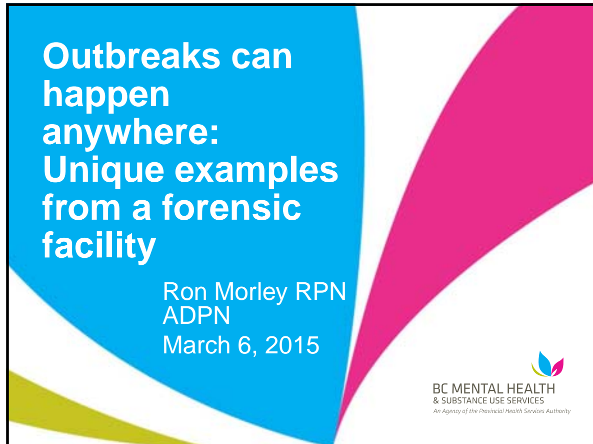
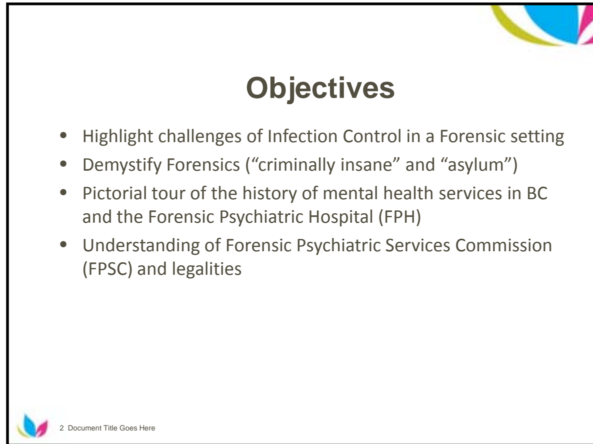

Outbreaks can happen anywhere: Unique examples from a forensic facility
Ron Morley RPN ADPN
March 6, 2015
BC MENTAL HEALTH
& SUBSTANCE USE SERVICES


Objectives
Highlight challenges of Infection Control in a Forensic setting
Demystify Forensics ("criminally insane" and "asylum")
Pictorial tour of the history of mental health services in BC and the Forensic Psychiatric Hospital (FPH)
Understanding of Forensic Psychiatric Services Commission (FPSC) and legalities
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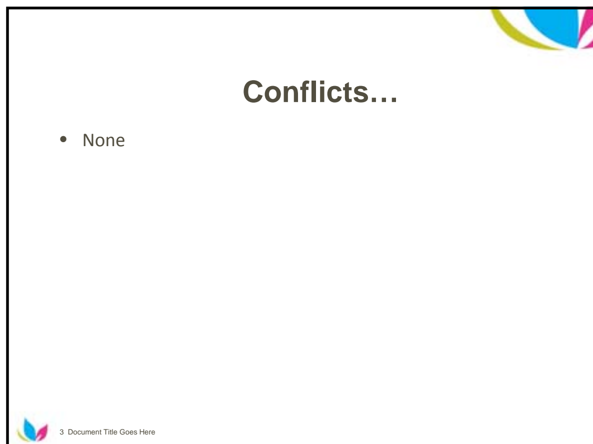
Conflicts…
None
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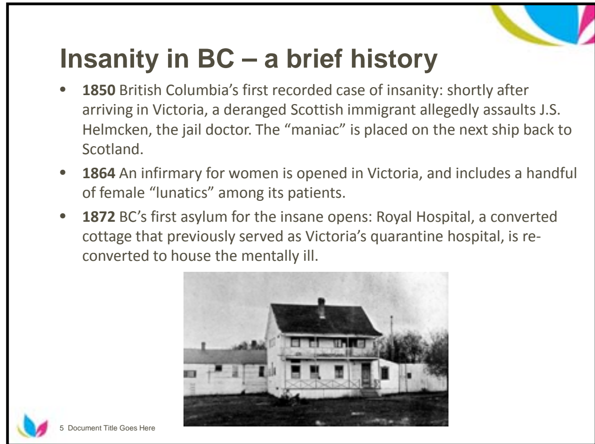
Something about me…

- Registered Psychiatric Nurse since 1990
- Worked at FPH since graduation
- Front-line Nurse, Shift Supervisor, Patient Unit Manager, Infection Control Nurse

Insanity in BC – a brief history

- **1850** British Columbia's first recorded case of insanity: shortly after arriving in Victoria, a deranged Scottish immigrant allegedly assaults J.S. Helmcken, the jail doctor. The "maniac" is placed on the next ship back to Scotland.
- **1864** An infirmary for women is opened in Victoria, and includes a handful of female "lunatics" among its patients.
- **1872** BC's first asylum for the insane opens: Royal Hospital, a converted cottage that previously served as Victoria's quarantine hospital, is re-converted to house the mentally ill.



1873 The **Insane Asylums Act** is passed, BC's first legislation addressing mental illness.

1878 The overcrowded Victoria asylum is closed and its 36 residents are moved to the newly-built **Provincial Asylum for the Insane in New Westminster** (later to become Woodlands)

1883 Work therapy is introduced; asylum residents are put to work in the gardens.

1897 The legislature passes the **Hospitals for the Insane Act**, stipulating that mentally ill persons could be committed to hospital under an **Urgency Order**, which required **two medical certificates**. The asylum in New Westminster is renamed the **Provincial Hospital for the Insane (PHI).**

1899 PHI population surpasses 300. In the absence of social services, the hospital is housing developmentally disabled people and unwanted, physically handicapped children along with psychiatric patients. Complaints are heard of serious overcrowding, poor hygiene and living conditions, and inadequate care.

1901 The psychiatric literature lists the principle causes of insanity as **heredity, intemperance** (alcohol), **syphilis and masturbation**.

1904 To relieve overcrowding, 48 male patients are transferred to a small asylum in Vernon, and the BC government purchases 1,000 acres in rural Coquitlam as the site for a new mental hospital – the beginning of **Riverview Hospital**.

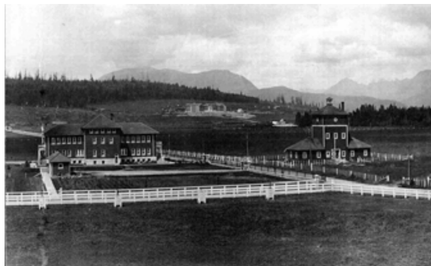
1905 Using mostly patient labour, housed on-site in temporary buildings, the Coquitlam site is cleared of forest and diked (with 8 km of under drains), and Colony Farm is established to grow food for the PHI.

1909 Construction begins on the new “Hospital for the Mind” on the slopes above Colony Farm; the locale would become known as Essondale, in honour of Dr. Henry Esson Young, the cabinet minister who advocated for the new hospital.

1912 Colony Farm gains a reputation as the best farm in Western Canada, employing the latest in farming techniques to produce over 700 tons of crops and 20,000 gallons of milk in a year.

1919 BC's first forensic psychiatric facility opens: the Provincial Mental Home for the Criminally Insane, at Colquitz (Saanich District) on Vancouver Island, with an initial intake of nine patients transferred from PHI. By year's end Colquitz would house 99 inmates, all male.

1920 Two permanent dormitories are added to the growing complex at Colony Farm, providing 75 beds for patients working on the farm.



1924 The Acute Psychopathic Unit (later called Centre Lawn) opens at Essondale, originally used for testing and recommending treatments for new admissions.

1930 The 675-bed Female Chronic Unit (later called East Lawn) opens, allowing most of the female residents of PHI to transfer to Essondale. BC's first training School for Psychiatric Nurses is established in the new building. The hospital's first occupational therapist is hired, followed a year later by the first social worker.

1932 The first graduates from BC's School of Psychiatric Nursing receive their diplomas.

1934 The Veterans' Unit (the first section of what would later become Crease Clinic) opens at Essondale.

1940 BC's Mental Hospital Act is amended, deleting all references to "lunatic" and "insane"; this year also sees the first male graduates from the nursing school.

1942 Electro-convulsive therapy (ECT) is introduced, followed soon after by sulfa drugs, then psychosurgery; all of BC's mental health facilities are reported to be seriously overcrowded.

1946 The first female physician is hired at Essondale; however, the hospital will remain gender-segregated until the early 1960s.

1949 Crease Clinic of Psychological Medicine opens, after the second half of the building is constructed (a mirror image of the first half, built in 1934). At Colony Farm, the Veterans Unit (Riverside Building) opens, the forerunner of today's Forensic Psychiatric Hospital.

1951 Essondale reaches its peak population of **4,630** patients. Pennington Hall opens, providing recreational services to patients.

1955 230-bed Tuberculosis Unit (now called North Lawn) opens at Essondale. The introduction of improved medications (Chlorpromazine), along with the opening of community mental health centres, boarding homes, and general hospital psychiatric wards, results in the start of a decline in Essondale's patient population.

1964 The Colquitz forensic psychiatric hospital is closed and its patients transferred to **Riverside Unit at Colony Farm**. In the 1980s, Colquitz was renovated to become the Wilkinson Road Jail.

1965 The BC Mental Health Act is introduced, bringing a number of administrative changes – *CCC captures suicide as an indictable offence*

1974 BC's **Forensic Psychiatry Act** is enacted, creating the Forensic Psychiatric Services Commission (FPSC) to provide mental health services for persons in conflict with the law. Over the next two years Riverside Unit at Colony Farm is transformed into the Forensic Psychiatric Hospital. FPSC opens its Vancouver clinic, the first of what would later become a province-wide network of regional clinics.

- **1983** With Riverview’s population continuing to fall, West Lawn is permanently closed. Farming operations at Colony Farm are discontinued – *temper tantrum fire*
- **1985** Signalling a nationwide trend to de-institutionalizing the developmentally disabled, Tranquille is closed; Woodlands will close in 1996.
- **1988** The BC Mental Health Society is established and takes over management of Riverview; the society’s provincially-appointed trustees are replaced by a community-based board of governors in 1992.

1990 The Mental Health Initiative introduces a comprehensive plan for the development of mental health services throughout the province. It focuses on replacing Riverview with smaller, more specialized regional facilities – *bed for bed closure?*

1992 The Crease Clinic becomes the second large Riverview building to close; the building will later embark on a second career as a filming location.

1997 A new state-of-the-art Forensic Psychiatric Hospital opens at 70 Colony Farm Road in Port Coquitlam, replacing the original Riverside Unit.

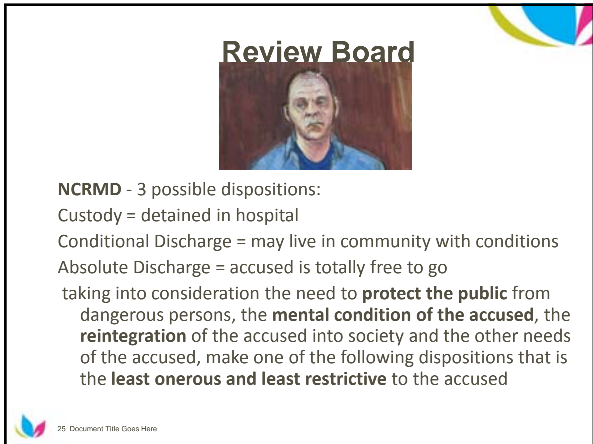
Who we are

- British Columbia's Forensic Psychiatric Services Commission (FPSC) is a multi-site health organization providing specialized hospital and community-based assessment, treatment and clinical case management services for adults with **mental health disorders** who are in **conflict with the law**.
- Hospital (FPH) and 6 community clinics (Vancouver, Surrey, Victoria, Nanaimo, Prince George, and Kamloops)
- 2 broad categories of patients – **Remand Assessment** and **Treatment**

Review Board

- The British Columbia Review Board is an independent tribunal established under the Criminal Code of Canada.
- The Review Board has ongoing jurisdiction to hold hearings to make and review dispositions (orders) where individuals charged with criminal offenses have been given verdicts of not criminally responsible on account of mental disorder or unfit to stand trial on account of mental disorder, by a court.
- It is the responsibility of the Review Board to protect public safety while also safeguarding the rights and freedoms of mentally disordered persons who are alleged to have committed an offence.

Review Board



NCRMD - 3 possible dispositions:

Custody = detained in hospital

Conditional Discharge = may live in community with conditions

Absolute Discharge = accused is totally free to go

taking into consideration the need to **protect the public** from dangerous persons, the **mental condition of the accused**, the **reintegration** of the accused into society and the other needs of the accused, make one of the following dispositions that is the **least onerous and least restrictive** to the accused

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Review Board (cont)

"unfit to stand trial" means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so and, if particular, unable on account of mental disorder to:

- understand the nature and object of the proceedings
- understand the possible consequences of the proceedings, or
- communicate with counsel .

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Psychosocial characteristics of FPH patients 2004 = 548 FPH patients assessed and/or treated

		Men	Women
Age		36.11	35.58
Gender		87.6%	12.4%
Ethnic origin	Caucasian	76.1%	66.7%
	First nation	7.9%	12.7%
Level of education	elementary	10.5%	6.1%
	junior high	32.7%	20.4%
	senior high	33.5%	36.7%
	post-sec	8.9%	22.5%
Marital status (single)		76.9%	57.6%
Employed prior to admission		9.2%	6.7%

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Mental health history of FPH patients

	men	women
Prior mental health history	88.5%	83.9%
Age of first contact		
0 – 12	15.9%	10.6%
13 – 17	17.5%	17.0%
> 17 years	66.7%	72.3%
Hospitalized		
Psych ward	72%	76.7%
Tertiary	35.1%	34.4%
Forensic	28.3%	21.9%
Pharmacological treatment	81.5%	85%

Mental health problems of FPH patients

	Men	Women
Axis I		
schizophrenia spectrum	61.6%	58.1%
substance use disorder	64.9%	47.5%
substance induced psychosis	10.8%	13.1%
bipolar disorder	8.5%	10.0%
major depressive episode	4.0%	1.6%
major depressive with psychosis	1.1%	7.8%
neurotic disorders	3.5%	3.1%
Axis II		
any personality disorder	58.7%	47.8%
antisocial	39.9%	11.6%
borderline	7.0%	23.3%
narcissistic	9.1%	2.3%

Infection Types at FPH

Snapshot February 20, 2015:

- HBV = 1 (*N*=190) 0.53%
- HCV = usually 10-20%
- HIV = 3 (1.5%) **Bob's Dx*
- Bites (human, dog)
- Annual amount spent on antibiotics = <$2,000 (most common infection is….)

Unique infection characteristics/challenges in psychiatric settings

- Outbreaks most often caused by agents circulating in community (Fukuta, Infect Control Hosp Epidemiol. 2013;34(1):80-88)
- Psych patients have fewer co morbidities than acute care patients; typically ambulatory and mingle freely on unit.
- Tend to have longer hospitalizations; attend congregate events (group or recreational therapy); average length of stay at FPH = 3 years
- Resistive to hygienic measures or health preventative measures (immunization – *Tim Horton's incentives = 65-80%*) due to illness
- ABHR ingestion = substance use disorder (FPH) usually 60-80% (Microsan = 70% alcohol; *400ml bottle in ceiling tiles*)

Unique infection characteristics/challenges in psychiatric settings (cont)

- FPH physically incompatible with basic contact precautions due to communal living arrangements (shared bathrooms and dining room)
- Isolation of floridly psychotic patient may have adverse effects on his/her psychiatric condition
- Use of mandatory mask in lieu of staff influenza vaccination leads to increased suspicion by paranoid patients
- Soap as a weapon
- Psychosis frequently masks medical symptoms (poor historians and unreliable)

Unique infection characteristics/challenges in psychiatric settings (cont)

- Secrecy of symptoms due to restriction of liberties (especially during an outbreak – patient or peer pressure)
- Patients intentionally expose staff to blood and body fluids by spitting or throwing body fluids ("code brown")
- Patient care equipment may become weaponry or escape tools (stethoscope, BP cuff, *Basketball bladder, Willie's consumption*)
- Cohorting of ill patients difficult; FPH at full capacity with waitlist – seclusion may be only option.
- "Shake and Bake" (methadone, not chicken)
- Metamucil uses

Unique infection characteristics/challenges in psychiatric settings (cont)

- Smoking cessation = created flourishing black market trade ($5-10/cigarette as high as $10 to inhale second hand smoke); patients always sharing cigarettes which negate contact precaution efforts.

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An Agency of the Provincial Health Services Authority