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MENTAL HEALTH CENTRE
PENETANGUISHENE, ONT.

"O A K R I D G E" D I V I S I O N

'Oak Ridge' is a maximum security hospital for male patients operating within the administrative framework of the Mental Health Centre, Penetanguishene, Ontario. It is a "second stage" institution; that is, almost all of its patients are referred from other institutions, including the courts, federal and provincial correctional institutions, county jails, regional psychiatric hospitals, and mental retardation facilities. When patients are discharged from 'Oak Ridge', they are usually returned to another institution before direct release to the street.

Historically, 'Oak Ridge' opened in February, 1933 as a "Hospital for the Criminally Insane". At that time it housed approximately 150 patients. In 1958 its capacity was doubled to the present 304 beds. Over the years "The Ridge" has developed from being primarily a custodial institution to one with a strong therapeutic orientation. These changes, which have been most marked in the past 15 years, have been achieved without jeopardizing the impressive security record of the building. In the last 24 years for example, there have been only two successful escapes. 'Oak Ridge' has never had a riot or a homicide and the suicide rate has averaged one every three years.

The therapeutic programmes at 'Oak Ridge' have attracted world-wide attention and visitors from all parts of the world have toured our facility. Staff members have produced a number of scientific and research papers pertaining to the hospital that have been published in professional journals or presented at scientific-legal conferences.

Patient turnover has increased markedly in recent years. In 1959, for instance, only 60 new patients were admitted to the hospital for the entire year. In 1973, there were a total of 414 new admissions, 191 of whom were sent by the courts on Warrants of Remand for short-term psychiatric assessment.

The courts also refer a number of patients to 'Oak Ridge' on Warrants of the Lieutenant-Governor [W.L.G's]. These are persons, charged with serious criminal offenses, whom the courts have found "Unfit to Stand Trial" or "Not Guilty by Reason of Insanity". In 1967, an Advisory Review Board was established to independently review each W.L.G. patient's case on an annual basis. When the Board feels it is reasonably safe to do so, it recommends to the Lieutenant-Governor that a W.L.G. patient be discharged from the hospital or, more often, transferred to a less secure setting.

We also accept convicted patients on transfer from penitentiary or correctional facilities, and dangerous patients from other Ontario Psychiatric Hospitals.

Organizationally, 'Oak Ridge' is divided into two units of four wards each:

Activity Treatment Unit [A.T.U.]
Social Therapy Unit [S.T.U.]

ACTIVITY TREATMENT UNIT:

The A.T.U. provides assessment, behaviourally-oriented treatment, and maximum security housing for 146 patients. As a group, A.T.U. patients represent a heterogenous number of behaviour problems, ranging from assaultiveness within other institutions to criminal offenses of varying degrees of severity. Psychiatric diagnoses are varied as well, although a large proportion of the patients are psychotic and/or below average intelligence. In general, the Unit is best

ACTIVITY TREATMENT UNIT [cont'd]

equipped to treat patients who are not well suited for traditional verbal forms of therapy, frequently exhibit problem behaviours within a hospital setting, and are not too old for intensive behavioural programming.

The ward programmes are based on security and behaviour modification principles. That is, patients earn privileges for exhibiting carefully specified desirable behaviours and lose privileges for undesirable behaviours. The programmes ward structure are designed in such a way that, as the patients develop more stable and acceptable patterns of behaviour, they move from the more secure, minimum-privilege, upper wards ["B" and "D"] to the less secure, maximum-privilege, lower wards ["A" and "C"]. Staff are continuously assessing the patients' progress and charting it on behavioural graphs and records. Transfer to the next level in the progression occurs only when the patients have met well-defined criteria for changes in status that have been laid down by ward staff.

The upper ward programmes are primarily aimed at reducing the incidence of assaultive behaviour, teaching basic hygenic skills and simple work habits, and improving the patients' mood and co-operation. "B" Ward functions as the admitting and initial assessment area for the Unit, whereas "D" Ward provides carefully structured, individualized programmes for long-term patients.

With transfer to a lower ward, patients progress to more complex activities where the rewards are less immediate and direct. During the day, patients typically work in any of a number of off-ward areas at paid jobs, ranging from packaging objects to hammering wooden skids.

ACTIVITY TREATMENT UNIT [cont'd]

Most upper ward patients go to "C" Ward initially. The "C Ward programme is similar to the upper ward programmes, but places greater emphasis on improving the patients' social skills and gradually shaping their ability to monitor and control their own behaviour. "A" Ward provides a relaxation of intensivd ward programming and a simulation of the kind of ward environment the patients will likely encounter on leaving 'Oak Ridge' for a regional psychiatric hospital, thereby allowing for an assessment of the patients' readiness for discharge.

The attendant staff play a major role in implementing the ward programme on the A.T.U. However, all the staff- attendant, medical-psychiatric, social work, psychology, nursing and recreational-vocational - work together as a team in their involvement with the programmes. A deliberate effort is made to promote an integrated, interdepartmental approach to staff relations. In part this is achieved by having a multi-disciplinary management committee on each ward chaired by the attendant supervisor of the ward.

While the ward programmes are the focal point of treatment on the A.T.U. the various off-ward recreational and vocational activities play an important role as well. These off-ward areas are currently developing their own treatment programmes and assessment procedures which, in turn, are closely allied with the programmes on the wards.

Some A.T.U. patients have problem behaviours not readily exhibited on the wards. Child molesters are one example. A specialized aversion therapy and sex education programme is available for child molesters whose behaviour on the wards has stabilized. The aversion therapy programme is treatment oriented, but with a strong research emphasis. In addition, there is an ongoing research project for the study of assaultive patients.

ACTIVITY TREATMENT UNIT [cont'd]

Looking ahead, the Unit plans to establish closer liaison with the institutions from which we accept referrals and to which we send our dischartes. A second, continuing goal is to develop more accurate criteria for assessing the dangerousness, treatability and discharge readiness of our patients.

SOCIAL THERAPY UNIT:

The Social Therapy Unit [S.T.U.] is located in the maximum security 'Oak Ridge' building and is comprised of Wards E, F, G, and H. Each of these 38-bed Wards is serviced by two daytime shifts of three or four attendant staff, with a single attendant in chargd during the night lock-up shift [11:00 p.m. to 7:00 a.m.]. The Professional staff complement consists of a half dozen individuals drawn from a broad spectrum of disciplines, with one psychiatrist in charge of this team and of the Unit.

The typical patient member of the Social Therapy Unit appears rather intact and articulate. Most are, in fact, diagnosed as some variation of character disorder: few are strangers to total institutions; many have long histories of antisocial behaviour. Average age is somewhere between 20 and 23.

Philosophical Background: The chronic shortage of professional help at 'Oak Ridge' has been an advantage in the development of Social Therapy Unit programs. Our philosophy is founded on ideas similar to those of Martin Buber - open and spontaneous dialogue is the meaning and goal of psychotherapy, and symptomatic behaviour is simply failure to relate effectively. With ideological guidance of this sort, it's immediately clear that the patients themselves possess the means to treat each other: it's only necessary that there be a person at each end of some relationship for it to be therapeutic. In fact, as our patients acquired greater skill at understanding themselves and each other, it became clear that for many situations they could

SOCIAL THERAPY UNIT [cont'd]

operate more effectively in this regard than could a professional. Similarities in experience, of course, allow patients a "head start" at empathy -- but more important, the fact that one's therapist has been formally identified "as a nut" allows one to compensate for his psychological astigmatism.

The role of therapist carries some responsibility. The success we've had at filling the role with patients nas encouraged development of the idea that these very dangerous people, in some situations, can be trusted to behave responsibly with minimal overt control. With the establishment of therapeutic communities as the vehicle of patient/patient therapy, it was unavoidable that patients would occupy positions of authority, and while ultimately answerable to the staff be directly monitored only by other patients. Since then, the practice of teaching responsible behaviour by simply requiring it has elaborated itself into a system that makes some patients a replacement for staff in control or service of particular programs.

An accumulation of considerable experience with therapeutic communities operating through the initiative and energy of patients, and nearly independent of staff involvement except in a supervisory capacity, has enriched our appreciation of the processes central to therapy. A notion currently growing in strength throughout the unit is that Community heals - i.e. that involvement as co-participant in and commitment to a group sharing beliefs and trust is sufficient to restore wholeness to the violent, anomic, self-conflicted people with whom we deal.

Some S.T.U. Features:

The Assessment Unit: To minimize the disruptive effect produced in the communities by the entry of admissions fresh from the prison subculture, a pre-treatment training program is operated on "H" Ward. The special emphasis of this program is control: almost all of every day is spent in groups supervised by "Teachers" - patients of known loyalty who are also veterans

SOCIAL THERAPY UNIT [cont'd]

of milieu therapy. The group sessions are devoted to study of papers on interpersonal behaviour, but actually the most important training comes with the privilege penalties for such behaviour as calling Attendants "screws" or referring to Teachers as "joint men": new admissions must learn that they are in a mental hospital and that the prison ethic [in the style, "do your own time and I'll do mine"] is out of place here. Though there is much discussion about therapy in these group sessions, none takes place here: The Assessment Unit must also deal with people sent by the courts on 30 and 60-day Warrants of Remand for psychiatric observation - these people must not be subjected to anything even faintly resembling treatment.

The Communities: Wards "G" and "F" contain therapeutic communities. The "G" Ward community operates with a social system assigning specializations and specific responsibilities, a bureaucratic pattern adapting well to patients who are reluctant to co-operate with peers and unwilling to work with or for The Establishment. The "F" Ward community is systematically isocratic, structured so as to accommodate those more motivated patients who already understand the ground rules. The program routine for both communities involves variously-sized group meetings and all-community Ward meetings usually from 8:00 a.m. to 4:30 p.m., in which patients must find time to discuss individual problems in living - as well as effect solutions to the everyday problems in ward and community maintenance.

Chemical Adjuvants: Major tranquilizers are used to a limited extent in the Social Therapy Unit - situationally, for the most part, and only as is necessary to alleviate symptoms interfering in some gross fashion with the milieu therapy processes. Uncommon in mental hospital tradition is our use of those psychogrophics functioning chiefly as pathology amplifiers. Scopolamine, Amytal-Methedrine, Dexamyl-Tofrantil, and sometimes LSD-25 have been used in the community setting in ways that have vividly uncovered deep disturbances underlying the virtually seamless personalities of our patients. The point is, of course, that only problems which can be seen can be solved.

SOCIAL THERAPY UNIT [cont'd]

The Total Encounter Capsule: An almost totally distraction-free area has been set aside on "F" Ward for special sessions in leaderless encounter therapy. The Capsule is a small, windowless room containing a toilet, a sink, and as many as seven nude patients who have volunteered to share those conditions, for periods ranging from three days to about two weeks. Food is liquid, [soups, milkshakes, etc.] served through plastic straws fixed in the wall. The flooring is four-inch foam covered with deep-pile carpet. Patients service and monitor the Capsule, from the outside, by means of a closed circuit television: at night it is observed and attended to by three patients working shifts; during the day, by five. Within the Capsule, stripped of the artifices and the diversions normally allowing or justifying or even promoting distances between people, patients are free to explore the truths of their game-playing patterns. As an opportunity for patients to test a variety of behaviour styles and to receive direct feedback from their social environment, the Capsule is unequalled. S.T.U. patients recognize it as an important path in the search of understanding of one's self and others.

OTHER PROGRAMS:

MAP - the Motivation Attitude Participation program retraining, under conditions of severe deprivation, those who have proven extremely disruptive in other programs.

"E" Ward - operating a relatively low-intensity program for the relatively "together" patients, which combines a minimum of structured interaction and a maximum of paid work in the Industrial Therapy programs.

The Sunroom - people who are psychotic, or for other reasons, unable to fit into structured program, may be kept in the "F" Ward Sunroom group. This program is small, unstructured and total: up to seven people living together in a large room 24 hours a day. The Sunroom is serviced and observed by the group of patients handling the Capsule.

SOCIAL THERAPY UNIT [cont'd]

Communication: A tradition of security considerations has kept the four wards isolated from each other to a considerable degree. On the whole, this has enhanced the community experience by discouraging members from significant social investment elsewhere. But recently, interward communication has been expanded at new levels: we currently publish a weekly newspaper for the S.T.U. and we are near completion of a four-ward video hook-up. Ultimately, we will have all our communities allied in a Social Therapy Village.