Development of an Acute Care & Stabilization (ACS) pathway between corrections and hospital

Dr. Kiran Patel
Tanya Connors
Vito Adamo
Alfredo Ramirez
Dr. Roland Jones
Dr. Alexander Simpson

camh

THE ACS BED

THE ACUTE CARE STABILIZATION BED

PARTNERSHIP

- **The Forensic Early Intervention Service** (FEIS) developed the ACS bed in collaboration with both the:
  - **Centre for Addiction and Mental Health** (CAMH)
  - **Toronto South Detention Center** (TSDC)

DEFINITION

- ACS is an innovative pathway to support the most mentally unwell within a Correctional environment
- The first ACS bed opened March 18th, 2018

SERIOUS MENTAL ILLNESS IN PRISONS

- Almost 11 million people are held in prisons across the world (Walmsley, 2016)
- Individuals with a serious mental illness (SMI) are significantly overrepresented in jails and prisons (Bland et al., 1998; Brink, 2005; Teplin, 1990)
- Rate of SMI is approximately 15% as per a large-scale meta-analysis of prevalence of SMI in prisons/jails (Fazel & Seewald, 2012)
- Many who screen positive do not receive further assessment or mental health services (Hayes et al., 2014)
- Only 35% of persons with schizophrenia received any care; similar for major depressive disorder (Simpson et al., 2003)
- Level of intervention does not match symptom severity (Hassan et al., 2012)

THE ACS INITIATIVE & ADDRESSING THE NEED

- Inmates with serious mental health needs in remand settings may occasionally require mental health services beyond the scope of what can be provided
- The objective of the ACS initiative is to identify and provide inpatient care and treatment to inmates who suffer from treatable serious mental conditions and who will most benefit from short-term admission to the structured and secure inpatient setting of the ACS
- **The ACS bed helps clients who are in need of acute assessment, treatment, and stabilization.**

FACTORS CONSIDERED UPON ADMISSION

- FEIS offers ongoing assessment and support to clients at risk of being unfit to stand trial or who pursue a not criminally responsible defense.
- New referrals into the FEIS program at TSDC are flagged and potential clients for the ACS bed are discussed weekly by the TSDC healthcare team.
- **1 to 4** clients are identified and queued for the ACS bed with an acute client being designated as the next candidate once the current client is discharged.

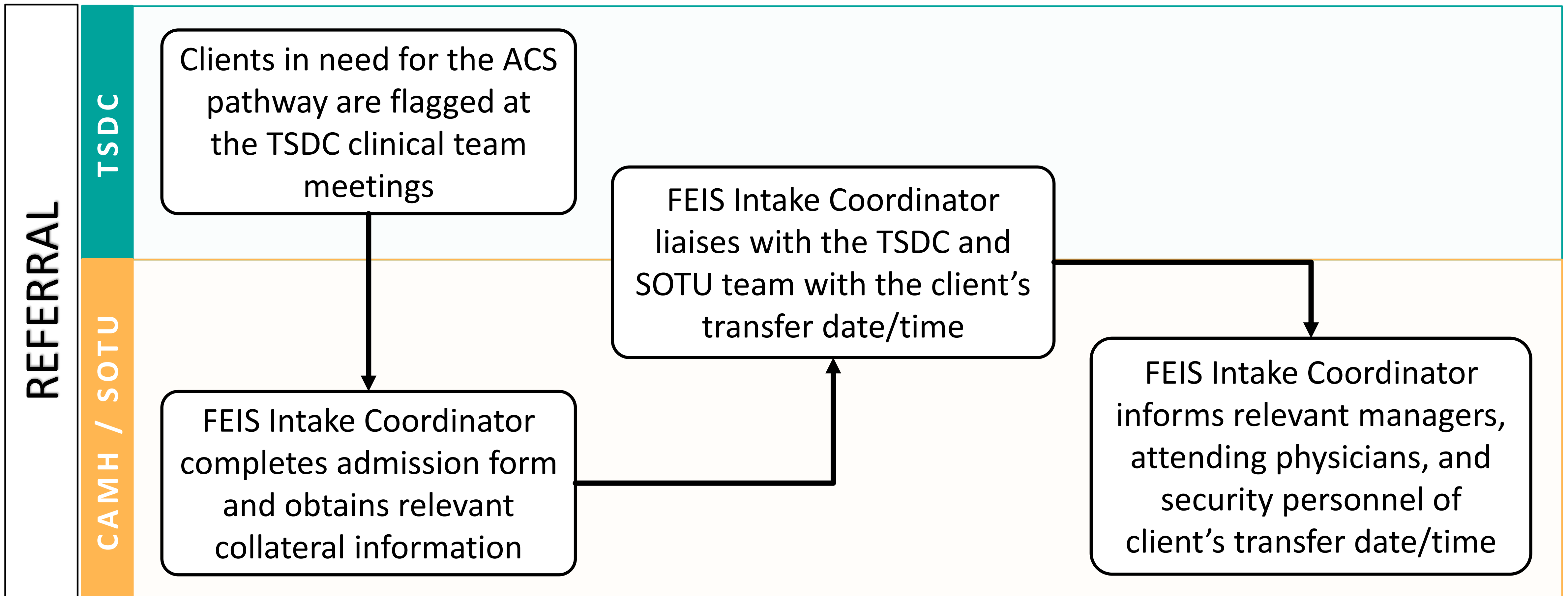
SELECTING A CANDIDATE FOR THE ACS BED

1. Has the client been referred to FEIS?
2. Does the client demonstrate features of a serious mental illness?
3. Is the client certifiable?
4. Can the client be managed in a medium security setting?
5. Is the client likely to respond to medication?
6. Is the client able to consent/likely to consent to treatment?
7. Does the client have any significant medical conditions/concerns?
8. Is there potential for the client to be released in a short period of time?

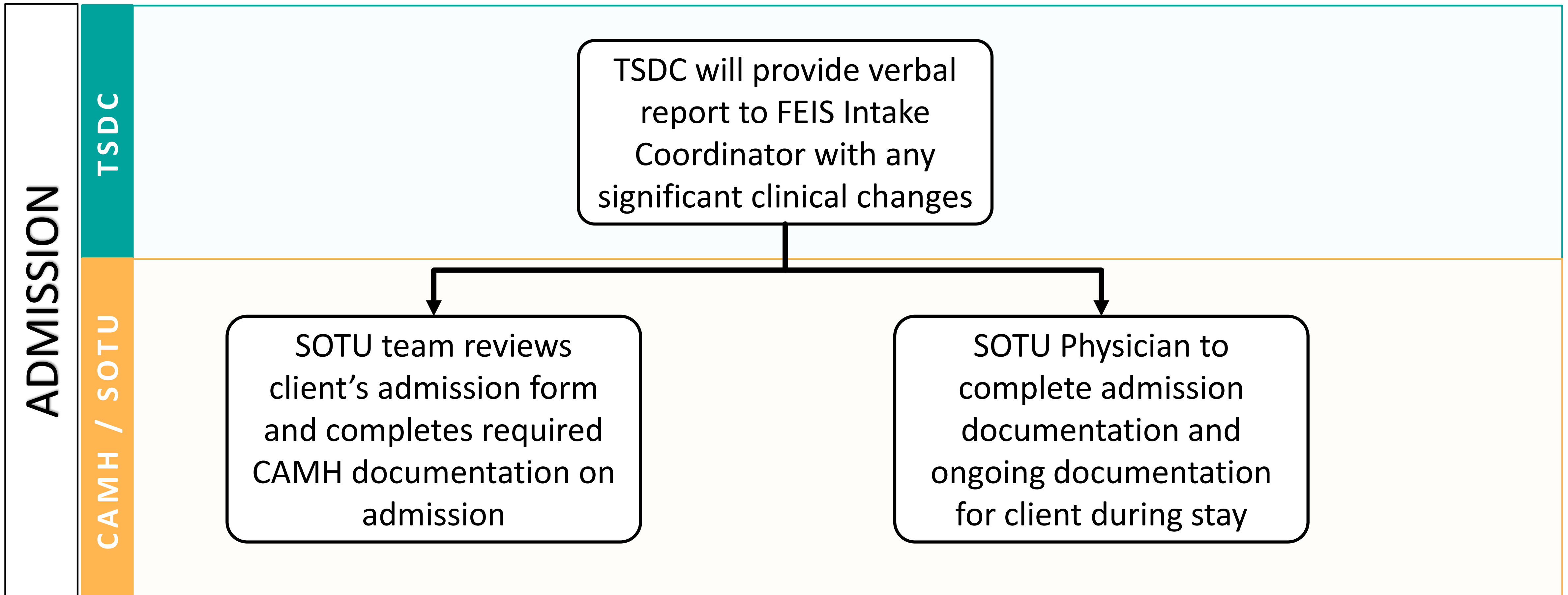
SOTU & THE FEIS INTAKE COORDINATOR

- The Structured Observation and Treatment Unit (SOTU) at CAMH provides interim assessment, treatment, and stabilization for male inpatients with major mental illnesses that represent a safety risk, until the patient is ready to be transferred back to the facility
- The unit houses a total of **8 beds,** in which the **1** ACS bed is located
- **FEIS Intake Coordinator** works as the liaison between the TSDC & SOTU teams, tasks include

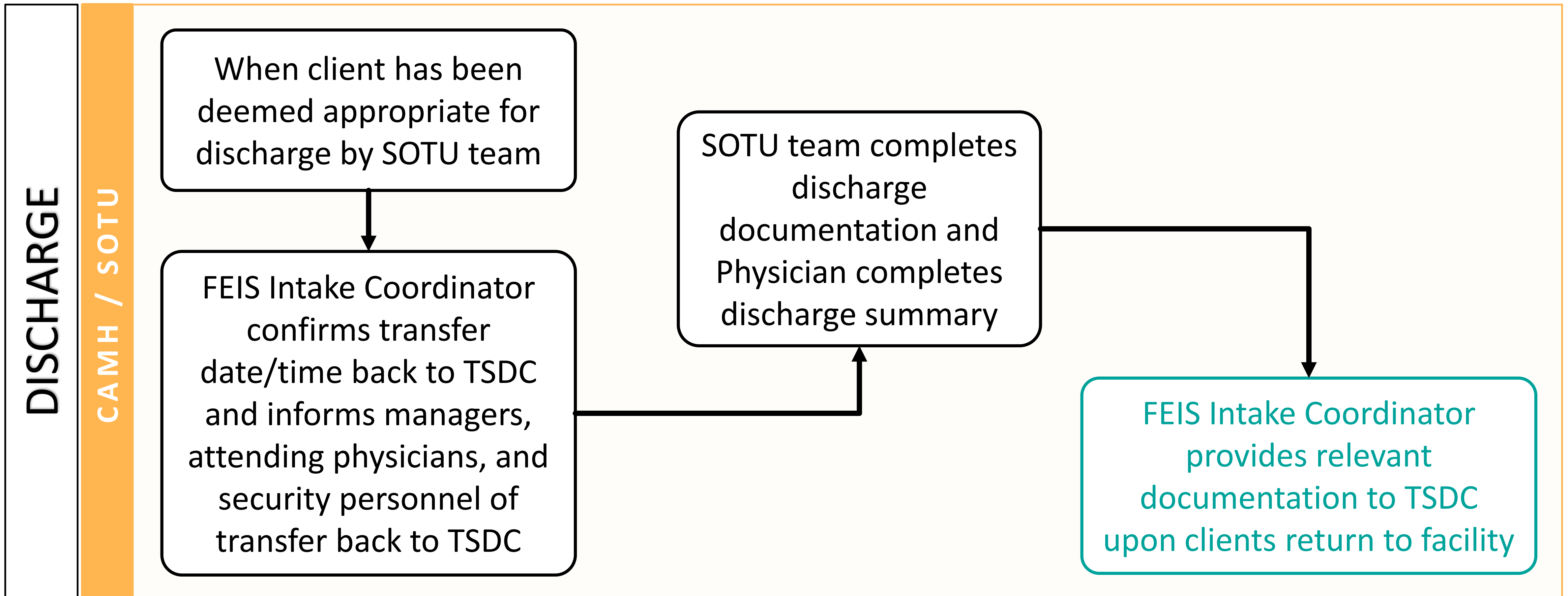
ACS PROCESS MAP – PART 1



ACS PROCESS MAP – PART 2



ACS PROCESS MAP – PART 3



TOOLS USED & STATISTICAL DATA

TOOLS USED ALONG THE ACS PATHWAY – PART 1

Measurement tools used:

- **Jail Screening Assessment Tool (JSAT)**
  - A validated screening tool developed for the purpose of identifying mentally disordered offenders in jails and prisons
  - Administered by FEIS clinicians as evaluation tool to assess current level of functioning and mental health need
- **Clinical Global Impressions – Corrections (CGI-C) Scale**
  - A validated assessment tool based on the overall severity of mental disorder
  - Ratings are based over the past 24 hours; combine clinical observation and collateral documentation
  - On a 7 point scale: 1 = no mental disorder, 7 = among the most severely ill

A FUTHER LOOK AT THE CGI-C

- Adapted from the Clinical Global Impression (CGI) Scale for use in correctional facilities (Jones, Patel, Moscovici, McMaster, Glancy, & Simpson, 2019)
  - Developed in-house to meet the need for a simple-to-use tool to measure severity of mental illness in remand settings
  - **Very good inter-rater reliability** and **test-retest reliability**
  - Can be used by multidisciplinary team
  - Advantage in correctional settings is that it can be used even with the most severely ill and behaviorally disturbed individuals, based on observation and collateral information
- CGI-C is a validated assessment tool (Jones, Gerritsen, Maheandiran, & Simpson, 2019)

THE CGI-C

Rating	Collateral	Interview / observation
1 No mental disorder	Participating fully in available programmes / roles / employment opportunities. Socialising appropriately. No behaviour or conduct issues.	No evidence of mental disorder. May have history of mental disorder, but no current symptoms.
2 Borderline mental disorder	Functioning well. Issues unlikely to impair functioning so as to come to the attention of correctional staff.	Generally functioning well. May not have previously received psychiatric diagnosis / treatment. Very mild or occasional symptoms that do not fully reach criteria for a diagnosis of any mental disorder, or only minimally cause distress or impairment in functioning.
3 Mildly ill	Generally functioning well. Unlikely to come to the attention of correctional staff on account of mental disorder	Clear but mild symptoms of a mental disorder. Maybe receiving treatment but have residual (mild) symptoms or may have borderline intellectual disability
4 Moderately ill	Some dysfunction. May be reported by correctional officers as exhibiting "odd" or "unusual behaviour" but not particularly disruptive. May be mild self-harm behaviour, intermittent shouting or banging in cell, but no physical violence. Hygiene maybe poor. Functioning may be impaired by physical manifestations of withdrawal from substances. Generally cooperative with correctional officers.	Obvious symptoms of mental disorder. Significant level of distress with possible suicidal ideation, significant self-harm and/or psychotic symptoms. Eating and drinking adequately. Neglecting hygiene. May require hospitalisation, if not already in hospital.

THE CGI-C

Rating	Collateral	Interview / observation
5 **Markedly ill**	Impaired functioning, may be significant verbal aggression, repetitive self-harm, uncooperative with officers, shouting or banging in cell for a significant part of the day. Minimal appropriate interaction with others. Likely under some “special handling” precautions within the facility if demonstrating risk to others.	Severe and constant symptoms of a mental disorder. Patient has significant distress which grossly impairs ability to function. Markedly abnormal mental status examination, but likely too ill to participate meaningfully in assessment.
6 **Severely ill**	Severe dysfunction. Will come to the attention of correctional officers. Likely disruptive in day to day activity, significant risk of, or actual physical aggression, smearing faeces, urinating on floor, attempting to assault, requiring physical containment. Impulsive and unpredictable. Under some “special handling” precautions within the facility and / or lockdown if posing risk to others.	Very severe and constant symptoms of a mental disorder. Patient has significant distress which grossly impairs ability to function. Markedly abnormal mental status examination, but likely too ill to participate meaningfully in assessment.
7 **Among the most severely ill**	Cannot function day to day. May be physically violent, attempting lethal self-harm or not eating/drinking. Very impulsive and unpredictable. Under “special handling” precautions within the facility or full lockdown if posing risk to others.	Extremely severe and constant symptoms, maybe catatonic, or very severely agitated, engaging in highly disturbed behaviours such as very severe, potentially lethal self-harm, and/or ingesting bodily waste.

DOI: 10.13140/RG.2.2.33235.43049

TOOLS USED ALONG THE ACS PATHWAY – PART 2

Clinical/Administrative forms used:

- Mental Status Exam (MSE) PowerForm
- Inpatient Direct Admission PowerForm
- Case Management Note

BREAKDOWN OF ACS BED – YEAR 1 & YEAR 2

Variables	Year 1: Mar 2018-2019	Year 2: Mar 2019-2020
# of days bed in operation	365	365
# of days bed occupied	343	327
# of clients admitted	19	19
Average length of stay	17 days	17 days
Bed utilization	94%	90%
On admission, the average CGI-C score of a client was	6 – Severely Ill	6 – Severely Ill
At discharge, CGI-C scores decreased by average of	2	2
# of clients discussed as candidate for the ACS bed	45	47
# of clients discussed admitted to the ACS bed	20	18

CUMULATIVE 2-YEAR INFOGRAPHIC

Data summary from March 2018 to March 2020

731 days
since bed opening

38
clients admitted

On admission, avg. CGI-C score of a client was **6**

92%
bed utilization

17 days
Avg. length of stay

670 days
bed occupied

At discharge, a clients' CGI-C score **decreased** by an avg. of **2**

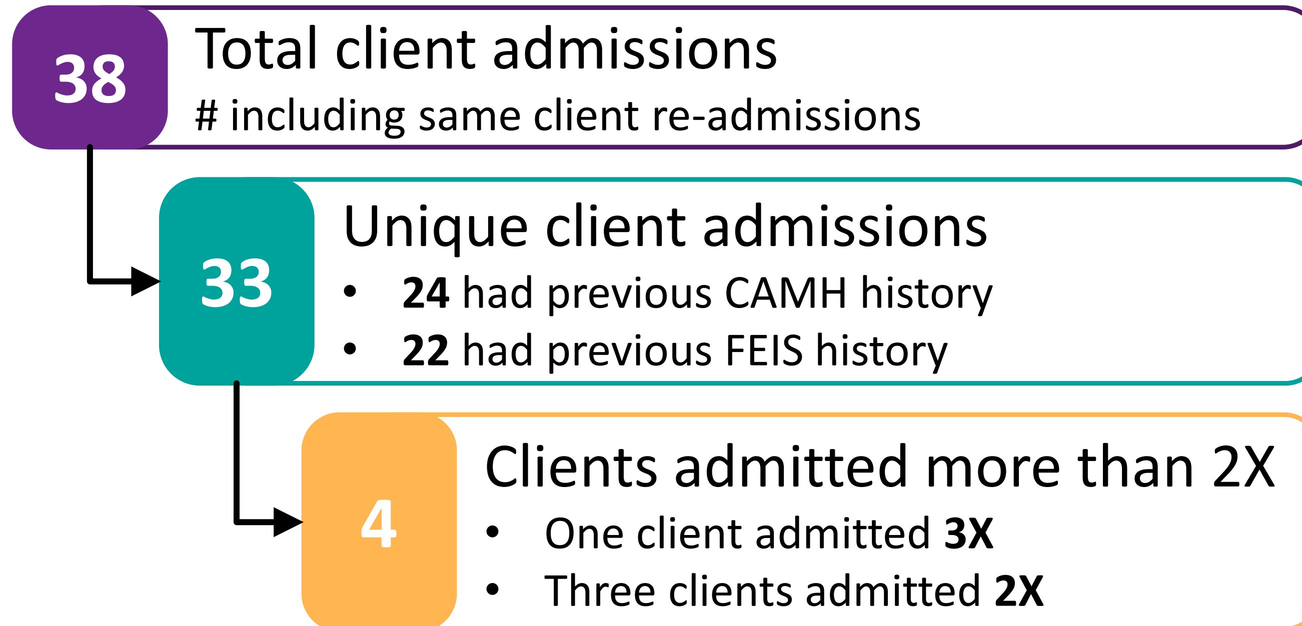
Based on clinical discussion, to date,

67%

of the clients admitted to the ACS showed significant improvement, sustained upon return to TSDC

Admissions are paused as of mid-March 2020 due to the COVID-19 outbreak; service pending

SNAPSHOT FOR ACS CLIENTS

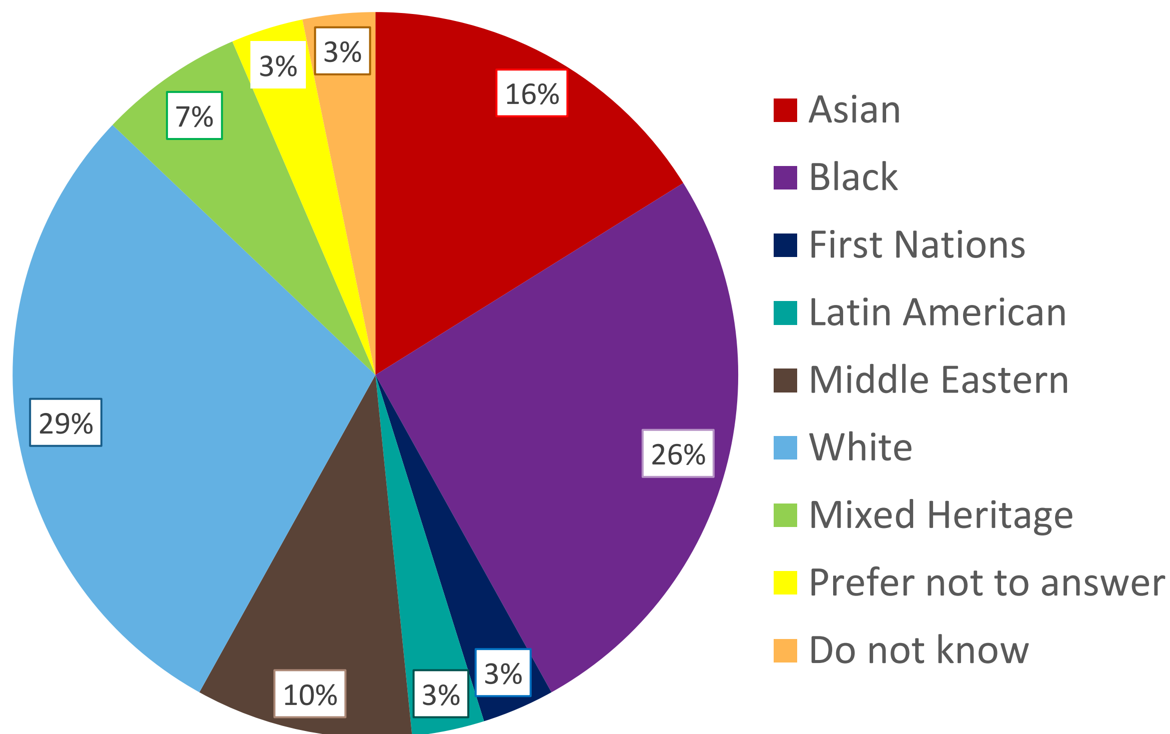


Min. Age
20 years

Avg. Age
30 years

Max. Age
55 years

ETHNICITY & DIAGNOSES (DATA TAKEN FROM PATIENT MEDICAL CHARTS)



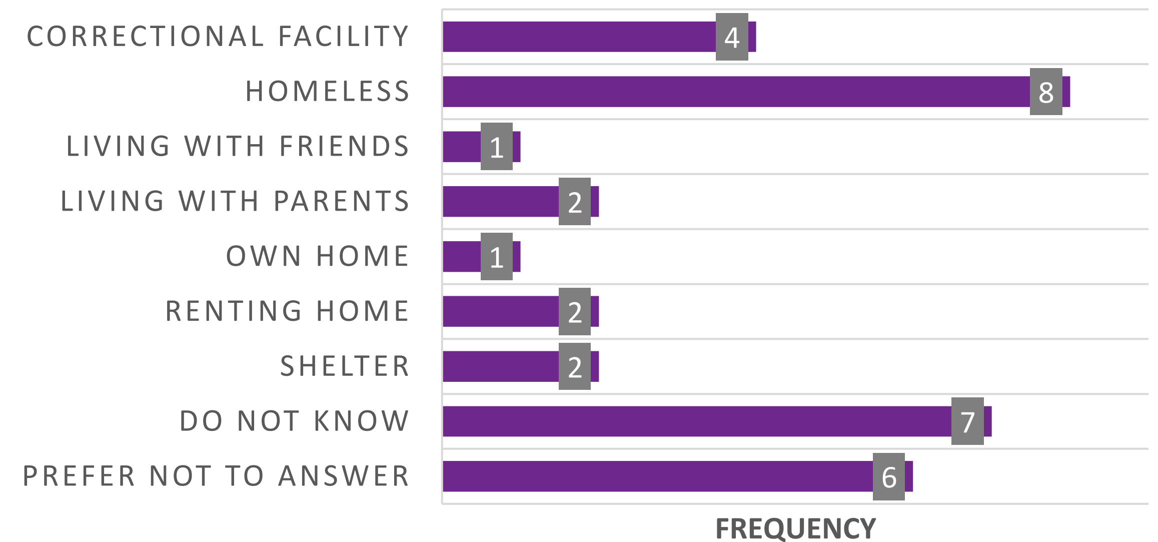
Ethnicity from chart - inpatient admission assessment form

Diagnosis**	Frequency*** (N = 33)
Psychotic Disorder	30
Substance Abuse Disorder	10
Antisocial Personality Disorder	10
Depression/Bipolar Disorder	3

***Diagnoses presented above are taken from client's medical chart, which would be a combination of the SOTU attending psychiatrist diagnosis and previous psychiatric documentation focusing on the most recent diagnosis prior to discharge from ACS bed.*

****Clients may have more than one diagnosis*

DATA COLLECTED FROM JSAT



¼ of clients had no social supports present

20 clients had previous incarceration history

INSIGHTS FROM THE DATA

- Multiple readmissions of same client to ACS bed
  - We had **4 clients** who were admitted 2 or more times
  - **One of these clients** were admitted during the same FEIS encounter
- Diagnosis had to be seen as treatable
- Outcome measures
  - Compared to admission, CGI-C scores showed a **reduction in severity of illness** at discharge
  - **More than half** of the clients following the ACS pathway, showed significant improvement which was sustained on return to TSDC
- High bed utilization

PROFILE OF A ACS CLIENT

CLIENT CASE STUDY (INFORMATION EDITED TO PROTECT IDENTITY OF CLIENT)

MR. W

Client History

- Aboriginal male in his 30's
- In custody for serious charges including murder
- Born and raised in small town north of Toronto
- Has several siblings and was raised by his extended family
- Left home to find work in early 20's
- Periods of homelessness, unemployment, hospitalizations (i.e., various hospitals/emergency rooms in GTA & Ontario)
- Lost contact with family and no record of follow-up after discharge from hospitals

CLIENT CASE STUDY - CONTINUED

MR. W

CAMH History & In custody at the TSDC

- Mr. W briefly attended CAMH outpatient group in 2013
- No other CAMH history prior to referral to FEIS in 2018
- In custody at the TSDC, the initial JSAT was completed by FEIS clinician indicating:
  - History of substance use
  - Previous charges
  - Previous periods of incarceration
- Most were minor charges of theft under
- No formal diagnosis on file

CLIENT CASE STUDY - CONTINUED

MR. W

In-custody prior to HNS bed

- During first days in custody. Mr. W:
  - Yelled, screamed, and was not coherent
  - Refused to look at or interact with corrections staff
  - Flooded his cell
  - Became very aggressive unexpectedly
  - Had a serious altercation with another patient resulting in extra charges laid against him while in-custody
- Mr. W moved to specialized Mental Health Assessment Unit

CLIENT CASE STUDY - CONTINUED

MR. W

Admission to HNS bed

- FEIS clinician visited Mr. W frequently over short period of time to gather more information and insight into his history
- FEIS Physician queried probable diagnosis of Schizophrenia
- Mr. W was not improving/not taking medication consistently
- Approximately a month after admission to TSDC, it was suggested that Mr. W be sent to the ACS bed at CAMH
- Mr. W stayed at the ACS bed for **17 days** and began receiving medication by injection

CLIENT CASE STUDY - CONTINUED

MR. W

Return to TSDC custody

- Upon return from ACS bed, Mr. W continued to **stabilize**
- With support from the FEIS clinicians, Mr. W **reconnected with his family** whom he had lost contact with for 8 years
- He began to **participate in programs** & moved to open unit
- He **participates in cultural activities** like smudging and conversing with an elder
- He keeps track of his medications & has been **proactive** in letting staff know if he does not feel well or missed a dose
- Mr. W remained in custody **without further incident** until March 2020 when he was granted NCR

MOVING FORWARD

FUTURE DIRECTIONS

1. A second bed was opened up in April 2021, with two more expected in the next few months.
2. Continue to improve triaging and general flow of transfer, aiming to always have client identified as next suitable candidate
3. Seek to address areas of improvements in our service and current processes
4. Continue to orient FEIS and SOTU clinical staff on the HNS procedures & processes
5. Solicit ongoing feedback from the TSDC for any improvements