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Under Warrant

A Review of the Implementation of
the Correctional Service of Canada's
'Mental Health Strategy'

Prepared for the Office of the
Correctional Investigator of Canada

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Executive Summary

This review of the Correctional Service of Canada's (CSC) implementation of its 'Mental Health Strategy' for offenders was commissioned by the Office of the Correctional Investigator as part of its investigation of the access and quality of mental health care for federal offenders. The review was conducted over 90 working days from April to November, 2009. It examined six areas that form the basis of CSC's 'continuum of care': 1) intake, 2) primary care, 3) intermediate care, 4) tertiary care, 5) community care and 6) staff development. Mental health human resources, governance/administration and stigma/discrimination were also explored.

The report reviews the legislative and policy authorities for the exercise of CSC's health care mandate. It is noted that health services, including mental health care for federal offenders, are not covered by the *Canada Health Act*, Health Canada or provincial/territorial health services. The Service assumes full responsibility for the mental health care of offenders under federal jurisdiction.

Research shows that prevalence rates for mental health problems and mental disorders in offenders is growing and significantly exceeds that of the general population. At admission 11% of federal offenders had a mental health diagnosis, 21.3% were prescribed psychiatric medication and 14.5% of male offenders had a past psychiatric hospitalization. Female offenders are twice as likely as male offenders to have a mental health diagnosis at admission. (Correctional Service of Canada, 2009j). The suicide rate for federal offenders is more than seven times the Canadian average while the number of serious self-harming incidents in prisons is rising. The mental health needs of offenders exceed the capacity, services and supports of the federal correctional authority to meet the growing demand.

Despite the fact that its 'Mental Health Strategy' was launched six years ago, it is significant to note that the Service was not able to provide an official and comprehensive strategic planning document that has been approved by the appropriate CSC authorities. This lack of an over-arching mental health plan seriously compromises funding, implementation, accountability and evaluation. A comprehensive plan is required based on an assessment of current and future needs, the services required to address these needs across the continuum of care and a realistic implementation plan over an appropriate period of time.

Although lacking an officially approved strategy, incremental and permanent funding has been received to enhance mental health services in areas such as intake, primary care, inpatient care, community care and staff training. However, the funding is not adequate, the pace of change is slow and there is no evidence that the government has been presented with a multi-year needs based plan for annual funding increases over the next five to ten

years. Intermediate care, which falls between primary care and acute inpatient care (the regional treatment centres), has not been funded and there appears to be no plan in place to address this need on an ongoing basis in the near future, except for the development of a pilot project in the Pacific Region.

Actions are being taken by CSC to address critical mental health human resource issues which include recruitment, retention, remuneration, professional scopes of practice, roles and responsibilities, accountability and liability. The Service is attempting to address these concerns, including the hiring of more mental health staff, but more action is needed as the human resource problem will only escalate over the next two decades. In addition to mental health staff, the report supports the more effective involvement of correctional and institutional parole officers in mental health delivery. While funding for mental health awareness training of front-line staff has been provided, it is noted that the training is not complete. The report recommends that the Service move to a hiring strategy for front-line staff that places more emphasis on the skills, competencies and knowledge required to manage an increasingly complex array of mental health issues and disorders.

The report notes that all too often security trumps treatment service delivery. CSC staff report a number of security barriers that impede access to treatment, many of which can be dealt with by relatively straightforward operational changes. It is also noted that the Service would enhance communications and collaboration by developing guidelines for clinical management plans in a Commissioner's Directive that would allow for more effective sharing of necessary clinical information with all 'circle of care' providers, including front-line staff who have the most direct contact with offenders.

Administration and governance also play an important role in service delivery. There is no unified administrative structure in CSC for mental health. While some of the constituent parts (e.g. psychiatry, community services) report to Health Services, others such as psychology and the regional treatment centres report to Institutional Operations. There is no matrix or network governance agreement related to mental health between the two branches of the Service. As a result, clinical accountability appears to end at the regional level and not at National Headquarters (NHQ) for many of CSC's treatment programs. At the end of the day, no one position within CSC is responsible for all of mental health.

Clinical input needs to play a more significant role in planning and policy development at CSC's national headquarters. A senior position responsible for administration and another responsible for clinical activity and accountability that report directly to the one position responsible for mental health, such as the Assistant Commissioner for Health Services, should be created. The clinical accountability position needs to be designated for a

regulated mental health professional and rotated between discipline leaders (e.g. Chiefs) of each of the regulated mental health professions.

Finally, the report notes that offenders are currently not very involved in the evaluation or planning of mental health and criminogenic services. 'Never about us without us' is an important and valuable principle related to program design, implementation and evaluation.

Introduction

At any one time, the Correctional Service of Canada (CSC or the Service) is responsible for approximately 21,000 offenders, of which 13,000 are in institutions and 8,000 in the community. Approximately 34,000 individuals move through the system each year (Correctional Service of Canada, 2009a). Offenders often bring with them significant multiple and interrelated issues including a history of criminogenic behaviours, mental health disorders, difficult and traumatic histories, limited educational and/or work success, gang involvement and substance abuse (Corrections Service of Canada, 2008c).

The improvement of an inmate's mental health functioning is central to the goals of incarceration (*Corrections and Conditional Release Act 1992*, hereinafter the CCRA). A reframing of the World Health Organization's definition of mental health to fit the correctional context (World Health Organization, 2003, p. 7) could read as follows:

One of the goals of incarceration is to assist inmates in recognizing their abilities in order to help them improve their coping strategies related to the normal stresses of life, to work productively, to contribute positively to their families and communities, and to avoid a return to criminal behaviour.

The Purpose, Focus and Methodology of the Review

This independent review was commissioned by the Office of the Correctional Investigator (OCI) as part of its investigation of the access and quality of mental health care for federal offenders. It examined the implementation of CSC's 'Mental Health Strategy'¹ which was first announced in 2004. The Federal Government allocated funds to enhance mental health services in 2005, 2007 and 2008.

¹ 'Mental Health Strategy' is in quotation marks to indicate that, although frequently referred to, no officially sanctioned or comprehensive CSC mental health strategy document was provided to the OCI by Corrections Canada.

The review focuses on the mental health problems and disorders of non-Aboriginal male inmates. CSC has a separate mental health initiative for women offenders (Correctional Service of Canada, 2002). There is no separate or dedicated mental health strategy for First Nations, Inuit and Métis offenders. They bring cultural traditions and healing practices which have been integrated to varying degrees into separate CSC programs. For more information please see the OCI's recently released *Good Intentions, Disappointing Results: A Progress Report on Federal Aboriginal Corrections* (Mann, 2009).

Although mental health and criminogenic programs (e.g. violence prevention, family violence prevention and sexual abuse interdiction) have much in common, this report does not deal with the latter given that CSC distinguishes between the two. Finally, this review does not include substance abuse as it is not included in CSC's 'Mental Health Strategy', although functionally, mental health and substance abuse are strongly linked.

This review was conducted over 90 working days from April to October, 2009. It involved an examination of CSC and Government of Canada planning, policy and funding documents, the academic and grey literature, discussions/interviews with CSC employees and interviews with a few outside agencies and individuals with a direct interest in federal corrections.

The review examined aspects of the six areas that form the continuum of care of the Service's 'Mental Health Strategy': 1) intake, 2) primary care, 3) intermediate care, 4) tertiary care, 5) community care and 6) staff training. In addition, human resources, governance/administration and stigma/discrimination surfaced as important issues.

CSC's implementation of the 'Mental Health Strategy' was reviewed by reflecting in part on progress made against recommendations found in three reports which focused in whole or in part on mental health in corrections in Canada since 2004. These include the *Enhancing Mental Health Services for Federal Offenders: Parts I and 2 of the Final Report of the National Review Committee for the Treatment Centres* (Correctional Service of Canada, 2005a), *Out of the Shadows at Last* (Standing Senate Committee on Social Affairs, Science and Technology, 2006), and *A Roadmap to Strengthening Public Safety: Report of the Correctional Service of Canada Review Panel* (Correctional Service of Canada, 2007a). Importantly, many of the recommendations provided in these documents converge in terms of mental health and corrections.

A number of policy and planning documents from CSC were also very helpful. The Service has an impressive number of policy documents in the mental

health area. Finally, professional standards and best practices were used as points of comparison and evaluation. Two examples include *Mental Health and Substance Use Services in Correctional Settings: A Review of Minimum Standards and Best Practices* (Livingston, 2009) and *Identifying and Accommodating the Needs of Mentally Ill People in Goals and Prisons* (Ogloff, 2002). They provided valuable bases of comparison from a professional standards perspective.

There was good and open access to staff members in institutions and community settings across the country. Arranging interviews and visits was easy and personnel were generous and accommodating with their time. However, information requests to National Headquarters (NHQ), while eventually forthcoming, often took a long time to process and sometimes required resubmission of the request. In some cases it took months to receive documents or basic data related to mental health operations. All requests for information and interviews with NHQ staff went through one senior staff member. Several NHQ employees were accompanied to interviews by their supervisor. The OCI gave CSC every opportunity to supply information and documents that they thought would be helpful or that needed to be part of the review. In addition, OCI was careful to receive verification from CSC's National Headquarters staff that the correct and most up-to-date documents were being considered.

Background

The deinstitutionalization of people with mental disorders occurred several decades ago across Canada. The view at the time, shared by a number of developed nations, was that improved pharmacological and psychological treatments would allow people to be better served by services provided in their communities, closer to home, work and social support. In many cases this has proven correct. At the same time, many people with mental health problems and disorders were left languishing, not receiving the treatment they needed and consequently coming to the attention of the police and the courts (Standing Senate Committee on Social Affairs, Science and Technology, 2006; Kaiser, 2004).²

The Standing Senate Committee on Social Affairs, Science and Technology conducted the first pan-Canadian comprehensive examination of mental health, mental health problems and mental disorders in the history of the

² 'Jails and prisons have become the psychiatric hospitals for many Canadians.' Paraphrased comment by Judge Ted Ormston, founder of Canada's first mental health court and Chair, Advisory Committee on Mental Health and the Law, Mental Health Commission of Canada.

country. This is astounding considering the extent of mental health needs in Canada (Alberta Mental Health Board, 2007). The examination resulted in *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Standing Senate Committee on Social Affairs, Science and Technology, 2006). This landmark document covered a large number of topics, one of which was mental health services in the federal and provincial correctional systems.

The Senate Committee concluded that offenders are not being well served, arguing strongly for a standard of mental health care within correctional institutions and in post-release settings equivalent to that available in the broader community. To not accomplish this is to conclude that the Correctional Service of Canada places a higher priority on retention than on rehabilitation. Further, the Senate Committee noted that a significant change in the programs, funding and attitude of CSC is required in order to implement the following:

“...a thorough mental health screening when an offender accesses a federal penitentiary. It requires funding to provide the programs and services to meet the mental health needs of the prison population. It requires that CSC ‘walk the talk’ with respect to the priority to be given to rehabilitation versus retention for public safety. The Committee also recognizes that consistent data collection and careful analysis as well as an expanded research capacity related to mental health will be necessary. In summary, the Committee urges Correctional Service Canada to give a higher priority to mental health and addiction needs, to devote as much attention to these needs as it does to risk assessment and security issues, to ensure that treatment and rehabilitation are smoothly coordinated.” (Standing Senate Committee on Social Affairs, Science and Technology, 2006, 13.2.4).

The lack of available mental health services results in inmates with untreated mental disorders being more likely than other inmates to serve their full sentences in incarceration (Correctional Service of Canada, 2007a). This is due to a number of factors including problematic behaviour that influences how inmates are managed in the institution. People with untreated mental disorders are by definition less able to ‘take responsibility’ for their behaviour without help. Staff members report they are often deemed ineligible for programs and less able to successfully complete the necessary steps required

for consideration for early release. As a result, many languish unnecessarily in segregation and remain in prison longer. To 'punish' people with mental disorders in this fashion is obviously discriminatory, unacceptable and does not meet the minimum standards set by the CCRA. It also does not serve the public safety needs of the broader community.

The Senate Committee also strongly recommended further mental health specific training for all staff and the "establishment of a case management system" much like that used in mental health services outside of jails and penitentiaries.

Mental health issues have been a major focus of every annual report of the Office of the Correctional Investigator since 2003/2004. In addition, mental health factors have played a major role in other OCI reports on topics such as the use of segregation, self-harm, suicide and deaths in custody. The Office has consistently raised the fact that the mental health concerns of inmates continue to increase dramatically while CSC's mental health services have not kept pace.

Mental Health Needs in Corrections

Research shows prevalence rates for mental health problems and mental disorders in offenders exceed those of the general population (Ogloff et al, 2007; Brink, 2005; Lurigio et al., 2003; Fazel & Danesh, 2002) and the Service reports substantial increases over recent years (Correctional Service Canada, 2005a). According to the latest available data, at admission 11% of offenders committed to federal jurisdiction had a mental health diagnosis, an increase of 71% since 1997, 21.3% had been prescribed medication for psychiatric concerns and 6.1% were receiving outpatient services prior to incarceration. A further 14.5% of male offenders had previously been hospitalized for psychiatric reasons (Public Safety Canada, 2009; Standing Committee on Public Safety and National Security, 2009). As concerning as these numbers are, they are likely underestimations (Correctional Service of Canada, 2007a) for a number of reasons including self-stigma and less than complete data. Improvements in CSC's ability to identify mental health problems and disorders at intake and across the continuum of care will likely see reported increases in these already high rates.

.....mental disorders in offenders exceed those of the general population.

In addition, offenders with mental health problems and disorders are likely to experience other problems, the most common of which is substance abuse. The number of serious self-harming incidents in prison (e.g. head-banging,

self-mutilation, use of ligatures) is rising (Correctional Service of Canada, 2009f). In a ten-year period (1998-2008), over 100 inmates committed suicide in federal penitentiaries. The suicide rate for federal offenders is more than seven times the Canadian average (Public Safety Canada, 2009).

Penitentiaries are by definition punitive environments for inmates and staff (Kunst et al, 2008; Moloughney, 2004). Going to jail is designed by society as punishment and as such is aversive. There is little doubt that the prison environment – stressful, crowded, violent, noisy and unpredictable - has a significant impact on both offenders and staff. In addition, offenders' adjustment to community life can be difficult, particularly for those with mental disorders (Ogloff, 2002). The means to maintain mental health while under warrant (offenders) or on the job (staff) must be issues of central importance to any correctional service. Assisting inmates to manage their mental health problems and disorders will improve their functioning thereby providing a better environment for both the offenders and the staff working with them.

The CCRA: What is CSC Required to Provide?

The *Corrections and Conditional Release Act* (CCRA) states the purpose of the correctional system is to “contribute to the maintenance of a just, peaceful and safe society” by providing for the “safe and humane custody and supervision of offenders” while “assisting” their rehabilitation and reintegration into the community. Section 85 explicitly includes mental health problems and disorders in its definition of health care. Section 86 (1) states “The Service will provide every inmate with (a) essential health care” which includes mental health care as per Section 85 and “(b) reasonable access to non-essential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration into the community”. Under Section 86 “The provision of health care under subsection (1) shall conform to professionally accepted standards.” Finally, Section 87 states that “The Service shall take into consideration an offender’s state of health and health care needs (a) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters and (b) in the preparation of the offender for release and supervision of the offender.”

The CCRA states that CSC must provide reasonable access to mental health services consistent with professionally accepted standards.

It is important to note that health services including mental health care for federal offenders are not covered by the *Canada Health Act*, Health Canada

or provincial/territorial health services. This leaves the total responsibility for the mental health care of institutionally and community based offenders to the Service.

CSC's 'Mental Health Strategy': Planning and Accountability

Conceptually the Planning is Excellent

Research and policy development have been strengths of CSC for decades, earning Canada a strong international reputation in this area. The Service's 'Mental Health Strategy', as referred to in a number of documents, is conceptually sound. It covers the basic components of a comprehensive continuum of care from entry into an institution to warrant expiry. Much of the content of the strategy is drawn from *Enhancing Mental Health Services for Federal Offenders* parts 1 and 2 of the Final Report of the National Review Committee for the Treatment Centres (Correctional Service of Canada, 2005a). The Committee's report went well beyond an analysis of the regional treatment centres (RTC's) to address issues across the continuum of mental health care. A second report entitled *A Roadmap to Strengthening Public Safety* (Correctional Service of Canada, 2007a) drew from and supported the National Review Committee's recommendations. The Roadmap is of particular interest as it forms the basis for the Service's current 'Transformation Agenda'.

Research and policy development have been strengths of CSC for decades, earning Canada a strong international reputation in this area.

'Draft: For Internal Use Only'

In spite of the Service's excellent policy work, a serious problem is the lack of an approved document delineating the CSC's 'Mental Health Strategy'. Many of the key policy documents supplied to the OCI by the Service for this review were marked "Draft - Not for Circulation", and often no author or accountable staff person or position was identified nor was a signature present to indicate official approval. Examples include, but were not limited to:

Many of the key policy documents supplied to the OCI for this review were marked Draft-Not for Circulation.

1. *Enhancing Mental Health Services for Federal Offenders: Correctional Service of Canada's Mental Health Strategy: Part 1 of the Final Report of the National Review Committee for the Treatment Centres.* (Correctional Service of Canada, 2005a). Original Report: May 17, 2004; Revised December, 2005. Draft - Not for Circulation.

2. *Enhancing Mental Health Services for Federal Offenders: Background Documents for the Intermediate Care Units and Intensive Care Treatment Centres: Part 2 of the Final Report of the National Review Committee for the Treatment Centres.* (Correctional Service of Canada, 2005a). Original Report: May 17, 2004; Revised December, 2005. Draft – Not for Circulation.
3. *Strengthening Community Safety Initiatives: CSC’s Community Mental Health Strategy. Results-based Management and Accountability Framework.* Draft For Discussion Purposes. (Correctional Service of Canada, 2007b). [No signature page; It contained track changes]
4. *Enhancement of CSC’s Mental Health Strategy: Results-based Management and Accountability Framework.* (Correctional Service of Canada, undated). [Draft, No signature page or date]
5. *Intermediate Care Mental Health Units: Description.* (Laishes, 2005) Draft – for discussion purposes only.
6. *Institutional Mental Health Initiatives.* (Correctional Service of Canada, undated). [No author or date]

The combination of these factors (draft documents, undated documents, no identified author, authority or administrative position, no evidence of official approval) made the review of the implementation of the strategy difficult. There is no officially sanctioned comprehensive mental health strategy against which to assess the effectiveness of planning and implementation. As a result, the OCI was careful to receive verification from NHQ staff that the correct and most up-to-date documents available were being used in this review.

No Official Comprehensive Mental Health Plan

Effective planning models include components such as a logic model containing a description of need; a work plan with goals, objectives, targets, timetables and those accountable; a business plan which ties resources to activities; and an evaluation plan, both formative and summative. Planning is often multi-year thereby allowing for managed growth and change over time (Treasury Board of Canada, 2008, 2005a, 2002). An official plan or strategy also includes approval from the most senior accountable official in the organization.

Treasury Board (2008) suggests *The Life Cycle Approach to Managing Results* (Figure 1) is a useful planning tool based within Results-based Management and Accountability Frameworks (RMAF). The Life Cycle model calls for a staged process for planning, implementing, measuring and reporting on results. RMAF's will be discussed in more detail below.

While there is no official comprehensive planning document for the 'Mental Health Strategy', there are a number of draft documents, as mentioned above, and an edition of *Let's Talk* (the Service's corporate magazine) that describe the intended plan (Correctional Service of Canada, 2004a). Some documents shared with the OCI had track changes editing still in place which suggests that the drafts themselves were not complete. Many of these documents have been in draft form for several years despite CSC having received funding to begin implementing parts of the 'Strategy'.

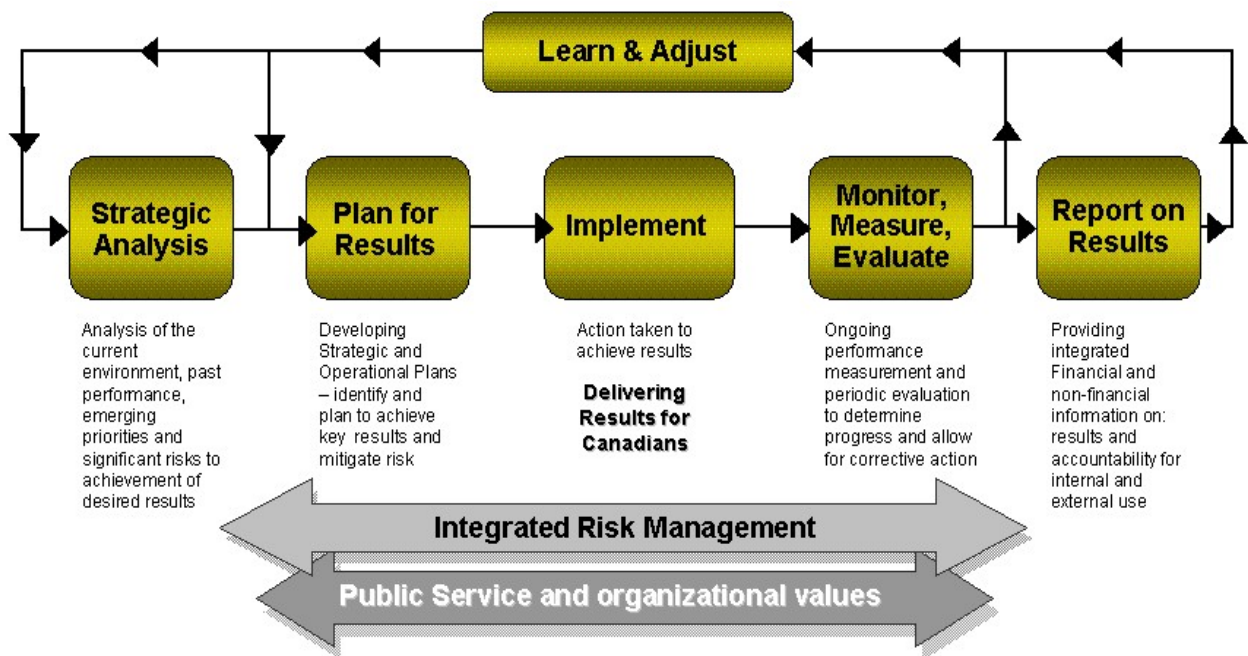
...there is no official comprehensive planning document for the 'Mental Health Strategy'...

The Service informed the OCI that the draft RMAF entitled *Strengthening Community Safety Initiatives: CSC's Community Mental Health Strategy* (Correctional Service of Canada, 2007b) was in fact an approved copy. The document was resent by CSC to the OCI with the word "draft" removed. However, the document still contained track changes, suggesting it was not yet finalized.

It is worth noting that some NHQ staff members were themselves surprised to discover that no overarching official planning or strategy document exists. In its absence, the Service recommended the use of a PowerPoint presentation entitled *OCI Presentation: Follow-up Actions on the Mental Health Strategy* (Correctional Service of Canada, 2005c), as the document that would best describe the 'Strategy' for the purposes of this review.

The deleterious effects of the lack of an approved comprehensive plan are serious. There is no overarching and long-term implementation strategy containing milestones, deliverables, dates and required resources matched to indices of need. There is no overarching business plan that links financial and human resources to implementation. Accountability for ensuring completion is not clear since no one individual or staff position is identified as ultimately responsible for progress. There is no comprehensive evaluation framework that contains pre-implementation benchmarks, annual progress markers, a reporting schedule and an examination of the plan's efficacy at regular intervals. There is no linkage strategy to ensure that the various components of the strategy work efficiently one with another.

Figure 1. The Lifecycle Approach to Managing for Results



Source: Treasury Board of Canada (2008).

This leaves the organization without a final and authorized touchstone reference point to refer to and to plan from thereby increasing risk, including the risk of program drift and clinical liability. The lack of clarity leaves little accountability for those responsible for implementing the strategy. There is no macro implementation/business plan outlining the next steps and the resources needed to meet them. Only one of the dozens of employees contacted during this review reported having seen the 'official' plan in its final form.³ According to some stakeholder organizations outside of CSC, the 'Strategy', such as it is, was not widely shared to gather comments and gain support.

Many employees with direct-line responsibilities and those with decision making authority reported that they were somewhat aware or not aware of the details of a mental health strategy. However, they all knew of the funding for new positions. Effective organizational buy-in and commitment to any plan or strategy requires informed and engaged staff at all levels of the organization. This appears to be missing, in no small measure due to a failure to follow accepted planning and implementation procedures.

³ The staff member was likely referring to an excellent overview article of the 'Mental Health Strategy' that appeared in *Lets Talk*, the Service's in-house magazine (Correctional Service of Canada, 2004).

In the absence of a comprehensive overarching planning document, specific implementation plans for component services across the continuum of care nested within the overarching plan were not available except the draft documents such as the RMAF entitled *Strengthening Community Safety Initiatives* (Correctional Service of Canada, 2007b). These secondary planning documents would contain the same information as discussed above as well as a clear delineation of roles and responsibilities, lines of authority (administrative and clinical), service guidelines and operational linkages to other components on the continuum of mental health care and to outside agencies (Livingston, 2009; Correctional Service of Canada, 2007a; Standing Senate Committee on Social Affairs, Science and Technology, 2006).

In the absence of an overarching planning document, specific implementation plans for component services nested within the overarching plan were not available...

The importance of component specific plans cannot be overstated. National Headquarters staff indicated that some of this work is in development post-hoc. For example, an RMAF for the Institutional Mental Health Initiative is expected to be completed in 2010/2011, even though the program is currently operating. The Service's 'Mental Health Strategy' was launched six years ago and funding was received for some components in 2005 (Community Mental Health Initiative), 2007 (Institutional Mental Health Initiative) and 2008 (Institutional Mental Health Initiative). There has been ample time to develop the requisite planning, implementation and evaluation tools in anticipation of funding and to set out a business plan requesting funding from each federal budget over a prescribed time frame.

Confusion in Program Accountability and Integrity

One way to evaluate the planning process is to review Results-based Management and Accountability Frameworks. RMAF's are management tools designed to help measure progress in attaining results from policies, programs and initiatives so improvements can be made to provide 'Results for Canadians' (Treasury Board of Canada, 2002). The Service developed two draft RMAFs as per Treasury Board guidelines (Treasury Board of Canada, 2008) for the funds received from the Federal Government to implement parts of the 'Mental Health Strategy'.

The draft document entitled *Enhancement of CSC's Mental Health Strategy: Results-based Management and Accountability Framework* (Correctional Service of Canada, undated) describes an initiative to ".....strengthen both the institutional and community mental health services to better prepare mentally disordered offenders for release and provide maintenance and

support services to offenders conditionally released to the community.” As the title suggests, the document includes portions of both institutionally-based and community mental health services while a second draft RMAF entitled *Strengthening Community Safety Initiatives: CSC’s Community Mental Health Strategy* (Correctional Service of Canada, 2007b) applies to community mental health services. The two documents cover some of the same ground yet are not effectively linked and neither meaningfully references a national mental health plan or strategy nor connects to the other constituent components of the continuum of care.

Enhancement of CSC’s Mental Health Strategy (Correctional Service of Canada, undated) deals with institutional mental health services from a psychiatric, nursing and clinical social work perspective, all of which are very important. The anomaly is that it does not include psychology, a significant component of the institutional service provision system. One explanation may be CSC’s organizational structure that places psychology and the regional treatment centres (RTC) within Institutional Operations and the other aspects of mental health within Health Services. Another is the ineffective link between the administrative and clinical areas within National Headquarters demonstrating a troubling lack of integration and coherence between policy, operations and evaluation related to clinical activities in general. These issues will be explored later under Governance.

The intake/screening/assessment component known as the Computerized Mental Health Intake Screening System (CoMHISS) received funding in 2007 under the Institutional Mental Health Initiative. The Service was not able to provide an RMAF for CoMHISS nor is CoMHISS included in the draft *Enhancement of CSC’s Mental Health Strategy* RMAF (Correctional Service of Canada, undated) that deals with institutional mental health services. Perhaps CoMHISS will be included in the Institutional Mental Health Initiative RMAF currently being developed.

Correctional Service of Canada Community Mental Health Initiative: Clinical Discharge Planning and Community Integrations Service Guidelines (Champagne and Felizardo, 2008) sets forth in detail an implementation plan for community based services. Unfortunately this document is not effectively linked to the ‘Mental Health Strategy’ nor is it integrated with CSC’s community mental health strategy RMAF (Correctional Service of Canada, 2007b) and other official documents that outline the community initiative. This is another example of excellent policy work within CSC that is not well integrated with mental health policy and operations.

The National Essential Health Services Framework (Correctional Services of Canada, 2009b) states that the Framework “.....is an important mechanism for promoting the quality and consistency in health services across the country, and allows CSC to make decisions based on monitoring and analyzing the effectiveness and efficiency of essential health services.” Essential health services are defined in the *CCRA* and in Commissioner’s Directive 800 (Correctional Service of Canada, 2008b) as including mental health care. The *Framework* document states that mental health and public health will be issues to be addressed in phase two. No rationale is given for this decision. Mental health services are already being implemented within institutions and in the community. This is neither acknowledged nor discussed. Not only is the *Framework* not integrated with the ‘Mental Health Strategy’, such as it is, it weakens the links between physical and mental health needs of offenders.

From a mental health perspective, the *Framework* seems orphaned from a consistent documented approach to mental health planning, implementation and evaluation. The Framework comes from Health Services and refers to mental health which includes psychology and the RTC’S, important mental health team members. Both currently report through Institutional Operations. It is difficult to understand how one part of an organization (Health Services) can make important decisions for another part of the organization (Institutional Operations) without a matrix or network governance mechanism in place. The organizational chart in Figure 4 (p. 43) does not show a relationship between the higher levels of the organization. On the other hand, it is equally puzzling to think that Health Services planning may not always include psychology or the regional treatment centres, both of which fall under Institutional Operations. This is another example of a confusing organizational structure which will be discussed in more detail below under Governance.

Funding is Welcome Yet Slow in Coming

CSC has received funding over the past several years for most of the pieces of the Service’s continuum of mental health care. All but intermediate care has received some funding since 2005. For instance, the Community Mental Health Initiative received \$29 million over five years in 2005 and the Institutional Mental Health Initiative received \$21.5 million over two years in 2007/08 and an additional \$16.6 million in permanent ongoing funding. These increases have resulted in the development of CoMHISS, the Mobile Interdisciplinary Treatment Assessment and Consultation Team, clinical discharge planning, improved community based services, increased staff training and more institutionally based staff in primary care. These are

important funding increases that will show improvements in service delivery over the short and long-term.

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The problem is that it is difficult to know what CSC sees as the needed complement of services to meet current and future needs. Clearly the present level of programming does not adequately address inmates' needs across the continuum of care. The lack of a long-term and well articulated plan does not give the government a staged multi-year funding program outlining annual increases across all of the components of the continuum to enable a smooth transition to a full level of services in the near future. An annually stepped long-term funding program would give Treasury Board and the government the information they need to support a multi-year funding strategy with annual increases across the entire continuum of care to address the mental health services deficits.

The lack of a staged funding program does not bode well for an important and ambitious project such as a mental health strategy in a large and complex organization like CSC. It was stated by several senior staff members that the Service wanted to implement changes slowly in order to have the capacity to implement effectively and to discover what works and what doesn't before going forward.

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This rationale sounds reasonable on the surface. However, mental health services within and outside of CSC have been operating for decades. There are ample Canadian and international models to draw upon from within and outside of corrections. Going slowly is not a preferred option. Going at a reasonable pace with annual increases in services across the continuum of care is what is required. For example, the need for intermediate care is not in question and should be implemented as soon as possible. It is currently in the initial planning stages and only one pilot project for offenders who repeatedly self-harm is being considered for funding.

The result of the current funding pattern is the development of services in one area and not in another (e.g. in primary care and not in intermediate care) thereby putting more pressure on the funded areas to 'take up the slack' and reducing their efficiency in dealing with their respective responsibilities. Funding is delayed to such an extent that, at this pace, it

could easily take decades to fully implement the 'Strategy' across the continuum of care. This is not an unreasonable estimate based on the progress to date. This timeline is unacceptable based on CSC's legislative obligations under the CCRA and the already identified and growing mental health needs of the offender population.

The Federal Government demands significant planning and accountability from non-government groups who receive grants and contributions (Treasury Board of Canada, 2000). Money is not advanced until a comprehensive plan is provided including a logic model, work plan, business plan/budget, evaluation plan and sustainability plan. Regular reporting is required to demonstrate progress and to ensure accountability. Funds can be withheld for non compliance or failure to meet requirements and timelines.

In this case, significant funds were advanced to CSC on the basis of much less detailed planning and reporting accountability than that generally demanded of the public. As demonstrated above, the Service was not required by Treasury Board to provide an officially approved overarching and comprehensive multi-year mental health plan and specific plans for each of the components of the continuum of care. In addition, the evaluation of the Institutional Mental Health Strategy is scheduled for 2011/2012 suggesting the program was funded without an evaluation plan and that there will be no annual evaluations to help with course correction as the program develops.

At least three CSC senior staff members stated that the government decided to fund a part of the community component of the strategy on very short notice (e.g. a matter of a few weeks). This makes planning and accountability very difficult and increases program risk.

Within the broader Canadian context, mental health needs have taken a 'back seat' to physical health and other concerns (Commission on the Future of Health Care in Canada, 2002; Standing Senate Committee on Social Affairs, Science and Technology, 2006). This lack of commitment to the essential and immutable importance of addressing mental health leads many to place mental health lower on the priority list thereby wittingly or unwittingly demanding and accepting less than satisfactory funding decisions. There are obviously many important needs within CSC and society, however, mental

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health is among the most urgently in need of immediate and continued action as a result of longstanding neglect.

From an examination of some of the responses of the Service to funding for mental health, it is easy to conclude that mental health, although a priority, may not be as important as other parts of the Service. For example, Recommendation 8 of the 2007/2008 Annual Report of the Office of the Correctional Investigator (2007, p. 64) states "I recommend that the Minister make securing adequate and permanent funding for intermediate mental health care a key portfolio priority". CSC, responding on behalf of the Minister, ignored the fact that no money was made available for intermediate care and stated that the additional money supplied by the government ".....will assist CSC to improve both the continuum of mental health care as well as the correctional results for offenders with mental disorders...". This response does not address the Correctional Investigator's concern regarding a complete lack of funding for intermediate care and it could suggest to the reader that the allocated funding will include intermediate care since it is part of the continuum of care. Not funding intermediate care is akin to being satisfied with supplying weapons to every fifth soldier.

An expanded analogy to the military is perhaps appropriate at this point. The Canadian Forces were in need of significant funding increases to address serious structural and human resource problems that had arisen over a number of decades. CSC is in the same situation. Significant funding increases are needed now to bring mental health up to professional and modern day standards.

A realistic, long-term and comprehensive mental health implementation strategy is needed that will assertively, convincingly and repetitively present solutions to the government to secure the needed resources annually over a multi-year planning cycle. The implementation plan needs to be CSC's number one issue to resolve. Without this commitment, the government will not act. Mental health has the same priority within government as it does in the larger community and there are many competing interests. Although attitudes are changing in Canada, without vigorous action on the part of CSC, the Service's mental health needs will not be adequately addressed for decades. CSC needs to become a strong champion for mental health within government. While the funding received for the current improvements is a welcome start, it falls short.

CSC's 'Mental Health Strategy': Implementation

Intake/Screening/Assessment: CoMHISS Comes On-Line

The Computerized Mental Health Intake Screening System (CoMHISS) is a specialized mental health screening tool involving the administration of psychological tests to consenting offenders as they enter the system. It is designed to support the clinical screening and assessment function, provide information for the correctional plan, help identify offenders at risk and provide standardized data for planning and evaluation. This is an important step. The data will be very useful in addressing offender needs and planning the comprehensive mental health continuum of care.

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The implementation of enhanced system wide screening will help the Service meet minimum standards (Livingston, 2009; Ogloff et al, 2007; Correctional Service of Canada, 2007a; Standing Senate Committee on Social Affairs, Science and Technology, 2006). The intake system combines the administration and interpretation of psychological tests with initial screening interviews with a nurse and a mental health staff person in the first days of admission to a reception centre to assess danger to self or others or a severe disorder. In addition, a relationship is established with the inmate that provides the assessment team with the opportunity to place the computerized assessment data in the broader context of the individual. Inmates that have mental health problems or disorders are seen for follow up assessment and/or treatment. Background information is gathered from a number of sources.

Discussions with staff demonstrate they have added services around the computer based assessment tool that match a comprehensive approach expected of professional mental health staff (Livingston, 2009; Ogloff, 2002). This is a good example of the positive effect of engaging regulated health professionals who are required to practice within best practices boundaries by their regulatory bodies.

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CoMHISS is taking a long time to implement. The OCI was given repeated assurances over a number of years (2005, April 2008 & March 2009) that full

deployment was imminent. NHQ staff indicated the pilot was to be completed in October/November of 2009 with national deployment to follow. The OCI is not aware of a detailed deployment or implementation plan for CoMHISS. Some key personnel involved in the pilot were not hired until April, 2009. Certainly the development of a computer based assessment system can be time consuming. However, this seems to have been a protracted process, missing several self-imposed deadlines. The new staff could have been hired before the arrival of the computer based programs to undertake screening, to carry out clinical intake duties and to help prepare the administrative, clinical and accountability architectures which are being developed post facto.

Some CSC regions have centralized intake systems while others do not. The OCI is also not aware of an implementation plan for CoMHISS that addresses uniformity of implementation in terms of program fidelity and human resources and which takes into account unique regional challenges. For example, the sole reception centre in the Ontario Region has one psychologist dedicated to CoMHISS. If there are not adequate numbers of regulated mental health specialists to supervise the intake process and to conduct in-depth assessments as required due to vacations, illness or job vacancies, the Service will not meet minimum standards and will increase risk and clinical liability.

It is at intake that a mental health clinical management plan for each inmate requiring mental health services is first developed. Other reports have called upon CSC to develop this tool and to integrate it with each offender's correctional plan (Livingston, 2009; Correctional Service of Canada, 2007a; Standing Senate Committee on Social Affairs, Science and Technology, 2006). The OCI requested a copy of a clinical management plan and was told that currently there is no standard template in use and that guidelines are being developed. Since regulated health professionals are required to keep up-to-date clinical records and treatment plans for all their patients, the necessary information is available from these service providers. It ought to be available from non regulated providers since they should also be keeping appropriate contact information, with clinical oversight by a regulated mental health professional.

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The clinical management plan would contain important information for the circle of mental health support or care in CSC and would inform the correctional plan and those responsible for carrying it out. The circle of care under the *Personal Information Protection and Electronic Documents Act* and

other privacy legislation allows for the sharing of necessary clinical information but not personal details among those involved in the care of the patient (circle of care). The clinical management plan is not the clinical file. It is a distillation of pertinent clinical information. It will not betray confidentiality and a patient's right to privacy. The plan would follow the offender throughout their time under warrant and be updated as needed. The Service needs to address this issue through a Commissioner's Directive that outlines what is to be shared within the circle of care in a clinical management plan. Since, as stated above, the information already exists, it is likely a matter of developing guidelines allowing appropriate information sharing in a manner that serves the needs of inmates and staff and that does not burden providers with extra paperwork. One issue is the electronic compatibility between the Offender Management System (OMS), CoMHISS and other platforms.

The information gathered through the intake process will be an important source of data for program planning and evaluation in addition to its clinical functions. However, a significant number of offenders will not be identified at intake but later through primary care or community services. This demonstrates the importance of an information technology platform that provides a seamless integration of CoMHISS, the Offender Management System and data in other platforms linking the components of the continuum of care. It is akin to developing an electronic health record as is being done in health systems. In fact, CSC has been attempting to develop an electronic record system for years and has invested significant funding to this end. To date, the investment has not yielded substantial progress and the system itself will take many more years to become a reality.

One minimal standard by which to assess an intake service is the effectiveness of the referral process. The CSC mental health related documents reviewed do not mention this issue in detail. Referrals are made between intake, primary care, RTC's and community care. Measuring the effectiveness of these transfers and the information shared is important in determining the effectiveness of the mental health system (Livingston, 2009). For example, are those referred seen in a timely fashion by the appropriate provider? This issue will be addressed below under Inter-Service Connectivity.

It is important for the Service to make the CoMHISS data and the results of its evaluation available to internal and external stakeholders to ensure that the data collected is of maximum utility at the clinical, program planning and evaluation levels. Making the data available and transparent will allow people to know if offender mental health needs are being met and how CoMHISS

can be improved. Otherwise, CoMHISS will not reach its potential. This principle of data sharing is important across the Service's mental health activities.

Primary Care: The Platform for Comprehensive Mental Health Care

Primary care "...focuses on health care services including health promotion, illness and injury prevention and the diagnosis and treatment of illness and injury." (Health Canada, 2006). It "...refers to mental health services directly available to offenders in correctional institutions." (Correctional Service of Canada, 2005a, p. 12). When problems arise, offenders should be seen by a primary care provider to assess/diagnose the problem and to provide the first level of treatment. Primary care also supports patients with chronic mental disorders or with physical illnesses and conditions with psychological complications.

The majority of inmates should receive most of their mental health services through primary care. It must be a readily accessible service to inmates and primary mental health care professionals should provide consultation support to correctional and institutional parole officers. Specialized services such as intermediate and tertiary care depend heavily on a strong primary care system to handle the majority of patient needs. This is also true of systems outside of CSC.

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The Service received funding in 2007 to increase the staff complement for primary care in the institutions. This is certainly an important step in the right direction that has been recommended by other reports (Correctional Service of Canada, 2007a, 2005a; Standing Senate Committee on Social Affairs, Science and Technology, 2006).

As noted above, there was no available detailed primary care implementation plan contained within a comprehensive mental health strategy. Without this information it is difficult to know what the necessary staff and program complement is in relationship to defined patient needs. Several factors are important to consider including the lack of intermediate care which puts more strain on primary care and the prevalence, incidence and severity of mental health problems and disorders by level of security and institution.

The increases in front-line resources are needed and welcome. They have the potential of making an important difference because more inmates should have the opportunity to access primary mental health care. On the other hand, these resources are in all likelihood not yet at professional standards

(Correctional Service of Canada, 2007a). This is particularly true in the absence of intermediate care.

The current institutional mental health staff complement issue is even more complicated by the split role of psychology and the housing of psychology and psychiatry in different administrative sections. Some staff members estimated that the majority of a psychologist's time in the institutions is involved in risk assessments for the Parole Board and crisis intervention with the remainder in primary care. This creates a staffing and clinical accountability problem for primary care (Standing Senate Committee on Social Affairs, Science and Technology, 2006). It is clear from discussions with CSC staff that psychology positions are considered part of the primary care staff complement on a full-time equivalent basis.

The current institutional mental health staff complement issue is...complicated by the split role of psychology and the housing of psychology and psychiatry in different administrative sections.

Some staff reported administrative impediments to effective collaboration between psychiatry and psychology. In some institutions this is apparently based on the fact that psychiatry administratively reports to Health Services while psychology reports to Institutional Operations. It was reported that this can result in difficulties in sharing basic clinical information, an inability to access files and reduced opportunities for consultation and interprofessional team based practice.

The Service received funding for primary care and indicated that they began recruiting immediately. CSC senior staff stated it was not possible to attract an adequate number of psychologists to fill the positions, and, as a result, reported filling more positions with other professionals such as nurses and behaviour technologists. Since each profession brings a different knowledge and skill set to the team, it is problematic to reduce the complement of one profession as this will significantly impact the levels and quality of available services and clinical accountability.

The move to interdisciplinary practice is becoming the norm in health care generally as well as in corrections. What is problematic is the fact that psychology positions were filled with non psychologists without a well articulated plan based on inmate needs and guidelines delineating administrative and clinical accountability, roles, functions and scopes of practice and what appears to be less than sufficient consultation with line staff. It is essential to build interdisciplinary teams with the mix of

professionals who have the knowledge, competencies and skill sets to deal with mild, moderate and highly complex cases. It requires a comprehensive plan which includes the co-ordination of both psychological and pharmacological interventions.

Correctional Officers and Institutional Parole Officers play an important and ongoing role that relates directly to mental health and as such they need to be better aligned with the primary care mental health team (Josi & Sechrest, 2005; O'Toole, 2005; Correctional Service of Canada, 2004b). Officers have the most contact with inmates and the manner in which they relate to offenders influences inmate behaviour. The mental health strategy needs to address the contribution of these two important roles, an issue explored in more detail under Human Resources.

Often mental health problems and disorders are not identified at intake. There are a number of reasons for this including self-stigma, sub-clinical levels at intake and the impact of prison life. The Service needs to ensure that a clearly defined process to expeditiously identify, assess and treat inmates who develop problems while in the general prison population is in place and working effectively. CSC employees indicated that all too often inmates were not identified in a timely fashion and their access to primary care services could be impeded by operational and security issues. The lion's share of this secondary identification will occur through primary care again underlining the need for adequate resources with the right professional mix. This reiterates the importance of integrating this new patient data with the CoMHISS and OMS data systems for use by the circle of care.

Intermediate Care: A Great Idea in Waiting

Intermediate care is the bridge between primary and tertiary care. It is intended to assist inmates who are

“...unable to cope on regular institutional ranges, and, in order to manage, they may require both a specialized environment and specialized services and interventions. The Intermediate Care Mental Health Units would assist mentally disordered inmates to better follow their correctional plans, remain out of segregation, lessen the likelihood of their experiencing emotional crises which lead to emergency transfers to the treatment centres, and to cascade to lower levels of security or reintegration into the community.” (Correctional Service of Canada, 2005a, p. 13).

The absence of this important component of the continuum of care puts increased pressure on already overstretched primary care services and the RTC's and renders the Service less able to meet the CCRA requirement to provide "essential health services" and "reasonable access to non-essential mental health care".

According to CSC staff, segregation and segregation-like units have become de facto intermediate care services. Offenders are often isolated for long periods of time without mental health interventions unless it is on an ad hoc basis. There is no evidence to support the long-term use of segregation as an effective substitute for intermediate or tertiary care nor has it been identified as a best practice for this group of patients.

According to CSC staff, segregation and segregation-like units have become de facto intermediate care services.

Inmates who need intermediate care have by definition complicated situations and serious problems. They need a team approach using best practices (Ogloff, 2002) which will have the benefits of providing necessary services to inmates, reducing their disruptiveness in the institution (Silver et al, 2008) and better preparing them for transition to community life (Correctional Service of Canada, 2007a).

Three models of intermediate care came to light during the review. The 'hub solution' (building or designating a part of one facility to serve several institutions), the 'outreach solution' (an interdisciplinary team of intermediate care specialists providing services to several institutions) and the 'in-house solution' (each institution provides intermediate care through an increase in their staff complement).

OCI has been informed that the detailed planning for intermediate care is underway. It needs to be completed quickly with adequate input from both the administrative and clinical streams. The plan should include program guidelines, clinical and administrative accountability, staff roles, functions and scopes of practice, adequate human resources based on need, etc. The Service has a sound policy basis form which to begin (e.g. Laishes, 2005). The plan needs to be completed as soon as possible in order to facilitate the receipt of funding from the government.

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Intermediate care has been strongly recommended for immediate implementation (Correctional Service Canada, 2005a) and yet planning

remains incomplete and funding has not been secured. Some staff indicated that intermediate care was left to later because the CSC staff members that were consulted were of the opinion that intermediate care was less of a priority in the event the Service received partial funding from the Government. Others were reportedly of the opinion that the Service wanted to start with some initial changes and to evaluate them before taking on the development of a new program. Others said it was too expensive to implement. Another explanation was the Service had not developed an intermediate care model in spite of a strong policy basis to work from.

These and other arguments are administrative in nature. From a clinical perspective, it is essential to move forward simultaneously across the continuum of care, so a balance of services is available and so other continuum components do not have to 'pick up the slack' and become overburdened. This is akin to aligning a car's tires without balancing them. The result is preventable tire damage.

Tertiary Care: The Regional Treatment Centres

The five regional treatment centres are psychiatric hospitals that provide high quality inpatient mental health services, training opportunities and contribute to important research. The role of the RTCs is to provide specialized services and inpatient care of a time limited nature to offenders with acute mental disorders. The expectation is that inmates will return to intermediate care or primary care in their parent institutions for longer term follow-up.

Unlike the situation in primary care, staffing and program patterns seem to more closely align with expected standards. However, reports have urged CSC to make important changes including the decommissioning of several facilities, increasing bed capacity, increasing staff complements and enhancing the therapeutic role of correctional officers (Correctional Service of Canada 2005a, 2007a). One report identified the "...inadequate resourcing of treatment centres, which has led to a deterioration in treatment centres' ability to provide a full spectrum of professional mental health care" (Correctional Service of Canada, 2007a, p. 96). Discussions with treatment centre staff suggest that there has been little movement to address these important areas.

... "inadequate resourcing of treatment centres, which has led to a deterioration in treatment centres' ability to provide a full spectrum of professional mental health care" (Correctional Service of Canada, 2007a, p. 96).

The RTC in the Atlantic Region reports not having the physical facilities to admit inmates

from maximum security institutions. This issue is compounded by the absence of intermediate care services and overstretched primary care services in home institutions in the region. As a result, these inmates do not receive the mental health services that they need let alone meeting the requirements set by the CCRA.

Internal reports have stated that the RTC's require a detailed renewal plan (Correctional Service of Canada, 2007a) based on an assessment of need and the recommendations of the National Review Committee for the Treatment Centres (Correctional Service of Canada, 2005a). Currently numbers of beds and therefore treatment availability is governed in no small measure by the capacity and physical infrastructure limitations of the facilities, not by the needs of the population in the region. In 2010, there is a physical capacity of about 666 beds in the five RTCs, inclusive of women offenders. The OCI estimates that the actual rated capacity of RTC beds is about half of what is required.

The National Review Committee recommended a change in security staffing for treatment centres suggesting that correctional officers be included as part of the treatment team. The Committee called for more extensive mental health training that would allow officers to adopt increased behaviour management, relationship management and treatment roles. The role change would improve the therapeutic potential of the RTCs' while helping to resolve the ongoing security/treatment conundrum. This idea of an expanded role for correctional officers will be discussed later under Human Resources.

The National Review Committee recommended a change in security staffing for treatment centres (Correctional Service of Canada, 2005a) suggesting that correctional officers be included on the treatment team.

The Committee recommended that offenders in CSC's community programs be admitted directly to RTCs when in need of inpatient services unavailable in the community, thereby bypassing the unnecessary step of incarceration in a home institution with a subsequent referral from the institution to the RTC. Once stabilized in the RTC, offenders could be released directly back to their community parole offices, again bypassing an unnecessary stop in their home institution (Correctional Service of Canada, 2005a). In this way, mental disorders can be managed through a clinical/therapeutic approach as opposed to an incarceration/security approach. Services would be accessed directly, thereby improving cost effectiveness and efficiency. There was no evidence that this recommendation is under consideration at this time.

Another interesting Committee recommendation (Correctional Service of Canada, 2005a) encouraged increasing funding to the RTCs to enhance their capacity to be the mental health training centres for their regions. Human resources could be drawn from the RTC and other institutions.

Community Care While Under Warrant

The Service has implemented a Community Mental Health Initiative⁴ (CMHI) (Correctional Service of Canada, 2007b) to augment its ability to address the mental health needs of offenders once they leave an institution while under warrant. The CMHI provides services designed to help offenders adjust to life in the community thereby reducing reoffending. CSC estimates 26% of offenders living in community correctional facilities have mental health problems and disorders while 23% take psychotropic medication (Correctional Service of Canada, 2004d). Research shows that the adjustment to community life can be difficult for offenders with mental disorders resulting in reoffending due to a lack of adequate services (Ogloff, 2002).

The added services provided by this new initiative are welcome as they show progress in an important area. During this review, parole office staff reported satisfaction with the program and recommended its expansion. Staff working in the program indicated that they were pleased with its implementation. They reported providing counselling and support to offenders and their families, making referrals for further evaluation and securing appropriate CSC and community based services.

The added services provided by the CMHI are welcome as they show progress in an important area.

At the same time, it is clear that more needs to be done. Not all parole sites have additional mental health support. Staff in some centres that received new staff indicated that the numbers were not yet adequate to address the need. CSC must develop as part of the 'Mental Health Strategy' a plan to expand the program to provide adequate levels of service based on offender need, professional standards, best practices and equitable and sufficient distribution across the country.

Equivalence of care (Correctional Service of Canada, 1994b) is a minimum standard that ensures "Probationers and parolees have access to the same level and standard of care as is available to individuals in the

⁴ "It should be noted that the Community Mental Health Initiative has also been referred to as the 'Substantive Support Initiative' and the 'Community Mental Health Strategy' in CSC documents." (Correctional Service of Canada, 2007b, p. 5).

community who are not involved with the criminal justice system.” It appears from document reviews and discussions with staff that the CSC’s community based services do not meet this standard due to a lack of resources. Interviews with CSC staff support the findings of reports that highlighted these issues (Correctional Service of Canada, 2007a).

Stigma and an undersupply of mental health professionals across Canada make securing access to non CSC professionals and programs even more difficult. Creative agreements with municipal, provincial and territorial governments have been identified as issues that need to be addressed to increase access while maximizing effective transition and the cost/benefit equation (Correctional Service of Canada, 2007a, 2005a). Staff report that serious roadblocks exist. For example, family physicians are in short supply. Often they do not want to add offenders to their practices. Some non CSC community based mental health programs and services will not accept referrals except from physicians. As a result, the offender can be left in limbo. Leaving an institution with a two-week supply of medications provides a small window within which to secure non CSC community-based mental health services (Correctional Service of Canada, 2007a). In addition, more than one CSC staff member strongly recommended an increase in agreements with community-based agencies to provide more community residential services.

Stigma and an undersupply of mental health professionals across Canada make securing access to non CSC professionals and programs even more difficult.

It took a long time to implement the CMHI. Funds were first received in 2005 and front-line staff began to be hired up to three years later. One reason for the delay is the very lengthy staffing process within the Federal Government that had to be adhered to. This slow program implementation is similar to the difficulties experienced by CoMHISS. Unlike CoMHISS, however, there was no technical infrastructure to deploy. The delay likely speaks in part to the hiring practices in the federal government and human resource capacity issues in CSC.

It took a long time to implement CMHI. Money was first received in 2005 and staff began to be hired three years later.

More than any other component of a criminal justice mental health continuum of care, community based services depend on their links to institutions and to non CSC community services. Developing and managing these relationships is of critical importance and CSC staff, to their credit, do it well, often under difficult circumstances. There are administrative issues

that can be addressed to better facilitate this important activity. Some of these are discussed in the next section.

Inter-Service Connectivity: The Connective Tissue That Holds the System Together

The ease with which people and information move from one provider, service or component of the continuum of care to another is important to treatment outcomes and is an indicator of the effectiveness of planning and service integration (Livingston, 2009). For example, if a person has a serious problem, is there an appropriate service, is it accessible and does information move as quickly and effectively as needed?

A comprehensive continuum of mental health care that spans the country serving thousands of people has many critical connections that are an integral part of the service delivery system. These interfaces are a prominent part of the implementation of a mental health strategy and as such need to be planned for and evaluated like any other important aspect of the continuum of care. This 'connective tissue' makes the continuum a continuum, rather than a series of discrete and independent silos. The connecting pieces need national standards based on best practices supported by the necessary technological and human infrastructure required to do the job (Livingston, 2009).

Discussions with CSC staff indicate that connectivity between mental health service components varies by regions, institutions and individuals. Some variation is inevitable and even useful. However, in one region, an 'ambulatory'⁵ program sees nursing staff from the RTC regularly visiting home institutions and working as outreach members of that institution's interprofessional clinical team. In another, it was reported that patients often 'just show up on the doorstep' of their home institutions from the RTC without prior notice and/or information.

CSC staff reported a lack of treatment solutions for some of the system's most behaviourally disordered inmates. Some are denied admission to the RTC's and so are the responsibility of their maximum security level home institutions where there is no intermediate care and primary care services are not equipped by definition to handle this

CSC staff reported a lack of treatment solutions for some of the system's most behaviourally disorder inmates.These patients reportedly receive little treatment and are often placed in isolation...

⁵ CSC uses the term ambulatory to mean mental health professionals travel to provide services. The more common use of the term refers to the capacity of patients to go to the location where services are provided.

level of problem. These patients reportedly receive little treatment and are often placed in segregation as a security measure or for their own safety where they receive few if any mental health services. In a similar vein, staff report that inmates who improve while in the Special Handling Unit known as the 'SHU' are often refused admission to their region's RTC because of the security risk and the previous level of behavioural difficulty. These patients either stay at the SHU longer than needed or return to their maximum security home institutions where there is the same lack of appropriate services described above. Inmates at the SHU receive treatment through security barriers due to security risks and the inappropriate design of the building. The Service's 'Mental Health Strategy' needs to address explicitly the issue of the most behaviourally disturbed inmates and/or those with personality disorders who staff report are not receiving adequate services.

Correctional Officers and Institutional Parole Officers (IPO) are a key to success in terms of inter-service coordination. They can facilitate, hinder or block inmate access to services. What is striking is the lack of guidelines regarding IPO's frequency of contact with each offender on their caseload.⁶

Effective integration between IPO's and Community Parole Officers (CPO) was also reported as sometimes problematic when inmates are transferred from institutions to community settings.

Transitions to community care can be difficult for offenders in general and particularly those with mental health disorders. Smooth transitions are essential to effective outcomes (Livingston, 2009).

Transitions to community care can be difficult for offenders in general and particularly those with mental health disorders.

These transitions can be one of the weakest program components in correctional systems (Morris, Steadman & Veysey, 1997). For example, psychiatrists and psychiatric nurses report frustrations in transferring information to community parole services. Health professionals are accustomed to dealing directly with each other, not going through intermediaries. This is the case in the community. There also appear to be growing pains with the new institutional discharge planners as they develop their role.

⁶ Community Parole Officers have clear frequency of contact requirements. CSC staff indicated that some IPO's may rarely meet a particular inmate. Depending on the institution, it has been reported to the OCI on more than one occasion that it is not unusual for some inmates to see their IPO as little as 2 to 4 times per year. IPO caseloads often change frequently, thereby compromising continuity, relationship building and efficiency.

Security Trumps Treatment

As mentioned above, an ongoing issue for any penitentiary system is the balance between security, rehabilitation and treatment (Correctional Service of Canada, 2007a). For example, the Vision of CSC's Health Services states: *"Improved offender health that contributes to the safety of Canadians"* while the Mission states: *"We provide offenders with efficient, effective health services that encourage individual responsibility, promote healthy reintegration and contribute to safe communities"* (Correctional Service of Canada, 2008d). The wording of the Vision and Mission suggest that an inmate's health is important when it promotes the goals of safety, security and responsibility, implying that health is not important in and of itself.

CSC mental health staff members were clear that too often security issues impede or prevent offenders from accessing programs and treatment, often for days and weeks at a time. In fact, several staff unequivocally stated that the situation had deteriorated significantly over the past decade. The problem relates to both regular and unexpected security situations and the measures used to address them. Factors such as the belief that security is more important than treatment when accommodations could be made or demands that remove security staff from treatment areas thereby rendering them inaccessible were mentioned. The report of the Standing Senate Committee on Social Affairs, Science and Technology (2006) suggested CSC may have a bias towards incarceration and punishment over rehabilitation (Standing Senate Committee on Social Affairs, Science and Technology, 2006, 13.2.4).

Security and mental health treatment are not polar opposites. In fact, the latter can aid the former (Correctional Service of Canada, 2007a). The 'Mental Health Strategy' needs to address the security/treatment balance and CSC needs to provide operating procedures and oversight to resolve the issues. Without making access an integral component of the strategy, it is highly unlikely a satisfactory resolution will be found.

Security and mental health treatment are not polar opposites.

Governance

A New Structure for Mental Health

A number of the issues addressed above are related to matters of governance and accountability. The development of a separate Health Services Sector under the leadership of an Assistant Commissioner is an

important step, giving both health and mental health more visibility and accountability. CSC's focus on mental health at the top levels of the organization is an important and fundamental prerequisite for transformative change. The Assistant Commissioner for Health Services has functional responsibility for all mental health staff except psychology and the regional treatment centres who report to the Assistant Deputy Commissioner for Institutional Operations.

This is an opportune time for the Service to examine the governance issues specific to mental health in order to develop a governance structure that has clear lines of administrative and clinical authority and accountability. As discussed above, some of mental health is housed in Health Services and some in Institutional Operations. Currently it begs the question 'If many people are responsible, who is ultimately accountable?' In fact, it is important that the Service has identified the strengthening of clinical supervision and the implementation of a comprehensive quality improvement program as governance objectives under CSC's Health Transformation Agenda (Correctional Service of Canada, 2008d).

The RTCs and the clinical aspects of psychology at a minimum, if not all of psychology, need to move to Health Services. This follows customary organizational practices in the community where clinical activities do not fall under non-clinical operations. Without this change, many of the issues discussed above will likely continue to see less than satisfactory resolution. In the interim, a clear matrix or network governance agreement or memorandum of understanding should be in place between Health Services and Institutional Operations regarding mental health.

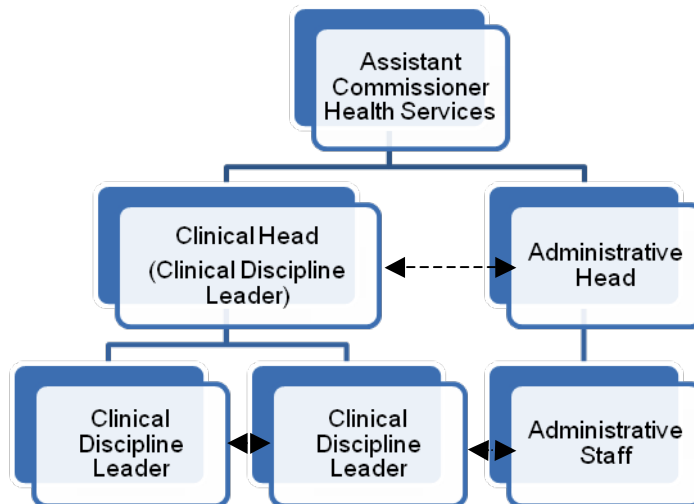
It is necessary to have powerful internal champions for mental health who are directly and ultimately accountable. This is true within and outside of the correctional world. Two very senior champions, an administrative head and a clinical head are needed, each reporting directly to the Assistant Commissioner for Health Services (See Figure 2). Professional standards as well as regulatory systems and provincial/territorial legislation place responsibility and accountability for clinical services in the hands of regulated health professionals. It is at this point that the administrative and clinical aspects of policy, planning, operations and evaluation meet.

It is necessary to have administratively powerful internal champions for mental health who are directly and ultimately accountable.

The regulated mental health disciplines need clearly identified national leadership positions with line authority and responsibility reporting to the

clinical head. Currently, for example, there is a Chief Psychologist with functional but no clinical line authority. The position seems to be increasingly marginalized in terms of clinical input into operations and planning at NHQ. This leads to a worrisome trend towards the 'bureaucratization' of clinical services and a growing divide between clinical and administrative activities as noted above. CSC staff reported a continued marginalization of the roles of clinicians in decision making that directly impacts clinical services. CSC staff and external stakeholder groups indicated that they have too little opportunity for meaningful input into the planning and implementation process. All this lends support for the organizational changes mentioned above.

Figure 2: Proposed Organizational Chart: Administrative and Clinical Accountability, National Headquarters



The clinical head would be drawn from the discipline leaders representing the regulated mental health professions. The term of office would be fixed, say three years, and rotated among the discipline leaders.

Currently the chain of clinical accountability can stop at Regional Headquarters, with, for example, the Regional Chief Psychologists reporting to non-clinicians. This is fine for administrative but not for clinical functions. The line of clinical accountability needs to flow directly from the regional chief for each discipline to the respective discipline's clinical leader or chief at NHQ (See Figure 3). The current organizational chart for the Institutional Mental Health Initiative is reproduced in Figure 4. Note the divided accountability

structure and the lack of connection between Health Services and Institutional Operations at the senior levels of the organization.

One of the realities of the federal bureaucracy is the frequency with which public servants change jobs. They often move to positions without a great deal of content expertise in the new area. This is particularly problematic in the provision of clinical services. This may also account for some of the confusion exhibited during the document review discussed above. Content expertise is essential in the clinical area. It is one of the fundamental values of accreditation and professional regulation. The proposed new organizational structure would help solve this problem. The clinical management positions would be filled with regulated mental health professionals who bring a level of clinical content and systems competency that is relatively stable across people and time. This stability will help support the administrative function and reduce the negative impacts from frequent staff turnover. It will also reduce the accountability and liability risks for the Service.

Figure 3: Proposed Organizational Chart: Regulated Mental Health Disciplines' Chain of Accountability



Performance Appraisal Tied to Real Change

Change often comes incrementally to organizations and CSC is no exception. However, changes in mental health that take a decade or more to plan and implement is not incremental, but simply slow. A suggestion from both within and outside of the Service urged that achieving clear performance objectives for substantive change in mental health implementation and evaluation be

tied to the annual performance pay of senior management. This suggestion demonstrates a deep commitment to change, frustration with the pace of change and the belief that mental health issues need to be more important within CSC.

National Standards with Local Flexibility

The Service has always tried to serve the two realities of national standards and the need for flexibility at the site or institutional level. It appears this has served the Service well over the years as it recognizes the Canadian reality that not all communities are the same. On the other hand, there are examples of regional inequities that go well beyond this principle. The Atlantic Region reports their RTC is not able to accommodate some offenders due to an inadequate physical facility while the Pacific Region has a new building that treats these same offenders and which reportedly effectively combines the RTC and the reception functions. This same region also has outreach services that interface between the RTC and the inmate's home institution. When asked why this exists in one region and not in the others, the most prevalent and disturbing answer is that it is too expensive to replicate across the country.

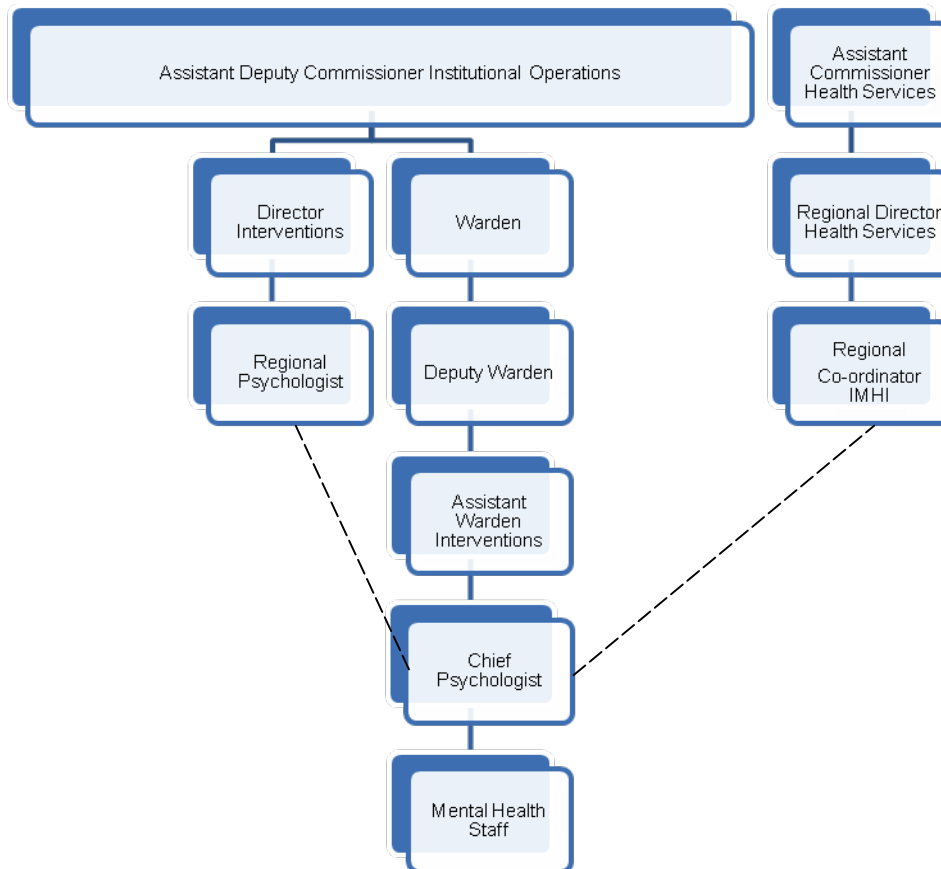
Other examples exist, some of which have been mentioned above. It behoves the Service to continue to establish basic national standards that ensure a similar quality and consistency of services across all regions (Correctional Service Canada, 2007a). There will always be a degree of regional or local variation based on the realities 'on the ground'. Effective innovations from one region can be replicated in other regions. Innovations and change need to 'lift all boats' to the expected professional standards and not 'sink all boats' to the lowest standards based primarily on non clinical concerns.

Accreditation

The Service has pursued recognition from Accreditation Canada since 2001. Accreditation can be helpful in demonstrating that services have attained a respected professional standard akin to those in the broader community and that the organization has the ability to continuously monitor and improve performance. To date, CSC has been successful in accrediting four of its five regional treatment centres. The RTCs in the Ontario and Atlantic Regions have difficulties because of their physical plants.

Accreditation is also important for the other components of the continuum of care; intake, primary care, community care and intermediate care when it comes available. In all likelihood, these functions will be seen by Accreditation Canada as components of one system.

Figure 4: CSC’s Current Organizational Chart and Reporting Relationships Related to the Institutional Mental Health Initiative



Source: Correctional Service of Canada (2009i). *Institutional Mental Health Service (Primary Care) Guidelines*. Government of Canada.

CSC senior staff indicated that, due to a lack of capacity, applications for the non accredited components of the continuum of care were not made at the same time as applications for the RTC’s. It is good to know that the Service has begun the accreditation process for all of its regular institutions and has successfully completed the first phase of the process, receiving the ‘primer’ award in September, 2009 (a pre-audit exercise). It is important to meet external professional standards. It gives the assurance that the Service is doing its job while providing direction for improvement.

Meeting Accreditation Canada’s criteria is one piece of the standards puzzle. Ensuring practices meet the regulatory standards set for the professional staff including scopes of practice, accountability, ethics and professional

conduct is another. Meeting best practices as suggested by, for example, the National Institute for Clinical Evaluation (NICE) in the United Kingdom, the CSC's own *Mental Health and Substance Abuse Services in Correctional Settings: A Review of Minimum Standards and Best Practices* (Livingston, 2009) and Ogloff (2002) is a third.

NHQ Capacity

The issue of capacity has been raised several times in this report. The capability of National Headquarters to adequately support and implement the 'Mental Health Strategy' is a concern. Obviously the Service provides mental health services on many levels and has good policy capacity. At the same time, it is not clear that the current organizational structure at NHQ has the necessary capacity to effectively support planning and implementation of mental health services. This is an issue in Canada both within and outside of the Service. CSC is developing and operating a comprehensive continuum of mental health care in a highly complex organization. An understanding of the specialized capacity needs of NHQ to plan, implement and evaluate mental health services is needed. Without it, progress will be limited to current internal capacity and not based on what is required to meet the need. Strengthening clinical input and mental health specific content expertise by making changes to the governance structure, by using part-time and full-time experts from within and outside of the service while implementing the organizational and administrative changes outlined above will help to address the issue.

CSC employees in the field may bridle at this recommendation. A recurring message in the interviews conducted for this review was the frustration with the significant increase in the size of NHQ compared to the limited resources to get the job done 'at the coal face'. Both of these points are legitimate and need to be addressed, one in concert with the other. Adding resources to NHQ while services are stretched and morale is low will only add to the problem. On the other hand, it is difficult to see how real progress can be made in a timely manner that meets professional standards if NHQ's specialized mental health clinical and organizational capacity is not enhanced.

A recurring message in the interviews conducted for this review was frustration with the significant increase in the size of NHQ with the obviously limited resources to get the job done 'at the coal face'.

Finally, recommendation 72 in *Out of the Shadows at Last* (Standing Senate Committee on Social Affairs, Science and Technology, 2006) called for an independent body such as the Mental Health Commission of Canada to review the Service's activities and progress on an annual basis. The Service

has profited from reviews over the past several years. An internal/external or completely external body such as the Mental Health Commission or one appointed by the Service to provide advice, direction and oversight regarding design, implementation and evaluation could be very useful and would help address capacity. The group would need to be made up of predominately clinical and administrative mental health experts and system users.

Mental Health Human Resources

Recruitment and Retention

CSC estimates that about four percent of its labour force consists of health care staff not including the regional treatment centres. For example, the Service employs about 750 nurses which accounts for about 37% of nurses employed by the federal government and CSC is the largest employer of psychologists in Canada (approximately 350). As of February, 2009, the vacancy rate for psychology was 22% and there was a deficit of 78 nursing positions when comparing the number who joined the Service minus those who left from 2004-05 to 2006-07 (Correctional Service of Canada, 2008d).

Roles and Functions

Some respondents in primary care indicated that the roles of psychiatrists and psychologists have narrowed over time. Psychiatrists report having moved to a practice based almost exclusively on biological psychiatry (e.g. medications, organic disorders and diseases) as a result of service demands and inadequate funding of psychiatric positions. In the past their role included psychotherapy and research. They suggested that this is a loss for psychiatrists in terms of job satisfaction, for offenders in terms of fewer available services and longer wait times, and for the Service in terms of recruitment and retention.

Some respondents in primary care indicated that the roles of psychiatrists and psychologists have narrowed over time.

The narrowing of the role of psychology was also frequently mentioned by CSC staff and in reports (Correctional Services of Canada, 2005a, 2007b; Standing Senate Committee on Social Affairs, Science and Technology, 2006). As mentioned above, psychologists predominately conduct assessments for the Parole Board and provide crisis intervention services with limited time left for mental health assessment and treatment and other responsibilities such as supervision, program planning and evaluation and research. Interviewees from within and outside of psychology expressed concern that this change had reduced the effectiveness of and access to

primary care services in institutions and reduced the attractiveness of the Service for psychologists, negatively impacting recruitment and retention. Most psychologists want a varied practice that includes assessment/diagnosis, treatment, program planning and evaluation, consultation, supervision and research.

Nursing roles are changing as well. On the one hand, new opportunities are opening up across the continuum of care. On the other, institutionally based nursing such as in the RTC's is becoming more difficult due to the prevalence and severity of mental disorders, the physical plant in most regions and the age of inmates (e.g. more care required for the elderly). These positions may become less attractive in the future. In terms of mental health, CSC staff indicated that professionals were sometimes hired with little or no clinical mental health or corrections knowledge or experience. In terms of nursing, targeting groups such as psychiatric nurses for mental health positions might help resolve part of this problem.

Nursing roles are changing as well. On the one hand, new opportunities are opening up...On the other hand, institutional based nursing is reportedly becoming more difficult...

The Service is adding clinical social workers and behaviour technologists to the institutional and community mental health teams. This expansion is in line with practices in the broader community (Canadian Collaborative Mental Health Initiative, 2004; Enhancing Interdisciplinary Collaboration in Primary Care Initiative, 2004) and in corrections (Ogloff, 2002). This is a good way to help address the supply and demand crunch. What needs to be clear are roles, responsibilities, scopes of practice, supervision and clinical accountability.

Backfilling: Using Visa to pay MasterCard

It is well known that mental health professionals are in short supply in Canada (Standing Senate Committee on Social Affairs, Science and Technology, 2006). There is competition from publicly funded mental health services (e.g. hospitals, clinics, schools, social welfare agencies) private practice and business and industry (e.g. employee assistance programs). This puts significant pressure on the Service's recruitment and retention strategies in order to compete. CSC human resource data show significant vacancy rates for mental health professionals

It is well known that mental health professionals are in short supply in Canada (Standing Senate Committee on Social Affairs, Science and Technology, 2006).

across the country (Correctional Service of Canada, 2009g; 2008d). The Service is well aware of these problems and is attempting to address them. Issues include pay and benefits, continuing education support, conditions of work, work/life balance, the perceived and actual importance of mental health within the Service, the breadth of roles, responsibilities and scopes of practice, barriers to service provision and meaningful inclusion in planning and decision making within CSC. Some of these factors are being addressed by the Service (Correctional Service of Canada (2008d). However, unless the Service addresses conditions of work, inclusion, scopes of practice and accountability structures and unless the government deals with the issue of the significant pay discrepancy in some regions for some disciplines, the other recruitment efforts may not be adequate.

Some employees interviewed for this report were concerned about the effect of filling new positions internally thereby leaving the vacated positions empty or filled by people from different professional backgrounds and skill sets. During the interviews it was clear that some recently hired employees were new to CSC while others had come from other parts of the Service or from provincial forensic systems. At least two issues emerged. As current recruitment efforts fill the new positions they may leave CSC or the provincial systems with a recruitment deficit to address. Is there really a net gain? In addition, hiring less or differently qualified people for positions because they are available significantly change the types of services offered, accountability structures and service quality. This should not be done without a human resource plan that meets professional standards and that has been well discussed with the professional groups involved.

Inducements in a Highly Competitive Market

The Service is aware of the problems it faces in terms of competitive salary scales for some professionals. Psychology is particularly problematic since pay rates can fall well below that available in some provincial health settings and private practice. Nursing is reportedly competitive in most but not all provinces. Psychiatrists indicated that working on contract provided competitive and attractive remuneration levels while working on salary was problematic.

The Service has taken steps to address the issue. However, part of the solution falls outside of the Service at the feet of the Federal Government's human resources and hiring practices. Changes need to be made or the impact on the Service will be significant over the next two decades. The demand for mental health services is strong in both the public and private sectors. A significant number of professionals will be retiring soon. The

supply of new professionals is limited. Realistic solutions need to be developed quickly.

An organization is only as good as its human resources (CSC Core Value 3). During the course of this review, it became obvious that the Service employs high quality employees who are dedicated to working with offenders. They see their work as contributing to the welfare of Canadians while helping people with troubled and difficult histories and lives. The work environment is difficult and sometimes harsh (Kunst et al, 2008; Bensimon, 2005, 2004). This commitment can't be taken for granted. Human resource solutions need to be found since the effects of the alternative are negative and cumulative.

*CSC's Core Value 3:
"We believe that our strength and our major resource in achieving our objectives is our staff and that relationships are the cornerstone of our endeavour."*

Centres of Excellence

As part of the solution, the Service might consider facilitating the development of one or two centres of excellence. For example, the Ottawa/Kingston area provides an unprecedented opportunity for education, training and research through its three universities, two community colleges, penitentiaries and parole offices. Centres of excellence would increase interest in criminal justice careers thereby improving recruitment and retention. The centres could be integrated with the pre-employment and continuing education paths of correctional officers as well as other public safety personnel such as police officers and court workers (Correctional Service of Canada, 2009c). Graduate programs as well as internships and residencies for graduate students in the regulated mental health professions would be important.

Communications, Inclusion and Knowledge Exchange

CSC's Core Value 4 states "We believe that the sharing of ideas, knowledge, values and experience..... is essential to the achievement of our mission." Interviewed CSC employees repeatedly indicated a lack of involvement and inclusion in decision-making and information sharing. Staff members with significant years of service said, for example:

*CSC Core Value 4:
"We believe that the sharing of ideas, knowledge, values and experience, nationally and internationally, is essential to the achievement of our Mission."*

1. "I learn about changes after the fact and not before."

2. "They say they are consulting with us but they are really telling us what they have already decided."
3. "I have learned more during this interview about what is going on across the country than I ever learned from CSC."
4. "We learn about major changes to our jobs or profession after the fact and in unofficial ways."
5. "NHQ makes all the decisions and doesn't consult with us."

These comments are important indicators of success or a lack thereof. CSC will be well served to improve effective ways to help clinical staff exchange ideas and innovations, to contribute to innovation, creativity and planning and to improve inclusion and social cohesion within the Service. Canada is a big country and CSC is a large and complex organization. It is a major task to keep people involved, motivated and informed. There are a number of ways of doing this that should be integral to CSC's operational implementation of the "Mental Health Strategy".

Correctional Officers: A Valuable Mental Health Resource

The increased utilization of correctional personnel will improve the efficiency of the 'Mental Health Strategy'. As part of the mental health team, they are invaluable. This issue is not addressed in the 'Mental Health Strategy' and as a result limits the extensiveness and

potential efficacy of CSC's mental health initiatives. The importance of correctional officers in mental health is underlined in CSC reports (Correctional Service of Canada, 2007a), *Out of the Shadows at Last* (Standing Senate Committee on Social Affairs, Science and Technology, 2006) and in the literature (Josi & Sechrest, 2005; O'Toole, 2005). Correctional Officers have daily contact with inmates, they build relationships, solve problems and identify signs and symptoms (Bonta and Andrews, 2007). As part of the mental health team, they can be invaluable. It is also true that at times some officers make the situation worse with antagonistic and obstructionist behaviour that 'stirs up' inmates or impedes their access to services (Skogstad, Deane & Spicer, 2006). Some studies show that mental health issues are the most difficult for officers and inmates to discuss (Dear et al, 2002; Hobbs & Dear, 2000).

It is doubtful that adding more mental health content to the correctional officers' initial training program or addressing the need through continuing education will be adequate. Rather, the Service should move fully to a hiring

The increased utilization of correctional personnel will improve the efficiency of the 'Mental Health Strategy'. As part of the mental health team, they are invaluable.

strategy that places more emphasis on the acquisition of identified knowledge and skills prior to application (Josi & Sechrest, 2005). It was reported by a senior staff member that applicants to CSC increasingly have college diplomas and university degrees. It should not be difficult for the Service to identify more specific degrees and courses as preferred or required pre-requisites for hiring. Officers would come to the workforce with a more solid background in a number of areas including mental health. CSC education and training could 'top up' this prerequisite knowledge and skills base once the staff members have been hired.

Police forces are increasingly using pre-employment psychological profiling to screen out unlikely candidates.

Correctional officers are an important member of the public safety team. Police forces are increasingly using pre-employment psychological profiling to screen out unlikely candidates. Internationally, some correctional services are using tools such as the Australian Institute of Forensic Psychology's *Public Safety Psychology Profiling System* (O'Toole, 2005) which involves psychological testing and an interview with a psychologist. CSC already assesses for abilities, skills and personal suitability, so this is a natural next step.

Testing and interviews will help eliminate those who exhibit unhelpful behaviour styles. The process shows significant cost saving potential (Lough, et al, 2007; Farkas, 2000). This issue is particularly timely considering the significant staff turnover which may occur over the next few years (Correctional Service of Canada, 2007a).

As part of the funding for the Institutional Mental Health Initiative, the government provided funds in 2007 for mental health training of staff including Correctional Officers. While some staff have received the training, to date it was reported that the training is not complete.

All staff and particularly correctional officers work in a difficult environment (Correctional Service of Canada, 2008c). The stress levels are constant, unlike those of other services such as police, border services, emergency response, etc (Kunst, et al, 2008; Lambert & Paoline, 2008; Bensimon, 2005; Bourbonnais et al, 2004; Samak, 2003). Effective coping with the ongoing stress levels is important to address. For example, Samak (2003) found double the rates of self-reported depression in correctional officers compared to the general public. Using continuing education to teach mental health knowledge, skills and self-care to staff is a good use of resources, should be part of the 'Mental Health Strategy' and is consistent with CSC's Core Value 3.

Offenders: Part of the Solution

There is a long tradition in mental health of peer, family and/or volunteer provided services. Including the opinions of offenders who have profited from mental health and criminogenic programming and those that have not is valuable information for program planning and service delivery. Asking service users is common practice in many sectors including mental health and is listed as an evaluation activity in the draft RMAF entitled *Enhancement of CSC's Mental Health Strategy* (Correctional Service of Canada, undated). CSC needs to adopt the phrase 'never about us without us' as an immutable guiding principle. There was initial resistance to asking so called 'crazy people' how to develop mental health services. Now it is becoming commonplace. The same resistance is likely present in corrections. The problem includes a lack of knowledge and understanding, fear, stigma and discrimination. The 'Mental Health Strategy' needs to address offenders as peer counsellors, contributors to program design and evaluation, and as a source of valuable feedback.

Never about us without us needs to be adopted as an immutable guiding principle!

Stigma and Discrimination

It is interesting that the issue of stigma and discrimination did not arise in discussions with CSC employees nor to any significant extent does it appear in CSC's mental health reports and documents and yet it figures so prominently in the work of the Canadian Alliance on Mental Illness and Mental Health (2002, 2006), *Out of the Shadows at Last* (Standing Senate Committee on Social Affairs, Science and Technology, 2006) and the Mental Health Commission of Canada (2009; Martin and Johnston, 2007). The two places it did arise were in discussions with an organization external to CSC where it was seen as the most important issue for the Service to address and in parole services which operate in a community context.

Stigma and discrimination exist, both inside and outside of the Service (Martin and Johnston, 2007; Standing Senate Committee on Social Affairs, Science and Technology, 2006). It is also true that mentally disordered offenders have the double stigma of being labelled both 'crazy' and criminal. CSC's community services staff agreed that stigma and discrimination are a serious issue with community residents, health service providers and employers. It is also highly

No mental health strategy is complete without a plan to identify and address stigma and discrimination.

likely that stigma exists within the institutions. Part of the solution may lie in pre-employment screening and educational prerequisites, performance appraisals, and continuing education. No mental health strategy is complete without a plan to identify and address stigma and discrimination.

Mental health as a sector has always been seriously discriminated against in terms of funding. Budgets for physical health have vastly outstripped funding for mental health based on comparable prevalence and burden data. It is unthinkable in Canada to deny basic physical health services to people with cancer or cardiovascular disease yet it is common place to not provide basic mental health services to Canadians of all ages. The government will need to invest significant amounts of money in mental health to make up for the decades of neglect to bring the Service to a level of best practices and professional standards. These investments will have to be made quickly and continue over the next decade or two.

Summary: Key Elements of a Comprehensive Mental Health Strategy for Federal Corrections

1. A fully integrated multiyear macro level mental health strategy is not available and needs to be developed in a timely fashion.
 - a. A long-term and comprehensive implementation strategy flows from the mental health strategy which assertively, convincingly and repetitively presents solutions to the government to annually secure the needed resources over a rolling multi-year planning cycle.
 - b. The strategy includes the six components of the continuum of care identified by the Service and links offender mental health needs with service delivery over rolling five year periods.
 - c. The strategy contains detailed plans for each of the six components of the continuum of care. These six component strategies are nested within the overarching macro level document.
 - d. All planning documents and updates are finalized in a timely manner, dated and approved under signature by the Service's most senior executive member responsible for mental health.

- e. The government is provided with rolling five year plans for annual funding increments across all of the components of the continuum of care in order to reach and sustain the goals of the mental health strategy.
 - f. The government agrees to a multi-year funding plan that annually provides permanent increases across all six of the components of the continuum of care and which address other critical issues such as human resources and organizational renewal.
 - g. The inclusive planning process effectively involves mental health staff in the field, relevant outside agencies and offender feedback.
2. The intermediate care component plan of the continuum of care is not available and needs to be quickly finalized so funds can be secured and implementation initiated.
3. Intake and assessment, including the Computerized Mental Health Intake Screening System, has yet to be comprehensively implemented in a timely fashion according to a well articulated implementation plan that addresses national standardization, regional differences and adequate staffing compliments at both the service provision and supervisory levels.
- a. All components of the continuum of care are effectively linked through mutually compatible electronic platforms so the clinical management plan which begins at intake becomes a useful tool for the circle of care spanning an offender's time under warrant.
 - b. CoMHISS data is used for planning and research purposes and is widely accessible both internally and externally to CSC.
4. Primary care resources and services are not as yet adequate and need to increase annually to meet population based primary mental health care needs in the institutions.
- a. Administrative barriers to effective clinical information sharing are reduced and eliminated.

- b. Correctional officers work more closely with primary mental health services.
- 5. Inpatient (tertiary) services are enhanced on an annual basis by increasing bed capacity and staff compliments, developing new facilities to replace those in need of decommissioning, and enhancing the therapeutic role of correctional officers.
 - a. An operational plan is developed to facilitate the direct admission of offenders in CSC's community mental health programs to the regional treatment centres and directly back to their community parole sites bypassing unnecessary incarceration in an institution to await referral to the RTC.
 - b. RTC's are supported to increase their mental health continuing education roles and functions in their regions.
- 6. The successful augmentation of community based services are not system wide. They need to be immediately expanded to include all parole sites to a level that meets the need.
 - a. More community based services within CSC and in partnership with municipalities, provinces and territories are developed to meet the demand and to eliminate roadblocks to accessing services.
- 7. Links between service components need to be regularly reviewed and changes made to ensure interoperable efficiency is a central piece of the mental health strategy.
- 8. A review of CSC operations through a clinical lens needs to be more regularly conducted to identify administrative, governance and operational barriers to effective service delivery.
- 9. Governance changes can bring more coherence and mental health specific expertise to CSC planning and operations including:
 - a. Bringing psychology and the regional treatment centers under Health Services.

- b. Ensuring functional responsibility for clinical accountability flows directly to the Assistant Commissioner for Health Services through the regulated health professions.
 - c. Enhancing clinically based input in planning, implementation and evaluation activities.
- 10. National Headquarters through the mental health strategy can bring a much more consistent and regionally equitable standard of service delivery across the country while still respecting regional differences.
- 11. Accreditation is important across the continuum of care and needs to be achieved as soon as possible for all of CSC's mental health services.
- 12. A detailed mental health human resources plan is central component of the mental health strategy.
 - a. The mental health of staff is supported through policies, programs and self-care.
 - b. The roles, functions and accountability frameworks for clinical service providers are well articulated:
 - i. Clinical accountability at the institutional level is clearly defined, is the responsibility of regulated mental health professionals and flows to the respective discipline leaders at National Headquarters.
 - ii. The hiring of providers with one set of knowledge and skills to fill the roles of providers with another set of knowledge and skills is based on a well articulated mental health human resource plan that is tied to offender needs (e.g. types of disorders, severity, prevalence) and not to other considerations.
 - c. Correctional officers, institutional parole officers and mental health services work more closely together. Pre-employment pre-requisites enhance mental health knowledge and skills upon entering the Service and pre-employment testing helps find the best individuals for the positions.

- d. Recruitment and retention are important aspects of the mental health strategy. Current activities of the Service are supported and key issues such as pay disparities, work/life balance, corrections specific education and training opportunities, more varied roles and responsibilities, increased interprofessional collaboration and increased inclusion in program planning and evaluation are addressed.
13. Stigma and discrimination identification and elimination become a central pillar of the mental health strategy.
 14. The ongoing evaluation of the effectiveness of service delivery in meeting offender needs and in the implementation of the mental health strategy is a central and ongoing activity of the strategy.
 15. The mental health strategy includes inmates and former inmates as valuable resources (e.g. peer counselling, program planning and evaluation).
 16. The mental health strategy includes the development of information sharing components to ensure better coordination between federal, provincial and territorial jurisdictions and to promote more seamless delivery of mental health services to offenders in Canada.

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