Hybrid Mental Health Correctional Centre: An overview of the Secure Treatment Unit
Standing Senate Committee on Human Rights
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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)

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 a 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

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.
- Serve the most vulnerable offenders within the 26 correctional facilities in Ontario.
- Facilitate effective reintroduction to residents’ home community and reduce recidivism.
- To develop a Centre of Excellence in Treatment, Education and Research with university affiliation.

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

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
Physical Design

- 100 beds in total. 4 self-contained units, each with 25 single bedrooms (37 maximum, 23 medium security).
- 2 units are medium security; one unit is maximum security.
- Each unit has medical observation/exclusion room and two have negative pressure rooms.
- Each unit has a 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 exclusion cell on the ground floor.
Admission Criteria — Specifics

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

Admission Criteria: Factors to consider

- Serious mental illness defined using definition Ministry of Health and Long Term Care 1990 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 MCHS facilities (due to complexity, monitoring needs or medication requirements);
- GAF < 50

Admission Criteria — Specifics

A. Diagnoses/Suspected Diagnoses

I. Psychotic Disorders AND/OR
II. Mood Disorders AND/OR
III. Anxiety Disorders AND/OR
IV. Substance Abuse Disorders: Alcohol and/or Substance Abuse
Dependence in addition to any of iv above AND/OR
V. Intellectual and Developmental Disabilities:
- Autism spectrum disorders in addition to any of iv above AND/OR
- Personality Disorders: personality disorders in addition to any of iv above or those posing a significant suicidal or self-harm risk.

* About 15 to 20% have intellectual disabilities

Admission Criteria — Specifics

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. Substantive physical or mental deterioration
  iv. Serious physical impairment of the person
  AND/OR

Admission Criteria — Specifics

B. Disability Related to Psychiatric Diagnosis

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

Remand Offenders and Immigration

Remand Offenders and Immigration Hold 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 2.6% remand, 0.4% immigration
Referral Process

- Formal referral process using new referral form with admission criteria incorporated.
- Holding facility typically refers as part of MDCS 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.

Admission Triage Process

Referrals reviewed and triaged by MDCS and ROHCS Admission & Discharge Coordinators:

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 sedation for clinical reasons in another correctional facility, and in need of admission within maximum of 1-2 weeks.
3. Clinically Routine: deemed not to warrant treatment unavailable in another correctional facility. Clinically routine admissions are placed on a waiting list and admitted according to Discharge Reserve Date to allow an optimum length of stay for core groups (typical 4-6 months) and should show some motivation for treatment.

Admission Process

- 4-6 month sentence optimum for participation in group treatment.
- All admissions are pre-planned allowing for special handling plans involving MDCS correctional staff, if required.
- Residents transported primarily by Offender Transportation System/Provincial Railways.
- 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.

The Royal's Clinical Team

<table>
<thead>
<tr>
<th>Role</th>
<th>Staff</th>
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</thead>
<tbody>
<tr>
<td>Clinical Director</td>
<td>Vocational Counselors (2)</td>
</tr>
<tr>
<td>Clinical Leads (x4)</td>
<td>Addiction Counselors (2)</td>
</tr>
<tr>
<td>Director, Patient Care Services</td>
<td>Dietician</td>
</tr>
<tr>
<td>Manager, Ph. Care Services (x2)</td>
<td>Teacher</td>
</tr>
<tr>
<td>Psychiatry (4.3 FTE)</td>
<td>Chaplain</td>
</tr>
<tr>
<td>Psychology (1 Ph.D, 3 M.As)</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>Social Workers (5)</td>
<td>Nursing Staff (44 RN,34 LPN)</td>
</tr>
<tr>
<td>Recreational Therapists (2)</td>
<td></td>
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</tbody>
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Mental health care staff, rather than correctional officers, provide the day-to-day supervision and care.
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.

STU Programs
- Four x 26 bed units:
  - 3E - Assessment and Stabilization Program (Maximum Security)
  - 2E - Sexual Behaviours Program (Medium Security)
  - SW - Trauma Disorders Program (Medium Security)
  - 2W - Aggressive Behaviour Modulation Program (Medium Security)
- No exclusivity, every unit able to manage any resident.

Milieu Treatment
- High and Very High Risk Residents on LBI-GR typically admitted to locked range/locked room wing or diamond on Assessment & Stabilization Unit (ASU) with movement on the 16 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/room/unlocked range).

STU Groups
Anticriminal Groups Assigned Using RNR Principles
- Psychoeducational and Mental Health Groups
  - Motivation and Symptom Management
  - Nutrition
  - Self-Esteem
  - Creative Expression
  - Relaxation
  - Understanding Your Illness
  - Preoccupation Group
  - Meditation and Mindfulness
- Anti-social Groups (externally triggered according to algorithms from LBI-GR with options for clinical considered):
  - Expressing Anger & Learning to Manage
  - EGO
  - Substance Abuse Psychotherapy (SAP)
  - Risk and Reliability (R&R)
  - SBT, Techniques Capture and Plans (STOP Domestic Violence)
  - Self-Regulation for Sexual Offenders and Adjudged Self-Regulation Group
  - Untreated Antisocial Therapy for Violence and Anger

STU – Other services
- Individual psychotherapy (motivational, cognitive behavioral, emotion focused)
- Interdisciplinary: medical, dietary, education
- Vocational, recreational, spiritual
- Native Institutional Liaison Officer (NILC)

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 counselors, nursing, vocational counselor, and psychiatrist may assist.
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 (e.g. OATC), AHA, DSO
- Clinical: Schedule 1 Hospitals, Community Treatment Orders
- MOCCE: Probation/Parole, Psychiatry, Programs,
- Financial: ODSP, OPF, Trillium
- Vocational: School, sheltered workshops

Admission and discharge statistics 2015 – 2016
- Admissions - 219
- Discharges - 221
- Patient Days - 36,934 days
- Occupancy - 88.2%
- Average length of stay - 155 days

Demographics
- N = 90 (April 11, 2015)
- Average age = 35 (SD = 12.2, Range = 16 to 97)
- Sentence length = 438 days, Ethnicity: 77% Caucasian, 10% Aboriginal, 6% Afro-Canadian, 1% Indo Canadian, 1%
  Asian, 1% Middle Eastern
- High risk on admission: LEI-OR = 27.40

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

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%)
Diagnostic Profile (2014-15): Axis II
- 68% had 1 Axis 2 Diagnosis
- 24% had 2 Axis 2 Diagnoses
- 3% had 3 Axis 2 Diagnoses
- 15-20% had intellectual disability

LSI-OR:
Snapshot April 11, 2015

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre-Discharge</th>
<th>Post-Discharge</th>
<th>Change</th>
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<tbody>
<tr>
<td>Very Low</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Low</td>
<td>11%</td>
<td>0%</td>
<td>11%</td>
</tr>
<tr>
<td>Medium</td>
<td>15.6%</td>
<td>15%</td>
<td>1.6%</td>
</tr>
<tr>
<td>High</td>
<td>23%</td>
<td>31%</td>
<td>8%</td>
</tr>
<tr>
<td>Very High</td>
<td>31%</td>
<td>45%</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>99%</td>
<td>99%</td>
<td>0%</td>
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Residents in Low or Very low risk categories (LSI-OR ≤ 10) are only admitted if emergency or critically urgent, and are typically kept separate from other residents in clinical isolation, and are returned to home restriction when stabilized.


Outcomes (2012-13):
Clinical Global Improvement Scale

Outcomes to March 2016

Recidivism Rate (2 year) of 49.8% for 2011-2012 cohort (n = 203)
48.8% percent reincarceration rate (not reincarceration) within two years vs 69.4 percent provincial average, this is in spite of a higher risk population than provincial average.
Conclusion

- This is a complex and difficult-to-treat resident population.
- This model of service (collaboration between mental health care professionals and MCCCO) 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 is 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.

Thank You