External Review of the Centre for Addiction and Mental Health's Forensic Services: Passes and Privileges for Patients

This report provides a summary of the findings and recommendations of an external review commissioned by the Centre for Addiction and Mental Health (CAMH). The views of the authors do not necessarily represent the views of CAMH or the Ontario Ministry of Health.

The independent review panel included the following local and international experts on forensic mental health systems, healthcare policy and administration, and community safety: Prof. Adalsteinn Brown (Toronto; Chair), Prof. Harry Kennedy (Dublin, Ireland), Prof. James Ogloff (Melbourne, Australia), Prof. Michael Doyle (Manchester, United Kingdom), Mr. Matt Torigian (Toronto), and Mr. Mark Handelman (Toronto).

Please see Appendix A for biographical summaries of the members of the independent review panel.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In Ontario, individuals found not criminally responsible of an offence fall under the jurisdiction of a panel of experts called the Ontario Review Board (Board). It is a "quasi-judicial" tribunal, chaired by a judge or a senior lawyer eligible to be a judge. This Board can remand these individuals to the care of a secure forensic hospital like the forensic units at the Centre for Addiction and Mental Health (CAMH). By law, the Board is required to impose only the 'least onerous and least restrictive' conditions necessary to ensure the accused 'is not a significant threat to the safety of the public'. The goals of forensic mental health services, therefore, are to maximize patient recovery and reintegration into the community and to protect community safety. Passes and privileges for leaves are a critical component of rehabilitation as is therapeutic programming. When managed appropriately, the leave process is highly effective in reintegrating forensic patients back into the community while still managing their risk. Although forensic mental health services should always work to reduce the length and rate at which patients abscond from care, there will always be some rate of absconding.

In June and July of 2019, there were three high-profile cases of patients who had been found not criminally responsible absconding from care (unauthorized leaves) at CAMH: one patient left the country, one committed two robberies, and one was returned the same day by the Toronto Police Service (TPS) without incident. Following these incidents, CAMH made several changes that reduced the rate of absconding from the forensic units and convened this independent review of the system used to grant passes and privileges to forensic patients.

The independent review panel has conducted extensive interviews with staff and patients at CAMH and with key stakeholders like TPS, reviewed the high-profile incidents and all relevant policies and documentation at CAMH, and completed a review of the scientific literature on patients absconding from forensic mental health care.

Although CAMH has been an international leader in studying unauthorized leaves by forensic patients and has taken several steps over the last several years to reduce these events, more can be done. The review identified 12 areas for improvement in the physical setting, communication with police, information management, and the passes and privileges system itself. The 12 recommendations are:

1. Immediately create a secure perimeter to enable ready access to fresh air without the need for passes for patient movement through non-secure areas. This action will reduce motivations and opportunities for absconding, and reduce the number of passes that require daily review. It will also reduce the need for escorted passes which will free up staffing resources for therapeutic programming.

2. Prioritize and expedite the long-term redevelopment of the forensic buildings as a matter of urgency.
3. Immediately create a memorandum of understanding (MOU) that specifies the information that can be shared between CAMH and Toronto Police and timeframes within which it must be shared. The goal is to ensure timely and safe return of patients to CAMH. This MOU must be shared with and understood by staff at both organizations.
4. Identify a set of key indicators for CAMH and TPS to track, trend, evaluate, and improve performance on return of absconding patients to CAMH and review these indicators as part of their regular meetings.
5. Make passes, privileges, and absconding an integral part of the electronic health record (EHR) system, including pass management and pass reconciliation.
6. Ensure the EHR can support easy, regular, and useful performance measurement of passes including tools such as dashboards.
7. Include absconding and therapeutic goals for forensic patients as part of the corporate scorecard.
8. Work with patients and their advocates to ensure clear understanding of the new system of passes and privileges.
9. Increase the level of meaningful activities and therapeutic programming to promote progress of forensic patients towards safe discharge.
10. Work with the media to promote better understanding of the forensic mental health system and its role in public protection.
11. Regularly monitor the new passes and privileges system to ensure that it contributes effectively to clinical care and decision-making, policy and procedures, engagement with clinicians, and community safety.
12. Continue to review patient placement within the new system to ensure that passes and privileges are commensurate with patients' needs, risks, and engagement with therapeutic activities.

We recommend that CAMH implement all of these recommendations. With these recommendations, CAMH will continue to be a leader in the improvement and study of forensic mental health services and absconding in particular. A strong forensic mental health system can achieve the twin goals of rehabilitation and community safety while maintaining public confidence in the system and reducing stigma around mental health.

BACKGROUND

Forensic Mental Health System and Process Overview

The forensic mental health system is often poorly understood. This system provides mental health services to individuals who have come into contact with the criminal justice system and is separate from the correctional system. In Canada, when someone is found not criminally responsible (NCR) on account of mental disorder, a provincial government-appointed tribunal decides where the person will go and their level of privileges such as the ability to visit the hospital grounds or be in the community with or without supervision. In Ontario, this tribunal is the Ontario Review Board (ORB). When the ORB orders someone to a secure forensic hospital setting for supervision and care, the hospital manages the person within the boundaries of that order including what types of passes and privileges are permitted. The ORB reviews each case and the types of permitted passes and privileges every year. Other possible dispositions for persons found to be NCR include conditional discharge (permission to live in the community subject to specific conditions) and absolute discharge. By law, the Board is required to impose only the 'least onerous and least restrictive' conditions necessary to ensure the accused 'is not a significant threat to the safety of the public' (*Criminal Code, Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625).

Forensic hospitals provide psychiatric assessment, treatment, care, and rehabilitation in a setting that is therapeutically safe and secure. This care is provided by psychiatrists, psychologists, nurses, social workers, and recreation and occupational therapists. (For more detailed information on forensic mental health services, see Bettridge & Barbaree, 2008.) Therapeutic safety and security are provided by means of physical/environmental, procedural and relational design, infrastructure and processes.[1] All of these elements may be delivered at high, medium, and low or minimal levels. Some elements are *blanket* measures while some are individualized. Typically, a forensic hospital will have wards or units at varying levels of therapeutic security to match individual patient needs. There is no rigid coupling between the level of physical, relational, and procedural security. A community residential service for those transitioning to the community may have, for instance, no physical security, limited procedural security but high relational security (Kennedy, 2002). In Ontario, there are nine forensic hospitals at medium- and low-security levels, and one high-security forensic hospital (Waypoint Centre for Mental Health in Penetanguishene, Ontario).

[1] Physical security includes perimeter security, airlock entrances, sight lines to control where the patient is and other safety fixtures and fittings; procedural security includes processes for preventing access to weapons, intoxicants, and contraband, and risk assessment and risk management broadly, including triage; relational security includes the quantitative ratio of staff to patients and the relational rapport and working alliance between staff and patients, as well as the human resources of specialist skills and delivery of specialist treatments.

While in hospital, forensic patients can gradually progress to units with lower levels of security and obtain passes that permit off-unit access or off-grounds and community access for different purposes. Within the boundaries set by the ORB, recommendations about patient passes and privileges are made by clinicians and are reviewed and, as required by law, approved by a special hospital office. At the Centre for Addiction and Mental Health (CAMH) this office is called the Office of the Person in Charge.

The goals of the forensic mental health system, as required by law, are to balance patient rehabilitation and reintegration to society with maximizing community safety. Although balancing these goals can be challenging, the system is effective. The likelihood that a person found NCR will reoffend after receiving treatment is relatively low. For example, a study of people found NCR in Ontario, British Columbia, and Quebec found that patients treated in forensic settings had a rate of recidivism (reoffending) of 22% following discharge. This is lower compared to other studies cited in the same paper that reported rates of recidivism of 34% for long-term Canadian prisoners and 70% for mentally disordered prisoners (Charette et al., 2015). The risk of reoffending can never be fully eliminated, nor can the risk of a patient absconding from care (an unauthorized leave) at a secure forensic hospital setting. However, unauthorized leaves are rare events and risk of these events can and should be reduced.

Unauthorized Leaves of Absence

We use the term forensic unauthorized leave of absence (F-ULOA) to describe unauthorized leaves by forensic patients that may occur while a patient is using passes to the hospital grounds or into the community. Leave is an important part of rehabilitation and can involve participating in therapeutic programs, spending time with relatives or friends, and strengthening the capacity to live independently. Leave also serves as a layer of public protection, as forensic patients regain the capacity to navigate themselves back into the community in a safe manner while still under a form of care and supervision. Most patients will be permitted some form of leave during the time they are in a forensic hospital setting; discharge from a forensic hospital is highly unlikely for those who have not been granted any leave nor used it appropriately (Lyall & Bartlett, 2010).

It is important to reinforce understanding of the scheme of the leave process: the ORB is responsible for determining if a person found NCR can be reintegrated into the community and, if so, to set broad parameters within which the hospital treatment team must craft a plan of treatment with the goal of patient reintegration. The ORB must review each patient's progress annually and may vary the parameters previously set. Patients who believe their liberty is unreasonably restricted can apply to the Board for review of their status and the Board may require additional leave for them.

Although granting leave is associated with risk, including risk of F-ULOA and risk of harm to self and/or to others, decisions to grant leave follow a thorough assessment of patient needs, risk level, mental state, and current progress. These factors, and therapeutic engagement in particular, are important for patients to build up their leave and progress through forensic secure units (Doyle et al., 2012).

In other words, leave is granted only when a clinical team has judged that leave is appropriate and safe for the patient and the community (e.g., Wilkie et al, 2014; Simpson et al., 2015), and the leave has been approved by the Office of the Person in Charge. Current clinical guidelines include structured decision-making approaches to determine leave (Scott & Meehan, 2017).

Research indicates that F-ULOA incidents vary regarding patient whereabouts and duration of time away. F-ULOA incidents are uncommon events, typically short in duration, and minor or benign in nature, resulting in no harm to the public (e.g., Mezey et al., 2015; Moore, 2000; Wilkie et al., 2014). In practice, many instances of F-ULOA are simply late returns whereby a patient did not return on time from an unaccompanied pass to leave the secure unit or hospital grounds. Notably, criminal offending and, specifically, acts of violence during periods of F-ULOA are very rare (e.g., Beer et al., 2009; Mezey et al., 2015; Wilkie et al., 2014). At CAMH, for example, there has only been one violent incident (robbery in June 2019) as part of an F-ULOA in more than a decade.

Although F-ULOA events are uncommon and most are minor, understanding these events is important. All communities are concerned about potential health and safety risks for patients and the wider public. When F-ULOAs are reported in the media, they can reduce the confidence in a particular hospital and in the forensic mental health system in general. They can increase stigma around mental illness. They can create significant costs and drains on police resources, and on hospital resources and hospital staff morale. They also cause concern for other patients who may be further stigmatized and worry about their own care plans being affected by the actions of other patients. For patients who undertake F-ULOAs, the duration of their detention at the hospital may increase and they face increased restrictions of liberty.

CAMH's Forensic Services

Located in downtown Toronto, CAMH has one of Canada's largest forensic services programs. This program provides comprehensive assessment and treatment services to individuals who have been in contact with the criminal justice system, most of whom (90%) have been found NCR.

The inpatient service has 192 beds, including 28 medium secure beds for assessment and triage, 54 medium secure beds, 100 minimum secure beds, and 10 additional forensic patients in non-forensic units. There is a total of approximately 170 patients under the ORB in inpatient

care who have very varied lengths of stay, some short (for instance, persons readmitted briefly) and others prolonged up to many years. During 2018-2019, there were 352 unique forensic inpatients (ORB patients and patients admitted for assessment or under a treatment order) and 3901 outpatients under the care of CAMH forensic community services (comprised mainly of persons seen in CAMH prison services). There are approximately 250 forensic outpatients who are under the ORB.

Only 15% of the forensic patients at CAMH are women. Approximately 80% of all patients have a primary psychotic diagnosis such as schizophrenia or a serious mood disorder such as bipolar disorder. Substance use problems are very common in this population and have been increasing over time. The majority of cases involved a violent index offence, with about 15% homicide or attempted homicide and a similar proportion of sexual offences. Forensic patients tend to enter the system in their mid-30s. About half of all forensic patients were born in Canada, 40% are voluntary migrants and 10% forced migrants.

F-ULOA events at CAMH

Movement in and out of the secure settings at CAMH is frequent with approximately 250 passes of different types issued to forensic patients daily. Almost half (47%) of all passes are issued just to enable patients to get fresh air or recreation on hospital grounds. In 2018, CAMH detected a rise in F-ULOA events and initiated activities to reduce the rate of F-ULOA. In 2018-19, there was a total of 59 F-ULOAs and more than half of these were inpatients with an unaccompanied pass (called indirectly supervised pass) where CAMH knew the destination and timing of the patient's visit to the community to, for example, attend a community-based program. Table 1 shows the distribution and rate of F-ULOAs at CAMH this year.

Table 1. Summary of Number of Passes per F-ULOA Event in 2 Time Periods: April-June and August-October 2019

Units	Number of F-ULOA Events	Estimated Numbers of Passes during Three Month Time Period	Rate F-ULOA / Passes Utilized
April – June 2019 General security units	10	26,372	1:2637
Total (General and Secure units)	**10**	**Not available**	**Not available**
August – October 2019 General security units	**5**	13,668	1:2734
Total (General and Secure units)	**5**	**15,440**	**1:3088**

Between August and October 2019, there was 1 F-ULOA per 2734 passes utilized (0.4/1000, 95% CI 0.1-2.1/1000). The percent of passes that are F-ULOA is approximately 0.031%, with about one-third being a late return and the largest part of the remainder accounted for by drug-seeking or other inappropriate but not criminal behaviour (such as using alcohol or

tobacco). Importantly, only one patient has committed a violent offence (robbery) during an F-ULOA from CAMH in over the last decade.

It is important to note when thinking about F-ULOAs that CAMH's forensic facilities are in downtown Toronto and surrounded with a high density of residential and commercial buildings. Although there are many positive benefits to this setting, such as assisting patients to learn to navigate the city while on leave, there are also many opportunities in the nearby community to attend high-traffic areas and gain access to alcohol and drugs. These features present unique challenges and make CAMH's forensic hospital setting distinct compared to other forensic hospital locations in Ontario.

Reasons for the External Review

Between June 1 and July 22, 2019, three forensic program patients at CAMH absconded from the hospital. One patient, who left CAMH while using an unescorted (indirectly supervised) hospital grounds pass, was charged by the police for two acts of robbery while F-ULOA. Another patient, who was exercising an indirectly supervised pass in the community, boarded an international flight and has not returned. The third individual left while on an escorted pass to use CAMH facilities and was returned the same day without incident. This series of cases generated significant attention. See Appendix B for additional brief descriptions of these cases.

On July 24, 2019, CAMH announced an external review of its policies and procedures on passes and privileges granted to forensic patients. On August 6, 2019, Ontario's Minister of Health announced that the provincial government would participate in and appoint an adviser to the external review.

Approach to the External Review

This external review was led by an independent panel with internal supports for project management and research (see Appendix A).

The tasks of the review panel were to:

- Examine CAMH's policies, processes, and procedures for granting passes and privileges for forensic patients;
- Assess current practices in granting passes and privileges for forensic patients and examine CAMH practice and performance relative to existing processes;
- Examine CAMH's processes and protocols for police notification and information sharing regarding F-ULOA;
- Generate a report to be made publicly available and delivered to the CAMH Board of Trustees, via the President and CEO, Dr. Catherine Zahn.

Throughout the external review, the panel was asked to maintain a systems perspective to assess both whether policies were followed and whether the pass system and policies meet the goals of the forensic mental health system.

With access to CAMH's incident reviews of the recent high-profile F-ULOAs, the approach to this review entailed:

- An independent review of the scientific literature on forensic patient absconding, as well as technological monitoring interventions (available upon request);
- A review of policies from other forensic hospital settings in Ontario, Canada, and abroad;
- A review of all relevant policy and procedural documents from CAMH;
- Review of CAMH's F-ULOA data and other data on utilization and staffing levels in the CAMH forensic units;
- Consultations with CAMH staff in Forensic Services and other units across the organization;
- Engagement with patients and a review of the physical facilities;
- Consultations with key stakeholders including the ORB, patient advocates, and the Toronto Police Service.

In addition to meetings by teleconference between October and November 2019, all panelists met in Toronto from December 9 to 11, 2019, for in-person interviews, the review of the physical infrastructure of the forensic units, and to reach consensus on the final recommendations for this report. Please see Appendix C for a list of consultations conducted.

Improvements since July 2019

CAMH has paid regular attention to F-ULOAs over time. In 2012, there was a review and overhaul of the Forensic Services approach to passes and privileges. A literature review and survey of policies and protocols in place at other hospitals revealed gaps in CAMH's practices. In response, forensic leadership developed a Leave Application Form, a tool to assist clinical teams to make more structured and transparent decisions regarding granting of passes and privileges (Simpson et al., 2015). Implementing this structured decision-making approach resulted in an approximately 40% reduction in forensic absconding incidents. This policy has remained in place. CAMH has also been compliant with a clinical practice guideline on granting passes and privileges that was developed by the Ontario Forensic Directors' Group. Following the identification of a rise in F-ULOA in 2018, a Failure Mode and Effect Analysis (FMEA) review of the forensic passes and privileges process was completed. This FMEA review resulted in 10 recommendations. All of these recommendations are under implementation or completed.

Following the F-ULOA events of June-July 2019 that prompted this review, the forensic program at CAMH undertook the following actions, including:

- All patient passes were suspended between July 22 to July 25, 2019, for a review by senior clinicians to ensure that all passes were at the appropriate level;
- Two security guards were added to initial or higher risk escorted hospital grounds passes;
- Pass processes were changed so that no passes were given before 10 a.m. to allow for clinical assessment prior to patients leaving their unit; and
- The Waypoint Elopement Risk Scale-Acute (WERS-Acute) was implemented to allow more structured risk assessment of patient F-ULOA.

We are aware of, and encourage, the ongoing initiatives and actions at CAMH to improve the passes and privileges system.

RECOMMENDATIONS

The review panel makes 12 recommendations to both improve the passes and privileges system and to enhance the care of forensic patients and community security in four key areas: physical redevelopment; communication with the police; information management; and programming, passes, and communications.

1. ***Critical needs for physical redevelopment***

The buildings in which the forensic unit at CAMH are housed and the physical facilities for care of forensic patients are dated and no longer fit for purpose. Constraints on the physical condition of forensic facilities may actually encourage F-ULOA and associated risks, particularly for a hospital located in a large urban downtown setting. CAMH's facilities for forensic patients do not have an adequate secure perimeter to support opportunities for patients to have fresh air, exercise, or move about outside of their units without risk of F-ULOA. This leads to a situation where even taking of fresh air for general security patients now involves a two-security guard escort along with another CAMH staff member. CAMH analyses show that 47% of total passes per week are used for hospital grounds and exercise which makes pass administration unnecessarily cumbersome. Elevators that provide access to general forensic services are not secure as well. In several ways, patients are accessing non-secure spaces just to access the outdoor yard. Two of the three cases that prompted this review may have been prevented had there been better access to secure fresh air and recreational activity. Additionally, new gym facilities which were previously being accessed by forensic patients are currently not in use by this patient population due to concerns about the exits. Discussions with patients and CAMH's own work on F-ULOA indicate that limited programming and secure access to fresh air are major drivers of absconding from care.

CAMH started planning for redevelopment in 2005, with the forensic unit redevelopment being the final phase of the redevelopment. Although the proposed forensic redevelopment will include a full spectrum of therapeutic programming and social spaces within a secure perimeter, we learned that the request for proposal will not be issued until 2022 which will delay redevelopment of the forensic buildings for many years.

Recommendations

1. Immediately create a secure perimeter to enable ready access to fresh air without the need for passes for patient movement through non-secure areas. This action will reduce motivations and opportunities for absconding, and reduce the number of passes that require daily review. It will also reduce the need for escorted passes which will free up staffing resources for therapeutic programming.

2. Prioritize and expedite the long-term redevelopment of the forensic buildings as a matter of urgency.

2. Communication with Toronto Police Service

In every F-ULOA, it is important to return the patient to CAMH as quickly as possible to protect the patient and protect the public. This requires prompt and appropriate communication with the Toronto Police Service (TPS) when F-ULOA episodes occur. Information conveyed from CAMH to TPS should include, as examples: identification of the patient; level of risk the person presents to themselves and/or others; and potential consequences if the patient ceases taking their medication and/or consumes alcohol or drugs.

We are aware of ongoing committee and liaison work between CAMH and TPS that have helped resolve a number of these issues. For example, TPS now has a liaison police officer for CAMH and senior police and hospital staff meet regularly. There is still room for improvement in communication between CAMH and TPS. Police sometimes lack the information they need to assess risk in F-ULOA cases and locate persons in the community. There is a lack of clarity about the nature and amount of information that can be shared with TPS to assist in their understanding of the patient and the risk they pose, as well as information necessary to assist in the rapid location of the patient. For example, it remains unclear whether CAMH staff may release current photos of patients to the police. Moreover, CAMH and TPS do not have a clear set of indicators with which to track and improve performance in the return of patients in F-ULOA cases.

Recommendations

3. Immediately create a memorandum of understanding (MOU) that specifies the information that can be shared between CAMH and TPS and timeframes within which it must be shared. The goal is to ensure timely and safe return of patients to CAMH. This MOU must be shared with and understood by staff at both organizations.

4. CAMH and TPS should identify a set of key indicators to track, trend, evaluate, and improve performance on return of F-ULOA patients to CAMH and review these indicators as part of their regular meetings.

3. *Information management*

Passes and privileges are a critical component of rehabilitation, as is therapeutic programming. When managed appropriately, local and international evidence shows that the leave process is highly effective in reintegrating forensic patients back into the community while still managing their risk. CAMH's electronic health record (EHR) does not support the effective management of passes. This creates three problems. First, CAMH staff cannot electronically manage the pass system with patient check-in and checkout. The system is still managed through paper-based documentation of return of patients and there is no automatic alert. Although quality improvement reviews have not identified pass management as a cause of F-ULOAs, they have identified it as a major potential risk for F-ULOA. Second, the system does not support dashboards and other ways of improving performance on F-ULOAs. CAMH is unable to generate automatic reports that allow the evaluation of passes and privileges. Finally, it is challenging to manage passes and privileges on a systematic basis. There is a need for information to ensure that passes do not conflict with the scheduling of programs and that they align with patients' therapeutic goals.

CAMH measures and tracks a number of performance indicators as part of their own performance management system and as part of their accountability agreements with the provincial government and its agencies. F-ULOAs are rare but important incidents. They are not included in the accountability agreements with government and its agencies, and it is a second-tier (lower priority) indicator on CAMH's own scorecard. This means that ongoing, structured review and reporting of this critical indicator does not happen.

While CAMH is a recognized leader in research on F-ULOAs, its information technology frequently requires manual extraction of complex data for monitoring, research, and patient care. We are aware of one ORB Hearing, for example, at which the patient's attending physician could not accurately testify as to when the patient's authorized leaves of absence from the hospital occurred.

Recommendations

5. Make passes, privileges, and F-ULOAs an integral part of the EHR system, including pass management and pass reconciliation.

6. Ensure the EHR can support easy, regular, and useful performance measurement of passes such as dashboards.

7. Include F-ULOAs and therapeutic goals for forensic patients as part of the corporate scorecard.

4. Programming, passes, and communications

Passes and privileges, combined with therapeutic and educational programming, are essential for the rehabilitation of forensic mental health patients and public safety following their discharge. Research and feedback from patients and staff show that primary factors behind F-ULOAs include boredom, frustration, and perceived lack of progress towards discharge (e.g., Simpson et al., 2015; Wilkie et al., 2014). In response to the three high-profile F-ULOA incidents, CAMH suspended passes between July 22 to July 25, 2019, to ensure that all passes were at the appropriate level. Following this review by senior CAMH clinicians, the blanket decision was made to reduce passes for any patient who had an F-ULOA in the previous six months and the entire pass system was revised. At the same time, there was significant public attention to the three F-ULOA cases. This attention fuelled perceptions that community safety was compromised despite the fact that only one patient has engaged in violent offending (robbery) while on F-ULOA at CAMH in over a decade.

CAMH is implementing a new pass system that continues to consider patient risk level and now creates greater linkages between the use of passes with patient engagement and progress with therapeutic goals. Feedback from patients and their advocates suggests that patients do not understand this new system and are concerned about the appropriateness of their classification under the new system. Some staff are also concerned about appropriate classification of some patients under this system. The current levels of physical and human resources for meaningful activities and therapeutic programming are insufficient given the goals of the new pass system.

Recommendations

8. Work with patients and their advocates to ensure clear understanding of the new system of passes and privileges.

9. Increase the level of meaningful activities and therapeutic programming to promote progress of forensic patients towards safe discharge.

10. Work with the media to promote better understanding of the forensic mental health system and its role in public protection.

11. Regularly monitor the new passes and privileges system to ensure that it contributes effectively to clinical care and decision-making, policy and procedures, engagement with clinicians, and community safety.

12. Continue to review patient placement within the new system to ensure that passes and privileges are commensurate with patients' needs, risks, and engagement with therapeutic activities.

The smoking policy and ban on tobacco at CAMH were raised with the independent review panel. However, there was divided opinion on the relative merits of the tobacco ban and an absence of evidence that this initiative has had impact on the risk of F-ULOAs. We also heard, and as CAMH leadership have noted, that there are patients in hospital who are ready to transition to community living but are unable to access housing. While not directly related to the passes and privileges system, these patients are in the wrong location for care. This creates unnecessary pass administration requirements and patients can become frustrated and at higher risk of F-ULOA. Finally, we reviewed literature on electronic or GPS monitoring of forensic patients who take unescorted leave in the community, but there is an absence of evidence on the effects of this approach on community safety and on patient rehabilitation. It may be a valuable topic for further study as noted in a previous review of forensic mental health services in Nova Scotia (Department of Health and Wellness, Department of Justice, & Capital District Health Authority, 2012).

Implementation of the above recommendations should reduce the risk of F-ULOA and allow CAMH to respond in an appropriate and proportionate way when high-profile F-ULOA events occur. This will ensure that the focus remains clearly and consistently on patient health and community safety, leading to proportionate responses to individual patients. Without these recommendations, in the future CAMH may find itself responding in a blanket way to adverse incidents. Response should not be dependent on publicity. Uptake of these recommendations should improve patient and staff experiences and, by reducing the motivations for absconding, enhance therapeutic outcomes and public safety.

CONCLUSION

The forensic mental health system must constantly balance the goals of rehabilitation, reintegration, and community safety. While the system effectively treats most patients and safely reintegrates them back into the community – as evident from low rates of reoffending – the system works best when the focus is on clearly identified therapeutic goals for each patient.

The forensic services at CAMH are well regarded and they have led the field globally in research on absconding. Much work is being done at CAMH to reduce the number and impact of F-ULOAs. However, it is unrealistic to expect that these events will ever be reduced to zero given that risk will remain in the assessment of patients for passes and privileges. To reduce both the motivation for F-ULOA and opportunities for F-ULOA, there are continuing needs for changes in the physical setting, in communications, in information technology, and in relevant systems, policies, and procedures. Monitoring is needed also to improve the response to F-ULOAs when they do occur. Given actions already underway at CAMH and the recommendations of this external review, we are hopeful that community safety will continue to be well protected and that the rate of F-ULOAs can be further reduced. Stigma can be reduced for forensic patients and around mental health in general through promoting a better understanding of the forensic mental health system. This would support the human dignity of forensic patients, promote patient rehabilitation and reintegration into society, and ultimately enhance public safety.

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APPENDIX A

Independent Review Panel Member Biographies

Adalsteinn Brown (Chair of the External Review Panel)

Adalsteinn Brown is Professor and Dean at the Dalla Lana School of Public Health at the University of Toronto. Prior to becoming Dean, he was the Director of the Institute of Health Policy, Management and Evaluation and the Dalla Lana Chair of Public Health Policy at the University of Toronto. Past positions include senior leadership roles in policy and strategy within the Ontario Government, founding roles in start-up companies, and extensive work on performance measurement. He received his undergraduate degree in government from Harvard University and his doctorate from the University of Oxford, where he was a Rhodes Scholar.

Harry Kennedy

Harry Kennedy is executive clinical director of the National Forensic Mental Health Service for Ireland and Clinical Professor of Forensic Psychiatry, Trinity College Dublin. He has been involved in the reform and reorganization of the Central Mental Hospital in Dundrum, Dublin and in 2020 will move the service to a new purpose built secure forensic hospital, with new services including a forensic child and adolescent service, a forensic mental health and developmental disorders service, and an extended women's service. Professor Kennedy has been involved in the design, commissioning and transition to new forensic hospitals and new models of care twice in the last 30 years. Professor Kennedy has taken part in invited reviews of academic and service departments of forensic psychiatry in various jurisdictions and as invited expert for the Council of Europe Committee for the Prevention of Cruel and Inhumane Treatment and Torture.

James R. P. Ogloff

James Ogloff is trained as a lawyer and psychologist. He is Foundation Professor of Forensic Behavioural Science and Director of the Centre for Forensic Behavioural Science at Swinburne University of Technology. He is also Executive Director of Psychological Services and Research at Forensicare, Victoria, Australia's statewide forensic mental health service. Professor Ogloff has specific expertise in forensic psychology, forensic mental health, mental health in the corrections system, mental health law, and the assessment and management of patients and offenders. He served as British Columbia's first Director of Mental Health Services for Corrections. He also served as a Chair of the Mental Health Review Panel for many years. He is a Past-President of the Canadian Psychological Association and a Past-President of the American Psychology-Law Society. He has worked in clinical and leadership roles in forensic mental health

services for more than 30 years and has led significant reform, as well as reviews of services internationally.

Michael Doyle

Professor Michael Doyle is a Deputy Director of Nursing and Quality at South West Yorkshire Partnership NHS Trust and an Honorary Clinical Chair in the Faculty of Biology, Medicine and Health at the University of Manchester. He has worked in mental health services for over 30 years. He has previously been accredited by the BABCP as a CBT therapist and has worked as Nurse Consultant specializing in Clinical Risk in Forensic Services. He has also served as President of the International Association of Forensic Mental Health Services. He has attracted significant research funding and published widely on psychosocial risk assessment, formulation and interventions, forensic mental health nursing and related subjects. He currently leads the West Yorkshire & Harrogate Health and Care Partnership suicide prevention advisory network. Professor Doyle has provided training, consultancy, evaluation and advice to health, social care organizations and criminal justice agencies across the UK, Europe, and beyond.

Matt Torigian

Matt Torigian is a leader in policing and public administration in Ontario, with a career that has spanned over 30 years and touched on all aspects of community safety. Matt served as the Deputy Minister of Community Safety in Ontario from 2014–2018 with a portfolio that included public safety and the Ontario Provincial Police, including police education and training. Additionally, for a time, he was responsible for overseeing Ontario's correctional system. Prior to his appointment to the Ontario Public Service, Matt served 29 years with the Waterloo Regional Police Service and was appointed Waterloo Region's fifth chief of police on December 12, 2007, a role he held for seven years. Matt is a past president of the Ontario Association of Chiefs of Police and served as a member of the board of directors with the Canadian Association of Chiefs of Police. Currently, he serves as a Distinguished Fellow at the Munk School of Global Affairs and Public Policy at the University of Toronto, where he is leading a global policing initiative within the Global Justice Lab.

Mark Handelman (Minister of Health's recommended panel member)

Mark Handelman was called to the Ontario Bar in 1978 and earned his Masters of Health Sciences in Bioethics from the University of Toronto Joint Centre for Bioethics in 2005. Until 2001, he practised law in London, Ontario, including civil litigation, criminal defence and prosecution. He was one of Ontario's first members of the Official Guardian Child Representation Program. Mark was appointed to the Consent & Capacity Board in 1998 and became a Vice Chair and Senior Lawyer Member in 2000. He served as Acting Toronto Regional Vice Chair and then Regional Vice Chair in 2001, for which he stopped practising law and moved

to Toronto. He was the Board's only Vice Chair for quality assurance and presided at over 2300 Board Hearings—including the majority of the Board's "end of life" cases. Mark was reappointed to The Consent and Capacity Board in August 2019. He was also a Lawyer Member of the Ontario Human Rights Tribunal for 10 years, where he mediated and adjudicated Human Rights complaints. Mark is Counsel to the law firm Whaley Estate Litigation, advising on capacity, guardianship and estate litigation matters. He is also a member of The Ontario Law Reform Commission Advisory Committee on End of Life Decisions and of the Joint Centre for Bioethics Assisted Death Task Force.

Secretariat support to the external review

Luanne Choo, BSc, PMP, is a Senior Project Manager with more than 14 years of project management experience in health care. She has been working at CAMH for the past seven years. She was integral in the rollout of their Electronic Health Record and led the Clinical Laboratory & Diagnostic Services and electronic Medication Administration Record implementation. Her current projects are optimizing the Electronic Health Record to support point of care specimen collection and tracking of passes.

Tara Marie Watson, PhD, earned her doctorate from the Centre for Criminology and Sociolegal Studies at the University of Toronto. She has longstanding research interests in substance use, drug policy, criminal justice, corrections, and public health, with specific and recent expertise in community-based harm reduction interventions and cannabis legalization. She completed postdoctoral research funded by the Canadian Institutes of Health Research at CAMH's Institute for Mental Health Policy Research. Since July 2019, she has been a Research Coordinator for CAMH's Provincial System Support Program.

APPENDIX B

Description of F-ULOA Cases from June-July 2019

On June 1, 2019, Kleiton DaSilva (age 44 at the time of the incident) absconded from CAMH. In accordance with the ORB's approved liberties for Mr. DaSilva, he was using an unsupervised pass to the general hospital grounds (what the ORB refers to as an indirectly supervised pass). Mr. DaSilva was found and arrested and charged by the police for two acts of robbery the day after he had left CAMH. Mr. DaSilva was found NCR in a 2009 case involving homicide and aggravated assault. In 2018, an ORB restriction of liberty hearing led to Mr. DaSilva being transferred to a more secure unit than where he was previously detained in CAMH's forensic program. As of April 2019, this ORB disposition remained unchanged.

On July 3, 2019, Zhebin Cong (age 47 at the time of the incident) left CAMH and it was reported that he boarded an international flight. He has not since returned. Although in May 2019 the ORB had granted permission for Mr. Cong to live outside of the hospital in approved accommodations with supervision, CAMH had not yet allowed this level of liberty and he continued to reside in the hospital. Mr. Cong was found NCR in a 2014 case involving the fatal stabbing of his roommate. Although his current location is uncertain, Mr. Cong had expressed wishes to return to China.

On July 22, 2019, Ahmed Sualim (age 27 at the time of the incident) had an escorted pass to use CAMH's gym facilities when he went missing for several hours. He was returned to CAMH later that same day without incident. Mr. Sualim had been found NCR for multiple charges of armed robbery and theft that occurred in 2012. In April 2019, the ORB retained his disposition to reside at CAMH with privileges that included residing in community accommodation that is approved by the person in charge.

The three cases noted above prompted this external review.

APPENDIX C

List of Interview/Consultation Groups

1. Forensic Leadership Team
2. Forensic Patients
3. Incident Report Team
4. Infrastructure and Facilities
5. Lawyers representing forensic patients
6. Legal and Security Services
7. Ontario Review Board
8. Patient Empowerment Team
9. Person in Charge
10. Physician-in-Chief
11. President and Chief Executive Officer, CAMH
12. Teams involved with incidents - Forensic General Unit A
13. Teams involved with incidents - Forensic General Unit C
14. Teams involved with incidents - Schizophrenia Unit B
15. Toronto Police Services Board
16. Toronto Police Service