrist is able to attend.

Patient Care Team:

The patient care team is made up of the treating psychiatrist, forensic care coordinator, and social worker assigned to a patient.

For applications not involving unescorted absences to the community, a member of the patient care team ("PCT") may present the application on behalf of the PCT in place of the treating psychiatrist.

The Committee will only consider an application if a member of the PCT attends the Committee meeting to provide further information as needed by the Committee.

If a patient does not have a PCT assigned, the treatment team will take the place of the PCT and any reference below to the PCT includes that treatment team.

Treatment Team:

The treatment team refers to all the staff assigned to a patient's care at any point in time, including the PCT.

C. PRIVILEGE LEVELS

There are 7 levels of privileges. Patients will progress through Levels 0 to 6 as their individual clinical situation permits. On occasion, a patient may skip a level if appropriate and supported by extensive supporting information and approved by the Committee.

Privilege Level 0

a. The patient may only access those off-unit activities that require all patients to participate (i.e.
airing court, gym).
b. Only in exceptional cases, will patients awaiting trial or their first Review Board hearing have
privileges higher than Level 0.
c. Remand assessment patients will have Level 0 privileges only.

Privilege Level 1

a. Patient may attend hospital-based programs in Ashworth and Birch buildings only (e.g., Act 1, Act 2, Power Hour, etc.) when escorted by two staff members.
b. Patients on Level 1 privileges will not have contact in programs with patients from closed or open units.

Privilege Level 2

The following privileges are available in addition to those within Level 1:

a. Attendance at programs within the Hospital when escorted by a) one staff member;
b. Fir Hall when escorted by one staff member (1:1 Fir Hall); Escorted by one staff member from the unit to the hospital grounds for the purpose of Supervised Grounds;
c. 1:1 and Supervised grounds.

Privilege Level 3

The following privileges are available in addition to those within Level 2:

a. Unescorted attendance at programs within the Hospital;
b. Unescorted Grounds Privileges;
c. Unescorted access to Fir Hall;

Privilege Level 3 Plus SSCO

The following privileges are available in addition to those within Level 3:

a) Staff Supported Community Outings (SSCO's) done in accordance with Policy CCR-705H (Staff Supported Community Outings);
b) Accompanied Day Leaves with a designated person (family or volunteer) approved by the PCT and Committee

Privilege Level 4

The following privileges are available in addition to those within Levels 2 & 3:

a. Unescorted Day Leaves that are specified and structured. These include day leaves to a specific, verifiable location and for a specified purpose such as to a Community Centre for Narcotics or Alcoholic Anonymous meetings, or for other community-based Drug and Alcohol treatment program.
b. Unescorted visits to verifiable locations such as Forensic Outpatient clinics or other community treatment centres. Unescorted therapeutic day leaves intended to allow patients to participate in time limited community access such as walks in the local area where the patient's return to FPH will be within one hour of his / her departure.

Privilege Level 5

The following privileges are available in addition to those within Levels 2-4:

a. Unescorted Day Leaves for leisure purposes into the Community, (e.g., Coquitlam Centre mall or Colony Farm Road), but within a specified time frame.

Privilege Level 6

a. The following privileges are only reflective of a community placement, not of a patient's community access:
    - Overnight Leaves;
    - Visit Leaves.

D. COMMITTEE PROCEDURES

a. Any patient may request that their PCT consider an application for an increase in their privilege level. The PCT will prepare an application for an increase in the patient's privilege level if the PCT believes the request should be supported.

b. A PCT may make an application on its own initiative to request a change to its patient's privilege level.

c. In preparing the application, the PCT must consult with the rest of the treatment team, the patient's unit nursing staff, and the Rehabilitation Services department and record any dissenting opinion.

d. The PCT completes the application form. A START completed within the past month **must** accompany **all** applications.

e. The application will include an assessment of the patient's risk level, including the index offence, history of violence and current propensity for violence.

f. The application will be reviewed prior to the Committee meeting by a Committee member to determine if it is complete. Incomplete applications will be returned to the PCT for resubmission.

g. Prior to the Committee meeting, Committee members who are scheduled to attend that day will review all applications prior to the meeting.

h. Committee meetings will be held in person. Attendance may be virtual only if in-person attendance is not practical.

   When applying for an increase in privilege level and/or transfer to a unit of lower security for HRP, the PCT must provide sufficient information, relevant to the application, for the Committee to make an informed decision whether to recommend the changes to the patient's privilege level.

i. The Committee, in reviewing a request for increase or reinstatement of a privilege level, considers the following factors:
   a. If patient's status is an elevated risk patient, then follow the Elevated Risk Patient protocol
   b. Risk assessment and clinical risk management strategies;
   c. Rationale for increased privileges;
   d. The patient's clinical and legal status;
   e. The potential impact of such privileges on victims and the community;
   f. The recommendations of the PCT; and
   g. Any other relevant information

j. Elevated Risk Patients: Only the Director can approve changes in elevated risk patients' permissions. This authority may not be delegated.

k. Applications for community access require an informational addendum describing any history of unauthorized absences, breaches, and direct-backs.

l. Per CCR-713H (Patient Leaves & Grounds Privileges), the PCT must request permission from the Committee to allow a patient to take debit/credit cards or government-issued identification while accessing the community. This permission must be sought with each community access application. This permission is only for the patient to have access to financial cards and government-issued identification when they are accessing the community. When not on an SSCO or Day/Visit Leave, these items must be retained by the unit in appropriate storage, as noted in CCR-805H (Patient's Personal Effects and Valuables).

m. Open discussion of all points of view from all persons present is encouraged at a Committee meeting. After the discussion, where possible, the Committee will make a consensus recommendation to the Director. If further information is needed to make an informed decision, the application will be re-scheduled to a future meeting. If no consensus is reached, the Director will consider the points of view and determine what privilege level the patient will have.

n. Minutes of the P&P will include:
    i. Who comprised the P&P Committee that day
    ii. The risk factors considered during consideration of the application
    iii. Risk mitigation strategies agreed upon
    iv. Access/links to the application and documents presented by the PCT
    v. Who presented from the treatment/care team
    vi. The recommendation of the Committee
    vii. The decision of the Director
    viii. The Privilege approved by the Director will be documented as set out in Section L

E. WITHHOLDING COMMUNITY-ACCESS PRIVILEGES

Physicians, nurses and/or the social worker, in consultation with the Nurse-in-Charge, may withhold a patient's exercise of their granted privilege for clinical reasons, including any risk management concerns.

a. When a privilege is withheld, the Most Responsible Provider (MRP) must place an order in Patient's electronic health record stating the patient's privilege is on hold and must discontinue all pass orders in Patient's electronic health record. A corresponding note is also entered in Patient's electronic health record and this

documentation will be completed by a staff member as delegated by the unit's Clinical Services Manager or Psychiatrist.

b. Where community access privileges within a particular level have been withheld for less than 14 days, they may be reinstated by the PCT without the approval of the Committee.
c. However, if the patient has been assessed by the ERP panel as an elevated risk patient, privileges may only be reinstated by the Committee and only by a new application to the Committee.
d. When community access privileges within a particular level have been withheld for 14 days or more, those privileges will remain withheld until a new application is made to, reviewed, and approved by the Committee.

F. Escapes and/or Unauthorized Absences

If a patient escapes or has been placed on Unauthorized Absence (UA) from FPH, the patient's privileges which allow access to the community (escorted or unescorted) will be withheld upon the patient's return to FPH until they are reinstated by the Committee.

G. Documenting Privilege Levels

Privilege levels and individual privileges are to be documented as follows:

a. Individual privilege levels (i.e., Level 1, Level 2, etc.) will be captured in the privilege level order and will be entered in the patient's electronic health record by the Director and will include information regarding the parameters of the privilege level.
b. The MRP will enter a specific a pass order, specifying the duration, location, and frequency in alignment with the privilege level order.
c. The Committee will document the decision of the outcome of the application in the patient's chart under the P&P Committee Decision note.

Appendix E

Recommendation 3: Elevated Risk Patient Protocol

This protocol manages the higher risk level that some patient's present. It is to be used when patients are being considered for lower security wards, participation in programs, access to the community and in preparing for Review Board hearings.

1. A patient is placed in the elevated risk category if the risk they present requires additional safeguards to prevent harm to themselves, other patients, the staff and/or the community.

2. A patient is placed in this category solely for the purpose of risk management. Their legal status and rights to liberty remain the same as any other patient.

3. The FPH will establish a Elevated Risk Patient ("ERP") panel. The ERP panel evaluates all FPH patients who are under the review board or *Mental Health Act*, other than patients on remand or other short-term placements, prior to any applications being made to the P&P Committee for increased privileges.

4. The Chair of the ERP panel is the Director of Clinical Forensic Risk or delegate.

5. Following the process set out below, the ERP panel will make recommendations to the Director concerning a patient. The Director will then determine whether the patient is, or is not, on the elevated risk category.

6. Members of the ERP panel shall include:
    a. The Director of Clinical Forensic Risk
    b. The Director or delegate
    c. A Second Psychiatrist
    d. An Operational Director
    e. Manager of the Review Board Department
    f. The Medical Director, when available

7. The PCT or the Treatment team will provide an assessment of the patient's risk to the ERP Panel. The assessment will include:
    a. A description of the index offence and any other incidents of violence that the patient has engaged in.
    b. An assessment of the patient's illness, prognosis if known and risk factors.
    c. Reports from the treating psychiatrist and the FCC.
    d. Any other report that may be relevant
    e. Any other circumstance regarding the patient that may be relevant

f. The most recent START assessment
g. Current risk mitigation strategies

8. The following factors are to be considered:
    a. The patient's illness is resistant to anti-psychotic medication
    b. The patient lacks insight
    c. The patient relapses quickly
    d. The patient has addiction to drugs or alcohol
    e. The index or other crimes committed were very violent
    f. The patient continues to demonstrate aggression and/or is violent
    g. The patient has a history of absconding
    h. The patient has untreatable disorders such as personality traits or neurocognitive impairment

9. On the recommendation of the PCT or senior FPH staff, a patient can be referred to the ERP panel at any time to determine if they should be categorized as a high-risk patient.

10. On the recommendation of the PCT or senior FPH staff, a patient who was previously categorized as being an elevated risk, can be reassessed by the ERP Panel to determine if they are no longer an elevated risk.

11. A risk assessment by a risk management expert or forensic psychiatrist, who is not on staff at FPH, will be obtained:
    a. When an application is made to the P&P Committee to grant an HRP unescorted leave or additional unescorted leaves from FPH.
    b. When a HRP is scheduled to have a RB Hearing, and the Director believes the RB may grant the HRP a conditional or absolute discharge, or the RB may direct the FPH to grant permissions.

    A risk assessment may be obtained whenever the Director believes it will assist in the management of a patient.

12. As per the P&P Committee Policy, when an elevated risk patient is denied an unescorted leave from the FPH due to concerns about their illness, conduct or risk, the patient's leave privileges are revoked until restored by an application to the P&P Committee.

13. When a elevated risk patient has a RB Hearing, the Director will be represented by counsel.

14. The ERP panel will be updated about any incident that occurs with an elevated risk patient.

15. The ERP panel will meet quarterly to review the risk assessment of each elevated risk patient and determine if further risk management strategies are warranted. An update will be provided by the patient's PCT for these quarterly meetings.

Appendix F

About Bob Rich

Mr. Rich grew up in Vancouver and obtained a law degree from UBC in 1979.

In 1980, after articling and being called to the bar, he changed course and joined the Vancouver Police Department (VPD), where he worked for 28 years.

During his time at the VPD, he held a number of positions, including:

- Detective
- Sergeant in charge of a patrol team in the Downtown Eastside
- Sergeant in charge of a surveillance team in the Downtown Eastside
- President of the Vancouver Police Union
- Head of Training and Recruiting
- Head of Human Resources
- Commander of District 2, which includes the Downtown Eastside
- Deputy Chief of Operations

In 2008, he left the VPD to become the Chief Constable of the Abbotsford Police Department (APD), a position he held until 2018. During his time at APD, much of his work focused on suppressing gang violence and supporting member's mental health.

During his time in leadership positions, he has focused on change management to improve policing procedures, prevent crime, and increase safety for the community.

In 2021, after requalifying as a lawyer, he began working as an associate counsel at the law firm of Wilson Butcher. The focus of his practice is criminal law and administrative law in relation to police disciplinary systems.

He has been awarded the Officer of the Order of Merit for the Police Forces in Canada (O.O.M.).