Hybrid Mental Health Centre Correctional Centre: An overview of the Secure Treatment Unit

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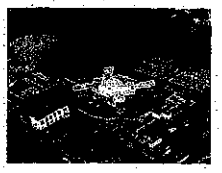
The Royal
Mental Health – Care & Research
Santé mentale – Soins et recherche

Secure Treatment Unit

The Royal's Integrated Forensic Program

(St. Lawrence Valley Correctional and Treatment Centre)

A 100 bed hybrid mental health centre and correctional centre serving seriously mentally ill adult male offenders from across Ontario serving a provincial sentence (less than 2 years)



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Integrated Forensic Program (IFP) Secure Treatment Unit (STU)

(St. Lawrence Valley Correctional and Treatment Centre)

- Opened in October 2003 to help manage the crisis of serious mental illness in our correctional institutions with view to improve safety and care while in custody, mental health outcomes, post sentence diversion and recidivism
- Contract between the Ministry of Community Safety and Correctional Services and The Royal

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IFP – STU Mandate

- Provide mental health centre standard services to seriously mentally ill offenders serving a provincial sentence (Schedule 1 facility).
- Deal humanely with residents with the most severe deficits within a safe, therapeutic environment.
- Service the most vulnerable offenders within the 26 correctional facilities in Ontario.
- Facilitate effective reintegration to resident's home community and reduce recidivism.
- To develop a Centre of Excellence in Treatment, Education and Research with university affiliation.

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MCSCS – The Royal Roles and responsibilities

- MCSCS responsible for overall administration and operation.
- MCSCS responsible for all site security: Physical and Procedural. Relational security mainly by The Royal.
- The Royal provides all clinical services as per contractual agreement.
- Co-operative and collaborative working relationship to create safe and secure environment that is sensitive to needs of seriously mentally disordered residents.
- The Royal's nursing staff provide day-to-day supervision and care on the unit.
- 80% staff health care vs 20% correctional

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Physical Design

- More hospital than prison-like
- Influenced architecturally by the Ontario Shores Mental Health Centre
- Uses a combination of dynamic and static security features
- Nursing care stations rather than control modules

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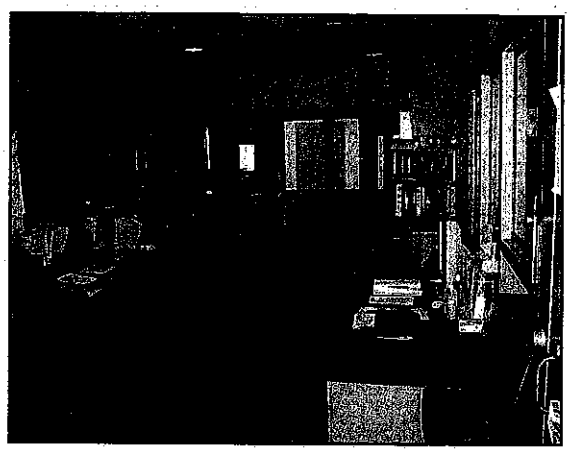

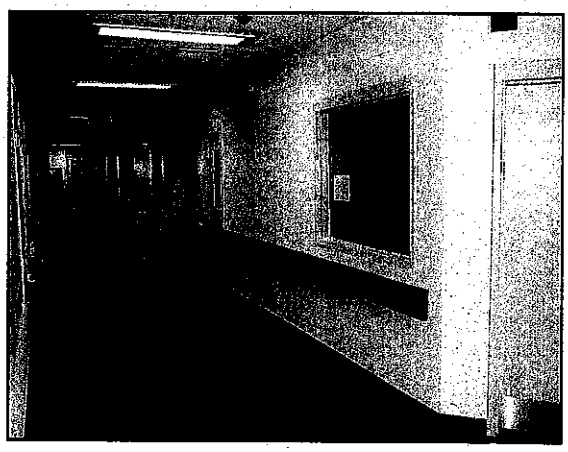

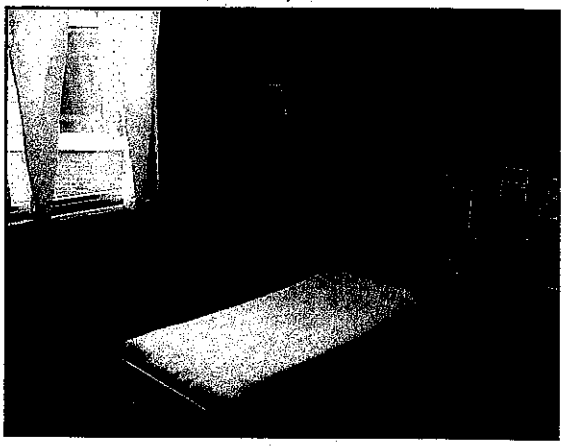

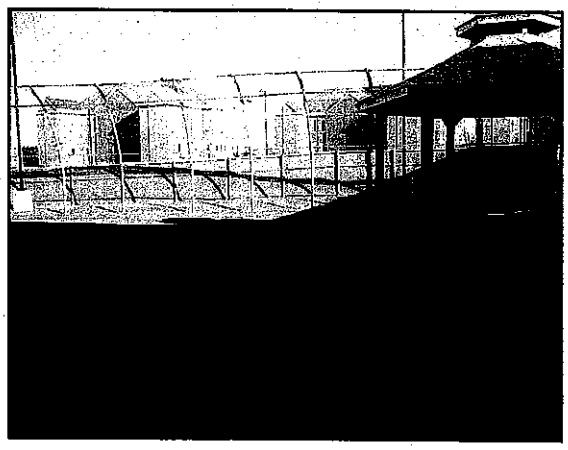

Physical Design

- 100 beds in total. 4 self-contained units, each with 25 single bedrooms (37 maximum, 63 medium security).
- 3 units are medium security; one unit is maximum security.
- Each unit has medical observation/seclusion room and two have negative pressure rooms.
- Each unit has separate maximum security "diamond" that includes 4 bedrooms and a dayroom for specialized needs (e.g. enhanced security or decreased stimulation).
- There is one padded seclusion cell on the ground floor.

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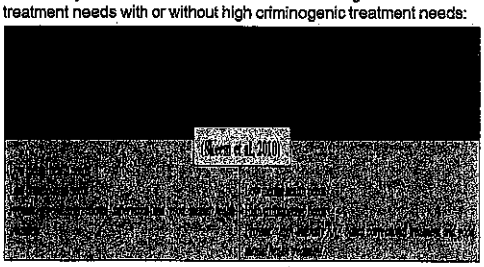
Admission Criteria – Specifics

Provincially sentenced adult male offenders with high mental health treatment needs with or without high criminogenic treatment needs:



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Admission Criteria:
Factors to consider

- Serious mental illness defined using definition Ministry of Health and Long Term Care 1999 which includes both diagnostic and disability criteria
- Mental illness that is or anticipated to be chronic (>6 months) or recurrent, and of an acuity warranting intense psychiatric services unavailable in other MCSCS facilities (due to complexity, monitoring needs or medication requirements); GAF < 50

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Admission Criteria
A. Diagnoses/Suspected Diagnoses

i. Psychotic Disorders AND/OR
ii. Major Mood Disorders AND/OR
iii. Anxiety Disorders AND/OR
iv. Concurrent Disorders: Alcohol and/or Substance Abuse Dependence in addition to any of i-iii above AND/OR
v. Dual Disorders: intellectual and developmental disabilities, including autistic spectrum disorders in addition to any of i-iv above AND/OR
vi. Personality Disorders: personality disorders in addition to any of i-v above or those posing a significant suicidal or self-harm risk.

* About 15 to 20% have intellectual disabilities

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Admission Criteria
B. Disability Related to Psychiatric Diagnosis

- Safety: meet criteria for certification under the Mental Health Act of Ontario
- A risk of serious harm &/or B incapable to consent to treatment
- At risk for:
  i. Serious bodily harm to the person
  ii. Serious bodily harm to another person
  iii. Substantial physical or mental deterioration
  iv. Serious physical impairment of the person
- AND/OR

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Admission Criteria
B. Disability Related to Psychiatric Diagnosis

i. Basic living skills: impairment in eating, dressing, toileting, hygiene AND/OR
ii. Instrumental living skills: unable to manage meds, money, getting around community, cleaning, shopping AND/OR
iii. Social functioning: impairment in relationships with family, friends, authorities, agencies, professionals; this may include vulnerability to predatory behaviour of others such as being target of bullying, or of emotional, physical, sexual or financial abuse

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Remand Offenders and Immigration

Remand Offenders and Immigration Holds will be considered by exception on a case by case basis if the following criteria are met:

1. Clinical Emergency/Urgency because of serious mental illness
2. Forensic Bed Not accessible in a timely manner
3. Local Schedule 1 emergency services have done assessment and are unable to meet needs locally

❖ 2012-2013 2.9% remand, 0.4% immigration

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Referral Process

- Formal referral process using new referral form with admission criteria incorporated
- Holding facility typically refers as part of MCSCS' classification process following sentencing
- Referrals received from all 25 ministry facilities in Ontario
- Court and community recommendations (i.e., psychiatric reports, pre-sentence reports) are taken into consideration

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Referral Process

- All referrals to SLVCTC shall be accompanied by a current updated LSI-OR, OTIS Mental Health Alerts, CPIC and other relevant supporting documentation:
  - Psychiatric Assessments and Progress Notes
  - Psychological, Social Work, Addiction or Medical Assessments
  - Pre-sentence Report
  - Police Report
  - Crown Brief
  - Inmate Letter
- Signed consent form to allow disclosure of information between MCSCS and The Royal health care teams

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Admission Triage Process

Referrals reviewed and triaged by MCSCS and ROHCG Admission & Discharge Committee:

1. **Emergency:** deemed likely certifiable under the MHA, and in need of admission within a maximum of 48-72 hours.
2. **Urgent:** deemed at high risk to become certifiable without acute intervention, or requiring seclusion for clinical reasons in another correctional facility; and in need of admission within maximum of 1-2 weeks
3. **Clinically Routine:** deemed to warrant treatment unavailable in another correctional facility. Clinically routine admissions are placed on a waiting list and admitted according to Discharge Probable Date to allow an optimum length of stay for core groups (typically 4-6 months) and should show some motivation for treatment.

* 2014-2015: 6.3% Emergency, 27.7% Urgent, 66.0% Routine

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Admission Triage Process cont'd

- Of note, there is no minimum sentence requirement or requirement for offender to be motivated for treatment if referred for emergency/urgent admission.
- Institution should notify SLVCTC as soon as possible if offender' s clinical status changes.

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Admission Process

- 4-6 month sentence optimum for participation in group treatment.
- All admissions are pre-planned allowing for special handling plans involving MCSCS correctional staff, if required.
- Residents transported primarily by Offender Transportation System/Provincial Bailiffs.
- Residents are typically transferred to home community institutions 1-2 weeks prior to discharge for release purposes.
- Residents not meeting admission criteria are reclassified and transferred back to referring or home institution.

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The Royal's Clinical Team

Clinical Director	Vocational Counselors (2)
Clinical Leads (4)	Addiction Counselors (2)
Director, Patient Care Services	Dietician
Manager, Pt. Care Services (2)	Teacher
Psychiatry (4.3 FTE)	Chaplain
Psychology (1 PhD, 3 MAs)	Pharmacist
Social Workers (5)	Nursing Staff (44 RN,34 RPN)
Recreational Therapists (2)	

Mental health care staff rather than correctional officers provide the day-to-day supervision and care.

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Assessment Process

- Assess suitability for STU; individuals with no identifiable SMI are reclassified and sent back to their home institution
- Identify mental health and criminogenic treatment needs
- Develop individual treatment plan to target identified mental health and criminogenic needs.
- Risk Needs Responsivity Model used to direct treatment of criminogenic needs

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STU Programs

Four x 25 bed units:

- 3E - Assessment and Stabilization Program (Maximum Security)
- 2E - Sexual Behaviours Program (Medium Security)
- 3W - Trauma Disorders Program (Medium Security)
- 2W - Aggressive Behaviour Modulation Program (Medium Security)

* No exclusivity, every unit able to manage any resident.

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Milieu Treatment

- High and Very High Risk Residents on LSI-OR typically admitted to locked range/locked room wing or diamond on Assessment & Stabilization Unit (ASU) with movement on the ½ hour to and from common room
- Pro-social attitudes and behaviors are rewarded by graduation from locked range to unlocked room wing of ASU, and from there to program on medium secure units with free movement (unlocked range/unlocked room)

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STU Groups

Anticriminal Groups Assigned Using RNR Principles

Psycho educational and Mental Health Groups

- Medication and Symptom Management
- Nutrition
- Self-Esteem
- Creative Expression
- Relaxation
- Understanding Your Illness
- Preparatory Group
- Meditation and Mindfulness

Anti-criminal Groups (referrals triggered according to algorithms from LSI-OR with option for clinical overrides)

- Controlling Anger & Learning to Manage It (CALM)
- Substance Abuse Psychotherapy (SAP)
- Risk and Rehabilitation (R&R2)
- Skills, Techniques Options and Plans (STOP Domestic Violence)
- Self-Regulation for Sexual Offenders and Adapted Self-Regulation Group
- Dialectical Behavior Therapy for Trauma and Anger

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STU – Other services

- Individual psychotherapy (motivational, cognitive behavioural, emotion focused)
- Interdisciplinary: medical, dietary, education
- Vocational, recreational, spiritual
- Native Institutional Liaison Officer (NILO)

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STU – Discharge Planning

- Social workers take lead in discharge planning and are assigned to each resident on admission
- Detailed psychosocial assessment to identify discharge needs
- Discharge discussed from time of admission and at every case conference
- Addiction counsellors, nursing, vocational counsellor and psychiatrist may assist

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STU – Discharge Planning

- Housing: Family/friends, Homes for Special Care, John Howard, Transitional Housing (CMHA), LTC, rooming houses, shelters
- Clinical: CMHA, Community Mental Health Clinics, Community Hospitals, St. Leonard Society, John Howard Society, Family MDs, Health Care Connect, Hepatitis C, Methadone Clinics (eg. OATC), AA/NA, DSO
- Clinical: Schedule 1 Hospitals, Community Treatment Orders
- MCSCS: Probation/Parole, Psychiatry, Programs,
- Financial: ODSP, CPP, Trillium
- Vocational: School, sheltered workshops

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Admission and discharge statistics 2015 – 2016

- Admissions - 219
- Discharges - 221
- Patient Days – 35,934 days
- Occupancy – 98.2%
- Average length of stay – 155 days

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Demographics

- N = 90 (April 11, 2015)
- Average age = 35 (SD = 12.2, Range = 18 to 67)
- Sentence length = 438 days Ethnicity: 77% Caucasian, 10% Aboriginal, 6% African-Canadian, 1% Indo Canadian, 1% Asian, 1% Middle Eastern
- High risk on admission
  - LSI-OR = 27.46

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Diagnostic Profile (2014-15): Axis I

- 97% had 2 Axis 1 Diagnoses
- 79% had 3 Axis 1 Diagnoses
- 52% had 4 Axis 1 Diagnoses
- 28% had 5 Axis 1 Diagnoses
- 16% had 6 Axis 1 Diagnoses
- 8% had 7 Axis 1 Diagnoses
- 4% had 8 Axis 1 Diagnoses

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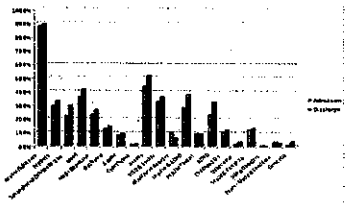
Axis I Diagnostic Profile of STU Residents



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Diagnostic Profile (2014-15)

- Most common diagnoses in population at STU:
  - Psychotic disorders (32%)
  - Alcohol/substance abuse/dependence (25%)
  - Mood disorders (20%)
  - Anxiety disorders (11%)
  - Personality disorders (5%)
  - Sexual disorders (3%)

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Diagnostic Profile (2014-15): Axis II

- 88% had 1 Axis 2 Diagnosis
- 24% had 2 Axis 2 Diagnoses
- 3% had 3 Axis 2 Diagnoses
- 15-20% had intellectual disability

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LSI-OR:

Snapshot April 11, 2015

Risk Level	Initial Risk	%	Over-ride Risk	%
Very Low	0	0%	0	0.0%
Low	1	1.1%	0	0.0%
Medium	14	15.6%	10	11.1%
High	32	35.6%	35	38.9%
Very High	43	47.8%	45	50.0%
Total	90	100.0%	90	100.0%

Residents in Low or Very Low risk category (LSI-OR ≤ 10) are only admitted if emergency or clinically urgent, and are typically kept separate from other residents in clinical seclusion, and are returned to home institution when stabilized.

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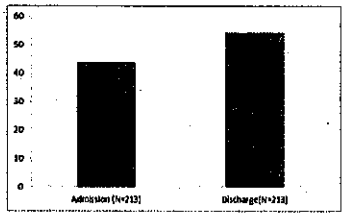
Outcomes: Global Assessment of Functioning (2014-2015)



Note. Residents obtained higher GAF scores on discharge as compared to their admissions scores, t(212) = -10.57, p <.001. Results indicate that residents have greater overall level of functioning after their stay at the STU. Results fall within the "serious" range at admission and progressed to the "moderate" range, according to the GAF measure (see DSM-IV-TR; Axis V).

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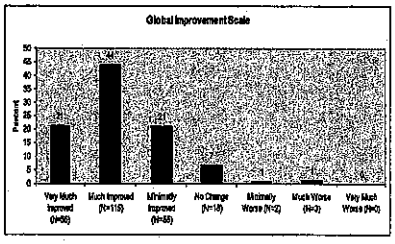
Outcomes (2012-13): Clinical Global Improvement Scale



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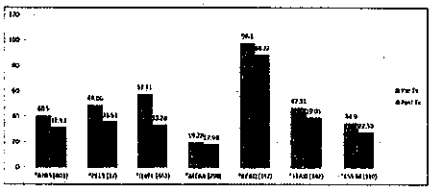
Outcomes to March 2016



Notes:

- An asterisk indicates statistically significant change
- Stats are presented only for those residents who have completed both pre and post questionnaires.

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Recidivism Rate (2 year) of 49.8% for 2011-2012 cohort (n = 203)

49.8 percent reincarceration rate (not reconviction) within two years vs 60.4 percent provincial average, this in spite of a higher risk population than provincial average

Risk Level (LSI-OR with override April 15, 2015 snapshot)	STU	Other MCSCS
Very low	0	1.8%
Low	0	5.1%
Medium	11.1%	23.1%
High	38.9%	39.1%
Very high	50.0%	30.8%

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Conclusion

- This is a complex and difficult-to-treat resident population.
- This model of service (collaboration between mental health care professionals and MCSCS) is innovative and data suggests improved outcomes in mental health quality of life indicators
- This type of service is likely here to stay, and may well be expanded.
- Building of community linkages are a priority
- The Royal is continuing to be proactive in working with this population through quality improvement, developing/enhancing best practice, specialized mental health services and measuring outcomes.

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Thank You

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