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# *Evaluation Report:*

# *Correctional Service Canada Contract with the Institut Philippe-Pinel de Montréal*

***Evaluation Branch,***
***Performance Assurance***
***July, 2008***
***File # 394-2-62***

Canada

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***Evaluation Report:***

***Contract with the Institut Philippe-Pinel de Montréal***

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## Prologue

The following report represents an evaluation of Correctional Service Canada's (CSC) Contract with the *Institut Philippe-Pinel de Montréal* (IPPM). This evaluation is the first to be conducted since the agreement was established by CSC in 1977. Consequently, certain methodological limitations emerged. More specifically, in the data collection phase of the project, it became clear that there were issues of poor data quality, lack of availability of originally defined indicators, small sample sizes for some analyses, and the need for a strong reliance on qualitative data. Although qualitative data permitted the triangulation of information, the constraints in reference to quantitative analyses did result in substantial methodological limitations. Notably, in hopes of ensuring a certain level of detachment, the evaluation was conducted in partnership with an independent consultant firm. Specifically, the firm of *Harry Cummings and Associates* was selected, in a competitive bidding process.

The study focussed on determining whether the services provided by IPPM to CSC are the most effective and efficient strategies to achieve expected/suitable results (i.e., success), and whether these services provide value for money (i.e., relevance and cost-effectiveness). The primary goal of the evaluation was to provide information to decision-makers in order to assist in determining the status of the contract with respect to its continuation beyond 2009. Key findings and recommendations are outlined in the report, however the Evaluation Branch felt it necessary to highlight and further contextualize some of the original recommendations.

The evaluation report recommends that the contract between CSC and IPPM be renewed as there remains a demonstrated need for the services provided by IPPM in relation to all implicated offender populations. Furthermore, the evaluation report recommends that the contract is cost-effective as indicated by per diem costs in comparison to CSC Regional Treatment Centres (RTCs); however, further detailed analyses, conducted by the Evaluation Branch, indicated that bed utilization rates are unconditionally critical to this finding. Consequently, cost-effectiveness is impacted as a function of bed utilization rates. The fundamentals of this potential impact are outlined Appendix 1 of the report. It is critical that decision-makers considering cost-effectiveness in relation to IPPM review this section of the appendix. Furthermore, findings demonstrated in this analysis demonstrate a need to continuously monitor utilization rates in order to maximize value for money.

## Executive Summary

The Institut Phillipe-Pinel de Montreal (IPPM) is a psychiatric supra-regional university hospital that specializes in forensic psychiatry. The treatment and services provided are tertiary and usually short-term. IPPM is the first and only medical facility in Quebec that offers a complete range of specialized services, in French and English, in the treatment and rehabilitation of mental health-justice patients under one roof. It also provides support services (through consultation and training) to primary care workers who are responsible for this clientele in the community.

Currently, the services provided by IPPM to Correctional Service Canada (CSC) are targeted towards three distinct groups of federal offenders: women offenders with psychiatric needs from across Canada, male offenders with psychiatric needs incarcerated in the Quebec Region and male sex offenders incarcerated in the Quebec Region. The CSC contract for services with IPPM is for three years (from 2006 to 2009) with the authority to extend the agreement for an additional three years if deemed appropriate. The estimated expenditure value of the contract over six years is $30 million ($5 million per year). This provides for up to 25 beds among the 300 beds at IPPM.

The study focuses on determining whether the services provided by IPPM to CSC are the most effective and efficient strategies to achieve expected/suitable results, as well as whether these services provide value for money (i.e., are relevant and cost-effective). This is the first evaluation of the contract with IPPM since the agreement was established by CSC in 1977.

The firm of Harry Cummings and Associates was selected, in a competitive bidding process, to carry out the evaluation in partnership with the Evaluation Branch of CSC. The evaluation was carried out between June 2007 and April 2008.

## The Evaluation

The evaluation was guided by the Terms of Reference, approved by the Evaluation Committee in October 2006, and the Results-Based Management and Accountability Framework, approved in January 2007.

The research design for the evaluation combined both quantitative and qualitative methodological approaches, including:

- file and document reviews;
- key informant interviews with key IPPM and CSC informants;
- offender satisfaction questionnaires; and,
- a quasi-experiment.

The use of multiple methods served to provide data on similar questions from a variety of sources, a process sometimes referred to as triangulation: coming to common conclusions from a variety of methods and lines of evidence.

Qualitative analyses included a content analysis of CSC's offender files for federal offenders sent to IPPM and of 53 key informants' open-ended interview responses. Themes were generated for evaluation objectives where appropriate (relevancy, success, cost-effectiveness, implementation issues and unintended effects).

Quantitative methods based upon both offender satisfaction questionnaires and a quasi-experiment were used to profile the samples of offenders, to identify trends and to compare various characteristics with a comparison group. In terms of the offender satisfaction questionnaires, offenders representing all three CSC offender populations at IPPM (17 women psychiatric offenders, 11 male psychiatric offenders, and 27 male sex offenders) completed written, face-to-face or telephone questionnaires. Frequency counts and independent sample *t*-tests were performed to assess offenders' perceptions of the services they received at IPPM.

In terms of the quasi-experiment, the IPPM CSC offender profile was compared with offenders in CSC institutions across Canada using quantitative data from both offender files and from the OMS CSC data management system. This provided a program group (IPPM) and a comparison group (CSC inmates at RTCs), as well as a time dimension for each group (pre-intervention and post-intervention). In total, data from 226 federal offenders sent to IPPM were considered, representing 35 women psychiatric offenders, 76 male psychiatric offenders, and 115 sex offenders.[1] Where possible, the characteristics of the IPPM groups and the RTC comparison groups were matched on static and dynamic risk level, Aboriginal status, aggregate sentence length and age at admission. For the women psychiatric offenders, the limited size of the comparison group restricted matching; however, analyses revealed no differences in static and dynamic risk factors between the IPPM group and the comparison group.

[1] Offenders in the women psychiatric sub-sample included all women sent to IPPM by CSC between May 2004 (when the women's unit was opened) and September 2007; offenders in the male psychiatric and sex offender sub-samples included all men sent to IPPM by CSC between January 1997 and September 2007.

Where sample sizes permitted, repeated measures analyses of variance were used to test for differences in continuous variables across time (i.e., from pre-intervention to post-intervention). Paired sample *t*-tests were used to test for between-group differences on continuous variables (e.g., rate of institutional incidents, post-intervention risk). Chi-square tests were utilized for comparisons involving categorical variables. Survival analyses were used to examine and compare between-group differences in rates of recidivism.

In addition to qualitative and quantitative analyses, cost-effectiveness analyses were used to determine whether the IPPM is a cost-effective approach to achieving desired outcomes and meeting the needs of CSC.

These results of all analyses are presented in the Key Findings section of this report and summarised below.

***OVERALL RECOMMENDATION:***

***On the basis of this review the contract between CSC and IPPM should be renewed as there remains a demonstrated need for the services provided by IPPM in relation to all three offender populations.***

***CSC should collaborate with IPPM in conducting a comprehensive evaluation of each of the three offender populations, including the collection of relevant data. A realistic and complete reporting strategy, including relevant performance measures, should be prepared and implemented on an ongoing basis.***

## General Findings and Recommendations

### *Governance and Accountability*

***FINDING 1: The Joint Committee is not meeting its basic requirements in terms of meeting at least once on an annual basis, providing oversight through a collective group, and developing and guiding a research agenda.***

***RECOMMENDATION 1: CSC must act immediately to ensure that the Joint Committee is operationalized as intended. Immediate priorities include confirming/identifying the committee members, establishing a formal meeting schedule, approving the Terms of Reference, and establishing a research subcommittee.***

***FINDING 2: Many CSC internal stakeholders are unfamiliar with the accountability structure of the contract. It was generally recognized that the reporting structure needs to be enhanced to ensure that CSC and IPPM stakeholders alike are fully aware of, and accountable for, the information/reporting requirements outlined in the contract and operational plans. Many CSC stakeholders are also unfamiliar with IPPM's programs and physical setting.***

***RECOMMENDATION 2: CSC should prepare a briefing note/document on the accountability structure as it relates to all three offender populations and circulate this document to all relevant CSC and IPPM personnel. Because many CSC stakeholders are also unfamiliar with IPPM's programs and physical setting, CSC should consider conducting a briefing day for CSC personnel on-site at IPPM. This briefing day could be open to CSC personnel from some of the local referral institutions.***

***FINDING 3: In 2006/2007 IPPM made an annual financial adjustment to account for unoccupied beds, resulting in a $93,150 cost saving for CSC. Relatively few CSC internal stakeholders, including some members of the Joint Committee, are familiar with how the funding formula with IPPM works, but there is a desire to be better informed. One area that continues to lack clarity in the contract relates to responsibility for certain costs, such as medical fees and health insurance costs.***

***RECOMMENDATION 3: CSC should prepare a briefing note/document on the funding arrangements with IPPM for dissemination among internal stakeholders. In accordance with privacy laws, the contract should be updated to specify how the medical fees and health insurance costs associated with offenders at IPPM are to be handled.***

***FINDING 4: Staff turnover is a hindrance for both CSC and IPPM in ensuring that all personnel are up-to-date with DBT and other treatment models. CSC provided DBT training, Women Centered Training, and Aboriginal Awareness training to IPPM staff in 2004, but there has been no follow-up training provided by CSC since this period. IPPM has continued to provide DBT training to its own personnel, facilitated by experienced IPPM staff. However, IPPM staff acknowledge the need for further training.***

***RECOMMENDATION 4: CSC should collaborate with IPPM in identifying training needs and opportunities to ensure that all appropriate IPPM staff are up to date on CSC treatment models. Training sessions should be led by CSC officials and conducted on site at IPPM to facilitate higher participation rates.***

***Cost-Effectiveness and Efficiency***

***FINDING 1: The 2006/2007 IPPM per diem cost of $595 per bed is comparable to that of CSC RTCs, which range between $391 and $584. Funding appears to have been allocated to IPPM as planned and financial adjustments have been made in response to changes in occupancy rates. However, differences in the way IPPM and CSC tabulate/report occupancy rates make it difficult to determine actual occupancy rates. Research conducted by IPPM is providing additional value that is difficult to quantify monetarily.***

***RECOMMENDATION 1: In order to ensure that source funding is directed toward the intended offender population, the allocation of funds should be based on the actual proportion of beds utilized by each offender population and not the estimated proportion. CSC and IPPM should agree to a standardized approach for reporting occupancy data.***

## Women Psychiatric Offender Program Findings and Recommendations

***Objective 1: Relevance***

***FINDING 1: The number of Canadian women offenders suffering from mental health problems is increasing, as is the complexity of offenders' behavioural problems. In the context of this trend IPPM is operating below its capacity. Contributing factors include limited awareness about the program among CSC personnel and offenders, the voluntary nature of admission and treatment and offender reluctance to self-admit to IPPM, delays in processing referrals, and a high rate of offenders refusing service at IPPM.***

***RECOMMENDATION 1: CSC should continue to monitor the occupancy rates of the women psychiatric offender beds at IPPM and low occupancy rates should be systematically flagged. CSC and IPPM should review the way IPPM services/programs are currently being promoted***

***in CSC institutions and explore options for increasing awareness among CSC personnel and offenders. CSC and IPPM should review the referral process to identify options for addressing issues that are causing delays. The Joint Committee should identify the causes associated with women's reluctance to self-admit to IPPM.***

***FINDING 2: No suitable community-based alternatives to IPPM were identified based on the feedback provided by key sources. Existing CSC facilities continue to require the specialized services of IPPM for the women psychiatric offender population.***

***FINDING 3: CSC stakeholders are generally more in favour of maintaining the existing services at IPPM and exploring opportunities for expanding/enhancing services at IPPM rather than developing new services within CSC. CSC stakeholders are also interested in examining research activities with IPPM as a way to add value to the contract.***

***RECOMMENDATION 2: The Joint Committee should examine options for expanding/enhancing services at IPPM to better respond to the needs of CSC.***

***FINDING 4: IPPM is generally being used for its intended purpose. However, the current service agreement with IPPM leaves CSC with no options for women offenders who will not self-admit to IPPM or those who refuse service while at IPPM. Furthermore, on some occasions CSC institutions refer "difficult cases" to IPPM in order to provide these offenders with alternative services that may prove more effective than those available within CSC institutions. IPPM is normally very strict in applying the admission criteria, but attempts to be flexible in accepting these cases.***

***RECOMMENDATION 3: The Joint Committee examine treatment options for women offenders who will not admit themselves to IPPM or those who refuse treatment at IPPM.***

***FINDING 5: Women offenders are generally satisfied with the services they receive at IPPM.***

***Objective 2: Design and Implementation***

***FINDING 6: The admission and exclusion criteria for women offenders contain sufficient detail and clarity and in most cases the women psychiatric offenders who are sent to IPPM meet the appropriate offender profile. However, CSC and IPPM sources identified the need for CSC personnel to be better informed about the admission and exclusion criteria and the referral and admission process. IPPM and CSC institution staff sources identified the need for more clinicians and psychiatrists from CSC to be involved in the referral/admission process.***

***RECOMMENDATION 4: In collaboration with IPPM and CSC institutions, the admission and exclusion criteria should be more intensely promoted by CSC within CSC and IPPM to ensure that the criteria are consistently applied. CSC should also review and confirm the key CSC/IPPM stakeholders that need to be engaged in the referral and admission process.***

***FINDING 7: All women psychiatric offenders generally have their mental health treatment plans adjusted while at IPPM. Offenders are under constant observation at IPPM and their***

***treatment plans are adjusted on a weekly and sometimes daily basis. However, the paper copy files provided by IPPM lack sufficient clarity and detail to determine whether treatments are effective.***

***RECOMMENDATION 5: IPPM reports/documents should clearly identify the treatment plan for each women offender. In addition, these reports should provide greater details regarding the objectives and any progress made toward achieving these objectives. Recommendations for post-IPPM treatment should also be clearly identified in the reports.***

***FINDING 8: IPPM is addressing the physical health needs of the women offender population. While women offenders are largely satisfied with the physical health services they receive at IPPM, they appear to be less satisfied with the cultural and religious/spiritual interventions that are made available at IPPM.***

***RECOMMENDATION 6: CSC and IPPM should conduct a review of the religious/spiritual interventions and Aboriginal activities at IPPM to ensure that the interventions are adequately responding to the needs of women offenders.***

***FINDING 9: Women offenders at IPPM are receiving services in the official language of their choice. However, preliminary evidence suggests that English-speaking offenders may receive service in the official language of their choice less frequently than French-speaking offenders.***

***RECOMMENDATION 7: Future evaluations should further examine the differences between French and English offenders and the frequency with which they receive service in their official language of choice.***

***FINDING 10: CSC internal stakeholders and IPPM staff are generally satisfied with the completeness and timeliness of the women offender information exchanged. However, staff at the Joliette Institution, including psychologists, behavioural counsellors, and parole officers, identified the need for additional details about offenders' experience/progress during their stay at IPPM and greater direct engagement with IPPM personnel to enhance the continuity of care.***

***RECOMMENDATION 8: CSC and IPPM should review communication and access to information guidelines/policies as well as privacy laws, consult with CSC institutions to confirm what types of information can be shared with personnel at CSC institutions, and examine options for providing CSC personnel with the information they need to enhance the continuity of care.***

***CSC and IPPM should review the reporting benchmarks for offenders and ensure that the relevant reports, particularly those referred to in the contract, are produced in a timely manner. It would be helpful if such reports followed a prescribed template, including a standard title (e.g., "Report: Assessment on Admission and Administration of Key Tests"), and identifying in a consistent manner the date, number of previous admissions, date of previous report if applicable, etc.***

***FINDING 11: CSC internal stakeholders are generally satisfied that IPPM's treatment models are consistent with CSC principles and that they complement CSC treatment models. However, it appears that staff turnover issues could be impacting the consistency of treatment in both the CSC and IPPM settings.***

***RECOMMENDATION 9: CSC should review the treatment models being used with the women offender population at IPPM and confirm the extent to which the programs complement CSC programs. CSC should ensure that relevant staff at CSC institutions are better informed about the treatment models being used at IPPM to enhance the continuity of care. CSC should identify and implement methods for ensuring a smooth transition between treatments received at IPPM and at CSC.***

***Objective 3: Success***

***FINDING 12: The services provided by IPPM are helping women offenders to function in a healthier and safer manner. The majority of women offenders reported an improvement in their self-confidence, their ability to overcome their difficulties, and their quality of life as a result of their experience at IPPM, while over 40% of women offenders reported an improvement in their ability to concentrate as a result of their experience at IPPM. As well, close to 40% of women offenders reported an improvement in their level of comfort with participating in correctional programs following their experience at IPPM. However, it appears that the positive results are not long-lasting once the offender returns to their CSC institution.***

***RECOMMENDATION 10: CSC should collaborate with IPPM to ensure a smooth transition process from IPPM back to the CSC institution and establish effective continuity of care mechanisms. In this way, CSC could determine if offenders need additional supports to facilitate their reintegration and to maintain the gains made at IPPM.***

***FINDING 13: The services provided by IPPM are helping to increase CSC's clinical understanding of women psychiatric offenders. IPPM services are also helping women offenders participate in treatment/programming upon returning to their parent institution.***

***FINDING 14: Relative to women psychiatric offenders sent to CSC's RTC, those sent to IPPM tend to have lower levels of functioning both prior to and following intervention. Anecdotal evidence suggests that women psychiatric offenders tend to stabilize following IPPM intervention, but this stabilization is often short-lived.***

***RECOMMENDATION 11: CSC should collaborate with IPPM in conducting a comprehensive evaluation of the IPPM women psychiatric offender program, including the collection of relevant data. A realistic and complete reporting strategy, including relevant performance measures, should be prepared and implemented on an ongoing basis.***

**Male Psychiatric Offender Program Findings and Recommendations**

***Objective 1: Relevance***

***FINDING 1: The number of male offenders suffering from mental health problems is increasing, as is the complexity of offenders' behavioural problems. Although CSC has expanded its internal capacity through CRSM to provide specialized mental health services for male psychiatric offenders, it still lacks the resources for providing services to offenders requiring incarceration in a maximum security facility that IPPM can provide in conjunction with the necessary intervention services.***

***FINDING 2: There are no suitable community-based alternatives to IPPM and existing CSC facilities continue to require the specialized services of IPPM for the male psychiatric population.***

***FINDING 3: IPPM is being used for its intended purpose in relation to the male psychiatric offender population. On some occasions CSC institutions refer "difficult cases" to IPPM in order to provide these offenders with alternative services that may prove more effective than those available within CSC institutions. IPPM is normally very strict in applying the admission criteria, but attempts to be flexible in accepting these cases.***

***RECOMMENDATION 1: CSC should continue to monitor the occupancy rates of the male psychiatric beds at IPPM as CSC continues to develop its specialized mental health interventions. Low occupancy rates should be systematically flagged.***

***Objective 2: Design and Implementation***

***FINDING 4: As reported by CSC internal stakeholders and IPPM staff, the admission and exclusion criteria contain sufficient detail and clarity and, in most cases, the male psychiatric offenders that are sent to IPPM meet the appropriate offender profile. Staff at Archambault Institution have limited awareness of the admission and exclusion criteria. IPPM and Archambault staff sources identified the need for more psychiatrists from CSC institutions to be involved in the referral/admission process as a way to help reinforce awareness of the admission and exclusion criteria and to enable CSC institutions to make more effective/appropriate referrals to IPPM.***

***RECOMMENDATION 2: CSC should consult with all relevant Quebec Region CSC institutions in developing and implementing strategies to better promote the IPPM admission and exclusion criteria for male psychiatric offenders among CSC personnel. CSC should also review and confirm the key CSC/IPPM stakeholders that need to be engaged in the referral and admission process.***

***FINDING 5: Male psychiatric offenders at IPPM are receiving services in the official language of their choice.***

***FINDING 6: In all or most cases, male psychiatric offenders have their mental health treatment plans adjusted while at IPPM. IPPM is also addressing the physical health needs of the male psychiatric population.***

***FINDING 7: CSC internal stakeholders and IPPM staff are generally satisfied with the completeness and timeliness of the male psychiatric offender information exchanged. However, staff at the Archambault Institution, including psychologists, behavioural counsellors, and parole officers, identified the need for additional details about offenders' experience/progress during their stay at IPPM and greater direct engagement with IPPM personnel to enhance the continuity of care.***

***RECOMMENDATION 3: CSC and IPPM should review communication and access to information guidelines/policies as well as privacy laws, consult with CSC institutions to confirm what types of information can be shared with personnel at CSC institutions, and examine options for providing CSC personnel with the information they need to enhance the continuity of care.***

***CSC and IPPM should review the reporting benchmarks for offenders and ensure that the relevant reports, particularly those referred to in the contract, are produced in a timely manner.***

***Objective 3: Success***

***FINDING 8: The services provided by IPPM are helping male psychiatric offenders to function in a healthier and safer manner. The majority of male offenders reported an improvement in their self-confidence, their ability to concentrate, their ability to overcome their difficulties, and their quality of life as a result of their experience at IPPM.***

***FINDING 9: Pre-post institutional adjustment and functioning outcomes did not change for either the IPPM male psychiatric offender population or their comparison group. Analyses suggest that, relative to RTC offenders, IPPM offenders tend to be lower in adjustment, functioning, and reintegration potential, as well as higher in need, when they are sent for assessment/treatment and these between-group differences persist following intervention.***

***FINDING 10: Male psychiatric offenders who received treatment services at IPPM exhibit similar recidivism rates compared to male psychiatric offenders treated at Regional Treatment Centres.***

***RECOMMENDATION 4: CSC should collaborate with IPPM in conducting a comprehensive evaluation of the IPPM male psychiatric offender program, including the collection of relevant data. A realistic and complete reporting strategy, including relevant performance measures, should be prepared and implemented on an ongoing basis.***

## Male Sex Offender Program Findings and Recommendations

***Objective 1: Relevance***

***FINDING 1: IPPM is occasionally operating below its capacity for the sex offender population. Delays in transferring sex offenders from CSC to IPPM once offenders have been approved for admission appear to be impacting the occupancy rate at IPPM.***

***RECOMMENDATION 1: CSC and IPPM should review the referral process for male sex offenders to identify options for addressing issues that are causing delays. CSC should continue to monitor the occupancy rates of the male sex offender beds at IPPM and low occupancy rates should be systematically flagged.***

***FINDING 2: There are no suitable community-based alternatives to IPPM and existing CSC facilities continue to require the specialized services of IPPM for the male sex offender population. CSC stakeholders are generally more in favour of maintaining the existing sex offender services at IPPM and exploring opportunities for expanding/enhancing the services at IPPM rather than developing new services within CSC.***

***RECOMMENDATION 2: The Joint Committee should examine options for expanding/enhancing male sex offender services at IPPM to better respond to the needs of CSC including the needs of dual sex/psychiatric offenders who are in denial about their problem.***

***FINDING 3: IPPM is generally being used for its intended purpose in relation to the male sex offender population.***

***Objective 2: Design and Implementation***

***FINDING 4: As reported by CSC internal stakeholders and IPPM staff, the admission and exclusion criteria contain sufficient detail and clarity, and, in most cases, the male sex offenders who are sent to IPPM meet the appropriate offender profile. However, staff members at La Macaza Institution identified a need for greater detail and clarity in the male sex offender criteria, while representatives from CSC and IPPM identified a general need for CSC institution and IPPM staff to be better informed about the admission/exclusion criteria.***

***RECOMMENDATION 3: In collaboration with IPPM and CSC institutions, CSC should conduct a full review of the male sex offender admission and exclusion criteria, as well as the referral and admission process. The review should identify and confirm the key CSC/IPPM stakeholders that need to be engaged in the referral and admission process, and ensure that the criteria accurately and consistently identify those offenders who are best suited for the programs at IPPM.***

***FINDING 5: Male sex offenders at IPPM are receiving services in their official language of choice.***

***Finding 6: In all or most cases, sex offenders have their mental health treatment plans adjusted while at IPPM. IPPM is also addressing the physical health needs of the sex offender population.***

***FINDING 7: CSC internal stakeholders and IPPM staff are generally satisfied with the completeness and timeliness of the male sex offender information exchanged. However, staff at parent institutions, including parole officers, identified the need for additional details about offenders' experience/progress during their stay at IPPM and greater direct engagement with IPPM personnel to enhance the continuity of care.***

***RECOMMENDATION 4: CSC and IPPM should review communication and access to information guidelines/policies as well as privacy laws, consult with CSC institutions to confirm what types of information can be shared with personnel at CSC institutions, and examine options for providing CSC personnel with the information they need to enhance the continuity of care. CSC and IPPM should also review the reporting benchmarks for male sex offenders and ensure that the relevant reports, particularly those referred to in the contract, are produced in a timely manner.***

***Objective 3: Success***

***FINDING 8: Pre-post institutional adjustment and functioning outcomes did not change for the IPPM male sex offender population or their comparison group. Analyses suggest that, relative to RTC offenders, IPPM offenders tend to be lower in adjustment and functioning when they are sent for sex offender treatment and these between-group differences persist following intervention.***

***RECOMMENDATION 5: CSC should collaborate with IPPM in conducting a comprehensive evaluation of the program, including the collection of relevant data. A realistic and complete reporting strategy, including relevant performance measures, should be prepared and implemented on an ongoing basis.***

***FINDING 9: Men who received treatment services at IPPM exhibit similar recidivism rates compared to those treated at RTCs.***

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**List of Acronyms**

| | |
|---|---|
| CCRA | Corrections and Conditional Release Act |
| CD | Commissioner's Directive |
| CSC | Correctional Service Canada |
| CRS | Custody Rating Scale |
| CRSM | Centre Régionale de Santé Mentale |
| DBT | Dialectal Behaviour Therapy |
| IPPM | Institut Philippe-Pinel de Montréal |
| NHQ | National Head Quarters |
| NPB | National Parole Board |
| OMS | Offender Management System |
| OPI | Office of Primary Interest |
| RMAF | Results-based Management and Accountability Framework |
| RMHU | Regional Mental Health Unit |
| RPC | Regional Psychiatric Centre |
| RTC | Regional Treatment Centre |
| SLE | Structured Living Environment |
| SHU | Special Handling Unit |
| SRS | Security Reclassification Scale |
| SRSW | Security Reclassification Scale for Women |
| TBS | Treasury Board Secretariat |
| UTA | Unescorted Temporary Absence |
| WED | Warrant Expiry Date |
| WOS | Women Offender Sector |

## 1.0 Introduction and Context

The Correctional Service Canada (CSC) Evaluation Branch has been mandated to conduct an evaluation of the contract with the Institut Philippe-Pinel de Montréal (IPPM) in order to determine the correctional and operational value it offers to CSC.

The evaluation was guided by the Terms of Reference, approved by the Evaluation Committee in October 2006, and the Results-Based Management and Accountability Framework (RMAF), approved in January 2007.

The study focuses on determining whether the services provided by IPPM are the most effective and efficient strategies to achieve expected/suitable results, as well as whether these services provide value for money (i.e., are relevant and cost-effective). This is the first evaluation of the contract with IPPM since the agreement was established by CSC in 1977.

## 1.1 Evaluation Rationale

### *1.1.1 Background*

CSC initially entered into a contract with IPPM in 1977 for the provision of psychiatric services to offenders incarcerated in the Quebec Region. At that time, a memorandum of understanding was established such that the province of Quebec provided psychiatric services to any offenders who were referred by a CSC physician. These specialized psychiatric and forensic services (offered in both official languages) were provided primarily to men who were incarcerated in the Quebec Region. In addition, provisions were made for CSC to refer women offenders with psychiatric needs on an urgent care basis. In 1979, specialized services in French and English were implemented at IPPM for male sex offenders, in addition to male psychiatric offenders.

In 2004, a dedicated unit that addresses the mental health needs of women offenders in both official languages was introduced at IPPM. This unit was established to provide services to women offenders requiring intensive mental health treatment whose concerns remained unaddressed by CSC's Intensive Intervention Strategy (1999).[2] Because regional treatment centres, with the exception of the Regional Psychiatric Centre in the Prairies Region, cannot

[2] CSC's Intensive Intervention Strategy (1999) is comprised of two components, the Structured Living Environment (SLE) and the Secure Unit (SU), aimed at providing safe and secure accommodation for women classified as maximum security and those with mental health problems by emphasizing intensive staff intervention, programming and treatment.

accommodate women offenders and because local psychiatric hospitals are rarely equipped to manage forensic cases, IPPM was selected to deliver services in both English and French to women psychiatric offenders. Unlike the men's unit at IPPM, the women's unit is open to incarcerated women from across Canada.

Currently, the services provided by IPPM are targeted towards three distinct groups of federal offenders: women offenders with psychiatric needs from across Canada, male offenders with psychiatric needs incarcerated in the Quebec Region and male sex offenders incarcerated in the Quebec Region. In 2006, the Minister of Public Safety approved the renewal of the contract[3] for a period of three years with the authority to extend the agreement for an additional three years if deemed appropriate. The estimated expenditure value of the contract over six years is $30 million ($5 million per year).

The current evaluation was conducted to inform decisions regarding options for the continuation/modification of the contract with IPPM prior to the contract renewal in July 2009. The timely completion of this evaluation ensures that the termination clause in the current contract, which requires a one-year notice of any intent by either party to terminate the agreement, can be respected.

### *1.1.2 Legislation*

The rationale for entering into the contract with IPPM was based on the CSC's legislative requirement to address the needs of offenders that could not be met through CSC's existing services.

The legislative basis for the provision of services to the three offender populations is the *Corrections and Conditional Release Act* (CCRA, 1992) and the *Commissioner's Directive* (CD) *800: Health Services* (2008).

In particular, pursuant to section 86 of the CCRA (1992), CSC is required to ensure that each offender receives essential health care, as well as reasonable access to non-essential mental health care that will contribute to the offender's rehabilitation and successful reintegration into the community. In accordance with *CD 800: Health services* (2008), essential health services entail access to screening, referral and treatment services, as well as reasonable access to other

[3] CSC Contract with the Institut Philippe-Pinel de Montréal, 2006-2012. 2005. Appendix B

health services that may be provided in keeping with community practices. In brief, essential services include emergency health care, urgent health care, both acute and long-term mental health care, and both acute and preventive dental care. Of particular relevance, mental health care entails the provision of care in response to disturbances of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life.

Also, section 76 of the CCRA (1992) stipulates that CSC is obligated to provide a range of programs designed to address the needs of offenders and contribute to their successful reintegration into the community.

Once offenders are admitted to IPPM, the provincial mental health legislation, *Loi sur les services de santé et les services sociaux*[4] and the Quebec Civil Code apply in addition to federal legislation.

## 1.2 Program Profile

The IPPM is a psychiatric supra-regional university hospital that specializes in forensic psychiatry. The treatment and services provided are tertiary and usually short-term. IPPM is the first and only medical facility in Quebec (as well as in Canada) that offers a complete range of specialized services in the treatment and rehabilitation of mental health-justice patients under one roof. It also provides support services (through consultation and training) to primary care workers who are responsible for this clientele in the community.

CSC uses the services of IPPM to treat the three distinct groups of federal offenders: women psychiatric offenders, male psychiatric offenders, and male sex offenders.

The province of Quebec, through services delivered by IPPM, is CSC's key service delivery partner. CSC entered into a sole source service contract with the province of Quebec for the provision of psychiatric services to offenders within federal institutions from July 24, 2006 to July 23, 2009 at an estimated cost of $5 million per year. The costs of the contract are based on a daily requirement for a total of 25 beds (men and women) at a rate of $479.00 per bed.[5]

Accountability for the contract with IPPM differs for the women psychiatric offender population and the male psychiatric/sex offender populations. With respect to the women's unit

[4] Health Services and Social Services Act
[5] Results Based Management and Accountability Framework - Contract with the Institut Philippe-Pinel de Montréal. 2007. p.15.

at IPPM, the Women Offender Sector (WOS) at National Headquarters (NHQ) is the Office of Primary Interest (OPI). The Health Services Sector shares in the responsibility for this portfolio. The Quebec Region is responsible for the administration of services provided by IPPM to the two male offender populations. The OPI for the male portfolios is the Regional Deputy Commissioner (Quebec Region).

A Joint Committee, comprised of representatives from both CSC (NHQ and the Quebec Region) and IPPM,[6] has been established and is chaired by a representative of CSC. The objectives of the Joint Committee are to monitor both quantitative and qualitative results attained by the implementation of the contract, establish coordination and reporting mechanisms, formulate appropriate recommendations in keeping with the needs of male and women offenders and the available resources, resolve administrative and clinical differences, as well as recommend research projects to the regional research committee. The Terms of Reference for the Joint Committee were drafted in 2007, but have yet to be finalized and approved.

### *1.2.1 Women Psychiatric Offenders*

While CSC offers a range of services to respond to the mental health needs of women offenders, the treatment services provided by IPPM are intended to address the following gaps in mental health care that have been identified within CSC (CSC, 2006, p. 5):

- Accredited mental health beds for women of all security classification levels willing to participate in treatment (voluntary treatment, capable to provide consent);
- Accredited mental health beds for involuntary treatment through mental health legislation; mentally ill women (deemed not capable to provide consent);
- Accredited beds for women who require services in French;
- Beds for women requiring an in-depth assessment upon admission to federal custody or at a critical period in their sentence and/or specialized treatment;
- Emergency psychiatric care/urgent situations;
- Services and intensive mental health programming for Aboriginal women; and,

[6] Joint Committee representatives include the Assistant Commissioner of the Women Offender Sector, the Director General of the Health Services Sector, the Assistant Commissioner Operations for Quebec RHQ, the Regional Administrator of Programs and Reintegration for Quebec RHQ, the Director General of IPPM, and the Director of Professional Services of IPPM.

- Ongoing psychiatric care, particularly for maximum-security women with severe mental health problems and/or with significant behavioural problems/personality disorder problems (historically, these women have anti-social attitudes and significant institutional adjustment concerns due to assaultive behaviour).

Under the terms of the agreement, IPPM is required to make available a minimum of 12 and a maximum of 15 beds to women offenders from CSC, 365 days a year.[7] Offenders are referred to IPPM from across Canada

As defined in the 2006 Treasury Board of Canada Secretariat (TBS) submission and reflected in the Operational Plan for the Mental Health Unit for Women Offenders (CSC, 2006), the objectives for the women offenders are to:

1. Assist them to function in a healthier and safer manner; and,
2. Permit them to access reintegration programs in the institutions in a more timely fashion.

As described in the Operation Plan for the Mental Health Unit for Women Offenders (CSC, 2006, p. 19), clinical assessment is the core element in the treatment of women psychiatric offenders at IPPM. Clinical information gathered during assessment is used to identify priority areas of intervention, update potential obstacles to change, and incorporate the offenders' strengths into the therapeutic process in order to promote healthy progress.[8] Given that one of the main objectives of the treatment is to return offenders to their parent institution, where appropriate, Dialectical Behaviour Therapy (DBT) is used to ensure a continuum of care. Psychotherapeutic approaches other than DBT (e.g., drug therapy) may also be used where they are deemed suitable in a particular case. IPPM also uses a psychosocial rehabilitation program to help offenders develop social/life skills.

IPPM also provides out-patient services to women offenders in order to provide continued access for offenders who have finished their sentence or are on parole.

[7] Women Offender Sector's 2006 Treasury Board Secretariat revised submission.
[8] The initial psychiatric assessment at IPPM lasts approximately 30 days and can include stabilizing the offender when she is first admitted.

The Operational Plan for the Mental Health Unit for Women Offenders divides the admission criteria into the following areas and referrals are made on the basis of one or more of the following (CSC, 2006):

- Need for psychiatric assessment;
- Participation in treatment (readiness, ongoing/long term); and,
- Response to emergency situation (need to stabilize the woman, provide intensive intervention).[9]

Women offenders must also provide their free and informed consent to participate in the IPPM treatment program.

The Operational Plan only identifies one main factor as an exclusion criterion for treatment: women under a Management Protocol resulting from involvement in a major security incident (e.g., a hostage taking or a serious assault against staff or inmate) who have not commenced the reintegration phase of the Protocol. Consideration is also given prior to admitting a woman if she is involved in a relationship with another woman that could interfere negatively with treatment, if there are incompatibility issues with other patients or if special situations on the unit exist that could influence the management of the unit (CSC, 2006, p. 22).

As well, during the referral process, the following elements are considered: upcoming National Parole Board (NPB) hearing; outstanding court date(s) / charge(s); proximity to a legislated release date; previous stays at IPPM; and motives for past refusals by IPPM or refusals for treatment by the patient. Proximity to a NPB hearing, court appearances or release dates may result in the referral being deferred until the NPB grants a decision and/or the outstanding issue has been addressed. The likelihood of ensuring a continuum of care must also be considered at the time of referral to IPPM.

IPPM staff members report that they receive 20-25 referrals a year. and a total of 43 women have been admitted to IPPM between May 2004 and August 2007. The admission process normally takes about 10 days, though emergency cases are admitted on a much faster timeline, usually within 48 hours, as the emphasis is on getting the offender to IPPM as soon as

[9] The Operational Plan notes that the emergency services at IPPM are likely more accessible to Joliette Institution given its close proximity. CSC staff sources confirmed that most of the emergency/crisis situation cases come from Joliette Institution.

possible. The paperwork for emergency cases is done at a later date, once the offender has been admitted to IPPM.

Although CSC typically seeks to reintegrate women offenders into their parent institutions prior to their release when possible, women offenders from any of the regional women's institutions may complete their sentence at IPPM.

### *1.2.2 Male Psychiatric Offenders*

The treatment services provided by IPPM to the male psychiatric offender population were designed to address the needs of those offenders who have already received treatment at the Regional Mental Health Unit (RMHU) or the Special Handling Unit (SHU), or of those in a regular institutional environment who have been referred by the RMHU for specialized treatment. These offenders can be characterized as suffering from severe mental illness and are often in the acute or sub-acute phase of their illness.

Under the current terms of the contract, IPPM is required to make three beds available to male psychiatric offenders from CSC, 365 days a year.[10] Offenders are referred to IPPM from the Quebec Region.

As defined in the 2006 TBS submission, the objectives of the program for male offenders with psychiatric issues are to:

1. Improve mental health of offenders through ongoing monitoring and appropriate medication; and,
2. Reduce the risk of violence within the penitentiaries through the development of adaptation strategies.

The contract between CSC and IPPM contains no official criteria for male psychiatric offenders. The admission and exclusion criteria for this population mostly focus on the requirement of the offender to show a clinical need and are not precisely defined in order to allow for flexibility in meeting the distinct needs of each male psychiatric offender. However, IPPM male psychiatric offenders are excluded if they exhibit dangerous behaviour.

[10] The number of beds allotted to male psychiatric offenders at IPPM has diminished in the last decade as a result of restructuring that enables higher capacity at the Centre Régional de Santé Mentale (CRSM).

### *1.2.3 Male Sex Offenders*

Under the terms of the contract IPPM is required to make 12 beds available to male sex offenders from CSC, 365 days a year. Offenders are referred to IPPM from the Quebec Region.

As defined in the 2006 TBS submission, the objectives for the male sexual offender program are to:

1. Teach offenders to control their violent and deviant actions by improving social skills and the quality of relationships; and,
2. Reduce the likelihood of risk to re-offend with respect to sexual offending.

The sex offender treatment program at IPPM is a 12 to 14-month program consisting of four standardized stages, although they may vary from one offender to another as the treatment for each offender is individualized. The first stage involves a one-month clinical evaluation. During the second stage, the offender is integrated into the treatment program and introduced to the therapeutic modalities. Intensive programming begins in the third stage as the offender participates in all activities of group therapies (e.g., anger control training, social skills training, relapse prevention, prevention of abuse and dependence on alcohol and drugs, modification of sexual preferences), as well as individual activities (e.g. orgasmic reconditioning, covert sensitization). The third stage takes an average of four to six months. During the final stage, which lasts no more than two to three months, the focus is on the offender integrating what has been learned. During this stage learned skills are tested during daily lifestyle functioning (Aubut, Proulx, Lamoureux & McKibben, 1998).

While CSC has high intensity sex offender treatment programs available internally in the Quebec Region at both La Macaza Institution (medium security) and Port Cartier Institution (maximum security), the offenders admitted to IPPM are considered to meet special criteria. The following criteria serve as a basis for considering candidates for admission to the IPPM sex offender program:

- Sexual offenders with limitations to their intellectual capacity (e.g., limited intelligence, slow learner, light mental retardation);
- Sexual offenders suffering from schizophrenia, psychological problems, mood disorders. The symptomatology is judged stable but requires monitoring because the sexual disorder may remerge; and,

- Sexual offenders who have personality disorders such that the severity of the handicap affects their ability to participate in CSC programs. These offenders are significantly functionally incapacitated, have impulsive characteristics, and engage in aggressive behaviour, physically and/or verbally.[11]

Typically, these high risk/high need offenders have histories of institutional violence and a diagnosis of mental illness.

With respect to exclusions, the offender must not be overly violent and IPPM tries to limit the number of sexual murderers that it has in the unit at one time – ideally no more than three at one time. It is also important for offenders to have the intellectual capacity to take part in the program; e.g., sex offenders who do not have the cognitive ability to participate in the sex offender program at La Macaza are typically referred to IPPM.

## 1.3 Program Logic Model

As presented in the program logic models, all three of the offender populations share the same desired long-term result/outcome which is for the services provided by IPPM to enhance CSC's ability to safely and effectively accommodate and reintegrate offenders into Canadian communities. They also share the same intermediate outcome of increased safety and security in CSC institutions. By appropriately and effectively addressing the mental health and correctional needs of offenders, CSC will be better able to contribute to the safe release of offenders from CSC institutions into the community. In particular, all treatment programs targeted towards offenders need to demonstrate that there is a positive impact on subsequent rates of recidivism.

### *Women and Male Psychiatric Offenders*

The activities in which the IPPM was to engage to achieve the goals of the agreement with respect to the women and male psychiatric offender populations are presented in the logic

[11] Memorandum from Karol Prevost, Assistant Deputy Commissioner, Institutional Operations, to Directors of La Macaza, CRR, Cowansville, Drummond, Port-Cartier Institutions, March 6, 2007.

model (see Appendix 2). The services provided by IPPM fall broadly within the following two categories: clinical assessment and treatment.[12]

1. Clinical Assessment
   - Conducting clinical assessments
   - Monitoring mental state, behaviours, and medication
   - Monitoring of physical state and symptoms
2. Treatment
   - Providing in-patient treatment[13]
   - Providing out-patient treatment
   - Providing emergency mental health treatment
   - Providing treatment for physical health
   - Providing auxiliary interventions[14]

Outputs associated with the above activities include intake assessment reports, individualized mental health and physical health treatment plans, psychiatric/pharmacological treatment, stabilization interventions, physical health services, auxiliary interventions, discharge reports, and community-based follow-up treatment.

The expected results of the activities carried out by IPPM consist of immediate, intermediate and long-term impacts as shown in Table 1.

---

[12] Clinical assessment and treatment functions are inter-related. Clinical assessment is an ongoing and dynamic process that continuously informs the treatment being provided to offenders; likewise, information gleaned from an offender's participation in treatment informs ongoing clinical assessment.

[13] A central tenet of the treatment model at IPPM is the concept of a therapeutic environment. The underlying premise of this concept is the idea that the environment itself is an integral part of the therapeutic process. In the context of a therapeutic environment, every interaction between staff and offenders is viewed as an opportunity for a teachable moment, wherein offenders are continuously afforded opportunities to practice skills both inside and outside of a formalized program setting. This approach increases the likelihood that behavioural gains made through treatment will be maintained upon discharge or return to their parent institution or the community.

[14] Consistent with the principles of a holistic approach to treatment and the therapeutic environment, IPPM provides auxiliary interventions to the three distinct offender populations. These activities are generally aimed at fostering self-worth and increasing personal functioning. To achieve these goals, an array of artistic, academic, physical fitness, and recreational activities are offered to the offender. Spiritual and cultural needs are also incorporated into these activities. In particular, spiritual and religious counselling is available to all patients, as well as access to Elders and cultural/spiritual Aboriginal activities.

**Table 1: Expected Results for Women and Male Psychiatric Offenders Receiving Assessment/Treatment at IPPM**

| Immediate | Intermediate | Long-term |
|---|---|---|
| • Increased clinical understanding of offenders<br>• Improved responsiveness of treatment plan<br>• Reduced symptomatology<br>• Increased use of adaptive skills/strategies<br>• Decreased misconduct<br>• Improved adjustment/functioning<br>• Increased ability to participate in treatment/programming | • Improved responsiveness of mental health treatment<br>• Improved quality of life for offenders<br>• Increased safety and security for staff and offenders in CSC institutions | • Safe and effective accommodation and reintegration of offenders into Canadian communities |

***Male Sex Offenders***

The activities in which the IPPM was to engage to achieve the goals of the agreement with respect to the male sex offender population are presented in the logic model (see Appendix 3). As with the women and male psychiatric offender populations, the services IPPM provides to male sex offenders fall broadly within the categories of clinical assessment and treatment.

- Clinical Assessment
  - Conducting specialized sex offender assessments
  - Monitoring mental state, behaviours, and medication
  - Monitoring of physical state and symptoms
- Treatment
  - Providing in-patient sex offender treatment
  - Providing out-patient sex offender treatment
  - Providing emergency mental health treatment
  - Providing treatment for physical health
  - Providing auxiliary interventions

Outputs associated with the above activities include intake assessment reports, individualized mental health and physical health treatment plans, sexual offender treatment program, physical health services, auxiliary interventions, discharge reports, and community-based follow-up treatment.

The expected results of the activities carried out by IPPM consist of immediate, intermediate and long-term impacts as shown in Table 2.

**Table 2: Expected Results for Male Sex Offenders Receiving Assessment/Treatment at IPPM**

| Immediate | Intermediate | Long-term |
|---|---|---|
| • Increased clinical understanding of offenders<br>• Improved responsiveness of correctional plan<br>• Reduced deviant behaviour<br>• Increased use of adaptive skills/strategies<br>• Decreased misconduct<br>• Improved adjustment/functioning<br>• Increased ability to participate in treatment/programming | • Improved responsiveness of correctional programming<br>• Increased safety and security for staff and offenders in CSC institutions | • Safe and effective accommodation and reintegration of offenders into Canadian communities |

## 1.4 Evaluation Context

As noted in the RMAF, the rationale for the contract between CSC and IPPM is linked to CSC's legislative requirement to address the needs of offenders that could not be met through CSC's existing services.

The evaluation findings are required before the contract renewal date in order to ensure that CSC is in a position to make an informed recommendation with respect to options for the continuation/modification of the contract prior to the contract renewal date in July 2009.

The purpose of the evaluation of the CSC contract with IPPM is to assess whether the correctional and operational value that the contract provides for the three distinct federal populations it services is the most effective, relevant, and cost-effective strategy to achieve expected/suitable results.

The objectives of the evaluation are to assess relevance, success and cost-effectiveness/efficiency issues. In particular, the evaluation addresses the following issues:

- The continued need or relevance of the services being provided by IPPM;
- The extent to which governance and accountabilities have been established with respect to the contract and the extent to which they are working effectively;
- The appropriateness of referrals and admissions to IPPM;

- The effectiveness of the services being provided in terms of their ability to produce expected outcomes and to meet the needs of CSC;
- The extent to which the treatment being provided by IPPM facilitates a coordinated continuum of care;
- The extent to which the services provided by IPPM are sensitive to the needs of Aboriginal offenders and to offenders' preferred official language of service;
- The cost-effectiveness of the contract compared to alternatives;
- The cost-effectiveness of the contract in financial and administrative terms; and,
- The overall assessment of whether the contract is reasonably priced.

The scope of the evaluation varies in relation to the three distinct offender populations at IPPM. The evaluation period for the male psychiatric and male sex offender populations covers the period between January 1997 and August 2007. The evaluation for these two offender populations primarily focuses on examining outcomes of the IPPM contract, including immediate and longer term outcomes associated with male offenders who have stayed at IPPM.

With respect to the women psychiatric offenders, the evaluation covers the period between May 2004 (when the women's unit was established at IPPM) and August 2007. The evaluation of this offender population is largely focused on output related indicators and immediate outcomes given the relative recency of the opening of the women's unit.

The evaluation was initiated in September 2007 and was conducted using a hybrid approach. Representatives from the CSC Evaluation Branch worked in partnership with an independent evaluation consultant (Harry Cummings and Associates).

## 2.0 Methodology, Design and Data Sources

A mix of both quantitative and qualitative methodological approaches was used in this evaluation, including file and document reviews, key informant interviews, offender satisfaction questionnaires, and a quasi-experiment. Combining different approaches is useful in triangulating results. The concept of triangulation is based on the assumption that any bias inherent in particular data sources, investigator, and method will be neutralized when used in conjunction with other data sources, investigators, and methods. This corresponds with the multiple lines of inquiry considered an important part of all best practice evaluations.

### 2.1 File and Document Reviews

Various documents from CSC and IPPM were reviewed to obtain relevant data related to the evaluation issues (program relevancy, governance and accountability, program design and implementation, success, cost-effectiveness).

The types of files and documents that were reviewed include:

- Results-based Management Accountability Framework – Contract with IPPM
- Contract between CSC and IPPM, 2006-2012
- Treasury Board Submission, 2006
- Draft Terms of Reference for the Joint Committee
- Mental Health Unit for Women Offenders, Operational Plan
- Male offender treatment program documents
- IPPM program treatment materials and administrative files
- Background articles on research at IPPM (e.g., Sexual Offenders' Treatment Program of the IPPM)
- Financial records

Offender Medical Files were also reviewed for all three populations of IPPM offenders to identify the purpose of their stay with IPPM, as well as their rates of completion and non-completion, and the reason for non-completion (if applicable). In addition, women's Offender Medical Files and Offender Psychological Files (paper copies) were reviewed to facilitate

pre/post analysis on a number of variables, including the attainment of treatment objectives, reduction in symptomatology, use of adaptive skills, and institutional adjustment.

## 2.2 Key Informant Interviews

Qualitative and quantitative data was collected through semi-structured key informant interviews (containing both closed- and open-ended questions). Key informant interviews were conducted with CSC internal stakeholders and IPPM staff, as well as with staff at three CSC institutions.

### *2.2.1 CSC Internal Stakeholders and IPPM Staff*

Key informant interviews were conducted with a total of 13 CSC internal stakeholders and 14 IPPM staff members, identified by representatives of the Joint Committee. The key informant interviews addressed evaluation issues related to program relevancy, governance and accountability, program design and implementation, success, and cost-effectiveness.

The questionnaires for CSC internal stakeholders and IPPM staff featured similar questions where possible to allow for comparisons across the different stakeholder groups. The questionnaires were semi-structured and featured a combination of qualitative (open-ended) and quantitative (Likert-type scale) questions.

Most of the interviews were conducted in a face-to-face setting (e.g., at CSC NHQ or IPPM), while some interviews were conducted by telephone in response to scheduling challenges.

A field visit to IPPM was conducted as part of this process. The field visit to IPPM and interviews with IPPM staff were conducted in November 2007, while the interviews with CSC internal stakeholders were conducted between December 2007 and February 2008.

Table 3 identifies the CSC internal stakeholders and IPPM staff members who were interviewed.

**Table 3: Key Informant Group Data Sources and CSC Internal Stakeholders**

| Key Informant Group | Data Sources |
|---|---|
| CSC Internal Stakeholders (13) | • Regional Administrator, Reintegration Programs in the Region of Quebec<br>• Assistant Deputy Commissioner, Operations, for the Region of Quebec<br>• Director General, Health Services<br>• CSC Clinical Advisor to Pinel Women Offenders<br>• CSC Health Liaison Officer for Pinel, Women's Unit (current and previous)<br>• CSC Parole Liaison Officer for Pinel, Women's Unit<br>• CSC Representative for all Male Populations<br>• CSC Representative for all Women Offender Units (current and previous)<br>• Manager, National Mental Health Programs<br>• A/DCW for Women Offenders Sector<br>• Director, Reintegration Programs<br>• CSC Program Officer (Sex Offender Programs) |
| IPPM Staff Members (14) | • General Manager<br>• Co-Director of Professional Services<br>• Director of Professional Services, Psychiatrist, Male Offender Unit<br>• Chief of Service and Scientific Development<br>• Coordinator of the Sex Offender Program<br>• Medical Director, Psychiatrist, Sexual Offender Unit<br>• Educator/Sociotherapist, Sexual Offender Unit<br>• Nurse. Sexual Offender Unit<br>• Sexual Offender Sexologist<br>• Psychologist<br>• Assistant Coordinator, Women's Unit<br>• Head Psychiatrist, Women's Unit<br>• Nurse technician, Women's Unit<br>• Special Educator, Women's Unit |

### *2.2.2 CSC Institution Stakeholders*

Key informant interviews were conducted with a total of 40 CSC institution staff members representing three different institutions located in the Quebec Region:

- Joliette Institution
  - Multi-level security institution for women
  - Structured Living Environtment (SLE) Unit and Secure Unit offer DBT and psychological treatment programs
- La Macaza Institution
  - Medium security institution for men

    - Tertiary-level clinical program for male sex offenders
- Archambault Institution
    - Medium security institution for men
    - Regional Mental Health Unit (RMHU) – offers intermediate health care to offenders with mental illness or personality disorders

These three sites were selected based on the number of offenders who have previously been to IPPM and who were located at these sites at the time of the evaluation. This approach was used to identify sites where there was the greatest opportunity to interview staff members who could provide informed views on their experience with IPPM and the offenders who returned from IPPM.

The key informant interviews addressed evaluation issues related to program relevancy, governance and accountability, program design and implementation, success, and cost-effectiveness. The questionnaires for CSC institution stakeholders featured similar questions as used in the CSC internal stakeholder/IPPM staff questionnaire to allow for comparisons across the different stakeholder groups. The questionnaire was semi-structured and featured a combination of qualitative (open-ended) and quantitative (Likert-type scale) questions. All of the interviews with CSC institution staff were conducted during two-day field visits to each site in January 2008.

Table 4 identifies the CSC institution staff members who were interviewed.

**Table 4: CSC Institution Staff Interviewed**

| CSC Institutions | Data Sources |
|---|---|
| Joliette Institution<br>(8) | • Director of Operations<br>• Head of Clinical Affairs, Maximum Security Units & Structured Living Environments<br>• Senior Psychologist<br>• Psychologist at SLE<br>• Psychiatric Care, Offenders in SLE<br>• Parole Officer, Offenders in Maximum Security and SLE<br>• Behavioural Counsellors (2) |
| La Macaza Institution<br>(7) | • Head of Program for Sex Offenders<br>• Manager of Evaluation and Intervention<br>• Assistant Director of Interventions<br>• Nurse (specializing in infectious illness)<br>• Nurse (specializing in mental health)<br>• Parole Officers (2) |
| Archambault Institution<br>(25; in the form of 5 group interviews) | • Co-Director of Centre Régionale de Santé Mentale (CRSM)<br>• Clinical Director<br>• Head of Mental Health Care<br>• Psychiatrist (contracted by CSC)<br><br>• Coordinator Active Care Unit<br>• Head of Team, Active Care Unit<br>• Coordinator of Social Reintegration Unit<br>• Head of Team, Social Reintegration Unit<br>• Coordinator of Admissions Unit<br>• Head of Team Admissions and Acute Care Unit<br>• Coordinator of Re-adaptation Unit<br>• Head of Team, Unit of RE-adaptation<br><br>• Nurses (3)<br>• Psychologist<br>• Educator<br><br>• Co-Director of Interventions<br>• Head of Health Care<br>• Manager of Evaluations and Interventions<br>• Co-Director Operations<br><br>• Parole Officers (4) |

## 2.3 Offender Satisfaction Questionnaire

An offender satisfaction questionnaire was administered to offenders representing all three of the offender populations that received services from IPPM. The CSC Evaluation Branch worked with the various CSC institutions to organize and administer the satisfaction questionnaire.

***Women Psychiatric Offenders***

Given the small size of the women offender population that has been to IPPM between 2004 and 2007, it was decided to administer the questionnaire to as many of the offenders as possible. An attempt was made to contact 30 of the women offenders. A total of five offenders had reached Warrant Expiry Date (WED) or were unable to participate and a further five declined to participate.

A total of 17 offenders participated and were contacted through the following facilities:

- Joliette
- IPPM
- Nova
- EIFW
- Grand Valley
- RPC Prairie
- Thérèse-Casgrain Halfway House

The number of times each woman offender was sent to IPPM (between May 2004 and August 2007) ranged from 1 to 3, with an average number of stays of 1.41 (*SD* = 62). Women offenders in this sample ranged in age from 21 to 50 years, with an average age of 33.7 years (*SD* = 10.0). Most of the women offenders in this sample were non-Aboriginal (64.7%).

The questionnaire was administered individually, face-to-face, or by telephone, by a representative of the CSC Evaluation Branch. The questionnaire for the women offender population was designed to capture mostly quantitative data. The issues addressed included:

- Offender level of satisfaction with treatment services related to their mental and physical health needs
- Offender perception that cultural, spiritual, religious needs were met
- Offender perception that alternate resources were made available when requested
- Proportion of offenders who received services in their official language of choice
- Offender perception that their quality of life improved as a result of having been at IPPM
- Offender level of comfort (willingness) and level of readiness to participate in correctional programs after their stay at IPPM

***Male Psychiatric and Sex Offenders***

An attempt was made to contact 17 psychiatric offenders and 40 sex offenders (this represents approximately 30% of the two male populations of offenders sent to IPPM since January 1997).[15] A total of 11 psychiatric offenders and 27 sex offenders participated and were located in the following facilities:

| Male Psychiatric Offenders | Male Sex Offenders |
|---|---|
| • Archambault<br>• La Macaza<br>• USD<br>• Drummond | • La Macaza<br>• Drummond<br>• Archambault<br>• LeClerc |

The number of times each male psychiatric offender was sent to IPPM (between January 1997 and August 2007) ranged from 1 to 8, with an average number of stays of 2.2 (*SD* = 2.0). Male offenders in this sample ranged in age from 21 to 56 years, with an average age of 42.6 years (*SD* = 9.6). All of the male offenders in this sample were non-Aboriginal.

The number of times each male sex offender was sent to IPPM (between January 1997 and August 2007) ranged from 1 to 4, with an average number of stays of 1.4 (*SD* = .81). Male offenders in this sample ranged in age from 24 to 69 years, with an average age of 45.8 years (*SD* = 10.8). Most of the male offenders in this sample were non-Aboriginal (74.1).

The CSC Evaluation Branch administered the male psychiatric and sex offender satisfaction questionnaire via paper–and-pencil questionnaires with the assistance of CSC staff in the institutions.

The questionnaire for the male psychiatric offender populations was designed to capture mostly quantitative data. Issues addressed for the psychiatric population included:

- Offender perception that their quality of life improved as a result of having been at IPPM
- Offender perception that their ability to concentrate improved as a result of having been at IPPM

[15] This component of the evaluation focused on men who are no longer at IPPM but who are still incarcerated. This approach addressed the challenge of tracking/finding individuals once they are no longer institutionalized.

- Offender perception that their self-confidence improved as a result of having been at IPPM
- Offender perception that their ability to overcome difficulties improved as a result of having been at IPPM
- Proportion of offenders who received services in their official language of choice

The focus of the male sex offender questionnaire only addressed the extent to which the offenders received service in the language of their choice.

## 2.4 Quasi-Experiment

A quasi-experimental pre- and post-intervention with comparison group design was used to demonstrate the effectiveness of the IPPM program/services across the three offender populations and the extent to which the program/services produced the desired outputs and outcomes.

In accessing the quantitative data for this initiative, a list of all offenders who had received assessments or treatment at IPPM between January 1997 and August 2007 (for men) and between May 2004 and August 2007 (for women) was provided to the evaluation team. The list was then tagged to data in the Offender Management System (OMS) in order to access quantitative outcomes as identified in the evaluation strategy. In addition, data regarding the purpose of the stay with IPPM, rates of treatment completion and non-completion, and reasons for non-completion (if applicable), were obtained through a review of Offender Medical Files. Comparison groups from CSC institutions were selected by matching characteristics of interest from the three offender populations at IPPM. These data were analyzed electronically using Statistical Analysis System (SAS).

The evaluation utilized data from 226 men and women sent to IPPM by CSC for one or more stays, including offenders who both did and did not complete the purpose of their stays. This total sample is divided into three distinct sub-samples of federal offenders: women psychiatric offenders (15.4%; $n$ = 35), male psychiatric offenders (33.6%; $n$ = 76), and male sex offenders (50.9%; $n$ = 115).[16] Offenders in the women psychiatric sub-sample represent all

[16] Over multiple stays at IPPM, two male offenders included in the total sample were admitted for both psychiatric and sex offender treatment. These men are therefore represented in both the psychiatric offender sub-sample and the

women sent to IPPM by CSC between May 2004 (when the women's unit was opened) and September 2007; offenders in the male psychiatric and sex offender sub-samples represent all men sent to IPPM by CSC between January 1997 and September 2007.[17]

### *2.4.1 Sample Composition of IPPM Offenders*

***Women Psychiatric Offenders***

Women psychiatric offenders were sent to IPPM for the purpose of either assessment (25.7%; *n* = 9) or both assessment and treatment (74.3%; *n* = 26). Among those sent for assessment only, the majority completed the purpose of their stay at IPPM (88.9%). The primary reason for non-completion of assessments (80% of terminated stays at IPPM) was the offender's refusal to participate in the assessment process; another 20% of stays were terminated prior to assessment completion due to the IPPM team's decision that the offender posed an undue security risk to others.

Among those women offenders sent to IPPM for both assessment and treatment, approximately half completed the purpose of their stay at IPPM (46.2%). The primary reason for non-completion (70.8% of terminated stays at IPPM) was the offender's refusal to participate in the assessment and treatment process; another 20.8% of stays were terminated prior to completion due to the IPPM team's decision that the offender lacked the appropriate motivation, abilities or skills for participation in the assessment and treatment process.

The number of times each woman offender was sent to IPPM ranged from 1 to 3, with an average number of stays of 1.44 (*SD* = .43). The majority of women offenders (54.3%) were sent to IPPM from multi-level security institutions, 10.7% were sent from medium security institutions, and 7.1% were sent from maximum security institutions. More than half of the women were serving sentences less than four years (57.1%), followed by those serving life sentences (25.7%), four to ten years (11.4%), and more than ten years (5.7%). Robbery was the most frequent index offence among women offenders (80%), followed by homicide (28.6%) and drug offences (5.7%). Women offenders in this sample ranged in age from 17 to 46 years, with an average age of 29.9 years (*SD* = 8.2). Most of the women offenders were non-Aboriginal (64.7%).

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sex offender sub-sample.

[17] Excluding offenders sent to IPPM by provincial courts for assessments.

### *Male Psychiatric Offenders*

Like women psychiatric offenders, male psychiatric offenders were sent to IPPM for the purpose of either assessment (42.1%; *n* = 32) or both assessment and treatment (57.9%; *n* = 44). Among those sent for assessment only, the majority completed the purpose of their stay at IPPM (84.4%). The primary reason for non-completion of assessments (80% of terminated stays at IPPM) was the offender's refusal to participate in the assessment process; another 20% of stays were terminated prior to assessment completion because the offender was released into the community.

Among those male psychiatric offenders sent to IPPM for both assessment and treatment, the majority completed the purpose of their stay at IPPM (65.9%). The primary reason for non-completion (35% of terminated stays at IPPM) was the IPPM team's decision that the offender lacked the appropriate motivation, abilities or skills for participation in the assessment and treatment process; another 40% of stays were terminated prior to completion due to the offender's refusal to participate in the assessment and treatment process.

The number of times each male psychiatric offender was sent to IPPM ranged from 1 to 3, with an average number of stays of 1.16 (*SD* = .47). The vast majority of these male offenders (93.2%) were sent to IPPM from maximum security institutions (including the Special Handling Unit), 4.1% were sent from medium security institutions, and 2.7% were sent from multi-level security institutions. Half of the male psychiatric offenders were serving sentences less than four years (50%), followed by those serving life sentences (23.7%), four to ten years (18.4%), and more than ten years (7.9%). Sexual offences were the most frequent index offence among male psychiatric offenders (61.8%), followed by robbery (48.7%), homicide (6.6%), and drug offences (3.9%). Male psychiatric offenders in this sample ranged in age from 19 to 63 years, with an average age of 34.75 years (*SD* = 9.74). The vast majority of the male psychiatric offenders were non-Aboriginal (97.4%).

### *Male Sex Offenders*

Among offenders sent to IPPM to participate in the sex offender program, half completed the purpose of their stay at IPPM (49.6%). The primary reason for non-completion (34.2% of terminated stays at IPPM) was the offender's refusal to participate; another 16.2% of stays were

terminated due to the IPPM team's decision that the offender lacked the appropriate motivation, abilities or skills for participation in the sex offender program, and 14.4% of stays were terminated because the IPPM team decided that the offender posed an undue security risk to others.

The number of times each sex offender was sent to IPPM ranged from 1 to 3, with an average number of stays of 1.16 (*SD* = .42). All of these sex offenders (100%) were sent to IPPM from maximum security institutions, including the Special Handling Unit. Just under half of the sex offenders were serving sentences less than four years (45.2%), followed by those serving four to ten years (27%), those serving more than ten years (13.9%) and those serving life sentences (13.9%). Sexual offences were the most frequent index offence among offenders sent to IPPM to participate in the sex offender program (77.4%), followed by robbery (36.5%), drug offences (9.6%) and homicide (3.5%). Sex offenders in this sample ranged in age from 18 to 61 years, with an average age of 37.09 years (*SD* = 9.84). The vast majority of the male sex offenders were non-Aboriginal (90.4%).

### *2.4.2 Measures*

***Reintegration Potential, Motivation Level, and Static and Dynamic Levels of Intervention***[18]

One way in which an offender's progress against the Correctional Plan is measured is through a reassessment of key measures for reintegration. The reassessment is conducted by a Case Management Team member and requires the re-examination of key measures for reintegration. This process results in an overview of the offender's progress. Key measures reviewed are those which assess the static and dynamic levels of intervention, motivation levels, and reintegration potential. The review can result in a change in these measures based on the caseworker's judgment, and is recorded in a Correctional Plan Progress Report. The reassessment is completed when there is a perceived change in the above-mentioned factors upon completion of correctional programs. It is also conducted upon request for Community Strategy, or Community Assessment related to an upcoming decision.

Progress in the *Static Level of Intervention* is based on the following:

- A review of static factors assessed at intake,[19] as well as:

[18] See CSC *Commissioner's Directive #705-6: Correctional Planning and Criminal Profile* for a more detailed description of these measures.

- Significant and sustained changes in the following factors
    - Time remaining to be served before probable release;
    - Existence of pro-social contacts that could assist with reintegration;
    - Significant disciplinary problems, segregation periods or preventive security concerns in the last year;
    - Performance on unescorted temporary absences (UTAs) and Work Releases (WRs);
    - Offender's progress/motivation to participate in his or her Correctional Plan.

Progress in the *Dynamic Level of Intervention* is based on the reassessment of each of the dynamic factors.[20] This is done by examining the number and seriousness of each factor, while considering the offender's progress related to the correctional plan and anything affecting the intensity of the dynamic factors, such as changes in personal situation, health, etc.

*Motivation level* is re-assessed against the following criteria:

- Recognition that a problem exists with lifestyle, behaviour and resulting consequences;
- Level of comfort with problem and its impact on offender's life;
- Level of feeling of personal responsibility for the problem(s);
- Willingness to change (e.g., expression of wish to change) or intention to fully participate in Correctional Plan;
- Possession of skills, knowledge required to effect change in behaviour (e.g., is ready to change);
- Level of external support from family, friends or other community members; and,
- The offender's Case Management Strategy Group.

*Reintegration Potential* is re-assessed based on the following criteria:

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[19] Static factors are based on historical information related to risk that is available at the time of the offender's admission to federal custody. Specifcally, the Statistical Information on Recidivism – Revised 1 (SIR-R1) scale, the Criminal History Record, Offence Severity Record, and Sex Offence History domains of the Offender Intake Assessment

[20] Dynamic factors are based on information related to need that is available at the time of the offender's admission to federal custody. Specifcally, the Employment, Family/Marital, Associates and Social Interaction, Substance Abuse, Community Funtioning, Personal/Emotional and Attitude domains of the Offender Intake Assessment.

- Score on the Statistical Information on Recidivism – Revised 1 (SIR-R1) scale;
- Level of intervention based on static factors;
- Level of intervention based on dynamic factors;
- Security reclassification scale outcome; and,
- Level of motivation.

***Security Reclassification Scale/Security Reclassification Scale for Women***[21]

In December 1998, CSC introduced the Security Reclassification Scale (SRS) for use with *male* inmates. This mechanically derived scale has been field-tested, with results suggesting a high degree of concurrent and convergent validity (Luciani, 1998). While initial classification (the Custody Rating Scale [CRS]) is comprised primarily of static variables, the SRS emphasizes dynamic criteria and proximal in-custody behaviour. The SRS has an approximate 25-point scoring range, with higher scores representing higher risk and resulting in higher security ratings. Like the CRS, the SRS also includes provisions for professional discretion for staff to override the scale's recommendation. Again, staff must clearly articulate their reasons for contravening the scale's recommendation.

While the SRS was developed, validated, and field-tested with male offenders, a parallel process was undertaken to develop a security reclassification protocol for women offenders. The Security Reclassification Scale for Women (SRSW) was designed to provide a national, objective, gender-informed classification tool that, in accordance with legislation, would assist in the placement of women into the 'least restrictive' measures of confinement. The scale development process took place between 1998 and 2000 and validation occurred between 2000 and 2003 (Blanchette & Taylor, 2007). Finally, the scale was implemented nationally in June 2005. The SRSW has an approximate 30-point scoring range, with higher scores representing higher risk and resulting in higher security ratings.

As noted above, the SRS and SRSW emphasize dynamic criteria and proximal in-custody behaviour. Accordingly, for the current evaluation, it was decided that, in addition to using the full scale scores, items within these scales would be used as proxy measures for the expected

[21] For additional information on these scales, please refer to Commissioner's Directive 710-6.

outcomes as identified in the evaluation strategy discussed earlier. These items will be examined pre- and post- time spent at IPPM.

## 2.5 Data Analyses

### Qualitative Analyses

Qualitative analyses for open-ended key informant interview questions and document/file reviews relied on content analysis to identify themes/issues. Themes were generated for the evaluation objectives where appropriate (relevancy, governance and accountability issues, design and implementation issues, success, cost-effectiveness and efficiency, and value for money).

### Quantitative Analyses

Quantitative methods were used to profile the samples of offenders, to identify trends emerging from the key informant interviews, and to compare various characteristics with a comparison group. Comparison groups included a sample of offenders from Regional Treatment Centres (RTCs) for both male psychiatric and sex offenders, and a sample of offenders from the RPC, Churchill Unit for female offenders.[22] For the two groups of male offenders, the comparison groups were matched on static and dynamic risk level, Aboriginal status, aggregate sentence length and age at admission. For women, the limited size of the comparison group restricted matching. However, analyses revealed no differences in static and dynamic risk factors between the IPPM group and the comparison group.

Where sample size permitted, repeated measures analyses of variance were used to test for differences in continuous variables across time (i.e., from pre-treatment to post-treatment). Paired samples *t*-tests were used to test for between-group differences on continuous variables (e.g., rate of institutional incidents, post-treatment risk). Chi-square tests were utilized for comparisons involving categorical variables. Survival analyses[23] were used to examine and compare between-group differences where data were censored.[24]

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[22] Only offenders from RTCs who had never been sent by CSC to IPPM were included among comparison group members.

[23] Survival analysis is a statistical technique that estimates the time taken to reach some event and the rate of occurrence of that event.

[24] Observations are referred to as censored when the dependent variable of interest represents the time to a terminal event (reconviction), and the duration of the study is limited in time.

**Cost-Effectiveness Analyses**

Cost-effectiveness analyses were used to determine whether the IPPM is a cost-effective approach to achieving results. Cost-effectiveness analysis is a decision-oriented tool that simultaneously considers costs and effects. It is more cost-effective if one operation yields the same level of effectiveness as others for lower cost (Levin & McEwan, 2003).

## 2.6 Limitations

### *2.6.1 File and Document Reviews*

Verbal communication is frequently used to share information between CSC and IPPM officials and, consequently, there is often no formal written record of this exchange of information. For example, Coordinating Committee members would sometimes speak directly with individual Joint Committee members to seek their input/feedback on issues. Consequently, though multiple document reviews were conducted and extensive interviews with key informants were carried out, it was not possible to fully explore some contract design and implementation issues.

With respect to Offender Medical File and Offender Psychological File reviews for those women offenders sent to IPPM, it was discovered that some paper copy files contained incomplete or missing documents and reports. In some cases the information was hand written and illegible. The files also lacked specific information on treatment plans being proposed or used or whether any progress was made. The reports generally indicate that treatment was conducted or that the offender met her objectives, but the records do not indicate what the treatment was or what the objectives were. As well, the reports do not always provide clear recommendations for future actions to be taken post-IPPM. As a result, it was often not possible to track offenders' progress while at IPPM.

### *2.6.2 Key Informant Interviews*

Information collected from the key informant interviews with CSC internal stakeholders, CSC institution staff and IPPM staff may have been prone to biases typically associated with self-report techniques (e.g., inaccuracy of recall, lack of information, or discomfort with self-disclosure). For example, some CSC institution staff had more limited engagement with offenders who stayed at IPPM and, in some cases, staff reflected on events that occurred more

than a year ago. However, the key informant interviews were conducted by independent consultants, which likely minimized the confidentiality concerns of the respondents and promoted greater disclosure.

The key informant interview guides for CSC internal stakeholders, CSC institution staff and IPPM staff were designed to cover all of the key evaluation issues (i.e., relevancy, governance/accountability, design and implementation, success, cost-effectiveness) for all three populations of offenders sent to IPPM. This made for a lengthy interview, particularly where the respondent had a long history with the program and was engaged with two or more of the offender populations; consequently, some interviews could not be fully completed.[25]

### *2.6.3 Offender Satisfaction Questionnaires*

Offender satisfaction questionnaire sample sizes were limited by the challenges associated with locating and recruiting participants who are no longer incarcerated in CSC institutions. Moreover, in some cases, much time had elapsed between an offender's stay at IPPM and his or her participation in the offender satisfaction questionnaire, calling into question the reliability of offenders' recall of the services received while at IPPM. Ideally, all offenders would have been interviewed shortly after their stays at IPPM to ensure that their perceptions regarding IPPM services were not influenced by post-IPPM experiences.

The women psychiatric offender questionnaire was administered in person or by telephone by a representative from the Evaluation Branch of CSC. This approach enabled the interviewer to respond to any questions that the respondent had about the questionnaire. However, given that the interviewer was an employee of CSC, the respondent may have had concerns about confidentiality and providing full disclosure. In contrast, the male psychiatric and male sex offender questionnaires were self-administered by the offenders; thus, discomfort with self-disclosure was likely minimised. However, misunderstanding of the questions may have impacted the validity of the data.

[25] Typically the incomplete interview portion was restricted to some of the general questions placed at the end of the interview where the respondent was asked to identify any unexpected outcomes and comment on what components of the contract they liked value least/most. Two of the eight key informants at Joliette Institution and two of the seven key informants at La Macaza Institution did not fully complete the interview. As well, two of the 14 key informants interviewed at IPPM did not fully complete the interview.

### *2.6.4 Quasi-Experiment*

Limitations of the quasi-experimental portion of this evaluation are associated with the nature of selection and placement of offenders to IPPM. Ideally, a true experimental design would generate the strongest comparisons for quantitative analyses. This type of research design would randomly assign offenders to either IPPM or CSC's RTCs from a pool of appropriate candidates. Because random placement was neither possible nor practical, the current evaluation report used a quasi-experimental design for quantitative analyses and a matching technique was employed to compare and assess effectiveness across a number of outcome measures for the male psychiatric and sex offender populations. However, matching was not feasible for the women psychiatric population due to the small numbers of women offenders sent to both IPPM and Churchill since the opening of IPPM's Women Unit in 2004.

Data quality issues stemmed from both lack of available OMS data and, in some cases, the complexity of manipulations required to analyse and interpret available OMS data. Consequently, some outcome indicators of success that had been identified in the Results-Based Management and Accountability Framework were replaced with SRS and SRSW proxy measures. Though the SRS and SRSW provide relevant data that are readily accessible in OMS, the recency with which these measures were introduced (1998 for the SRS and 2005 for the SRSW) precluded the possibility of carrying out some pre/post-intervention comparisons. Also, the standard use of omnibus parametric tests for outcome analyses were prohibited because SRS and SRSW sub-scales collapse continuous variables into discrete variables (for example, number of institutional incidents is coded as "none", "one", "two", and "three or more", rather than coded as a continuous variable). Lastly, given the infrequency with which SRS and SRSW scores are re-assessed (i.e., annually, in most cases), it was not possible to determine the precise length of time that had elapsed between post-IPPM/RTC intervention and first occurrences of key events, such as first post-intervention incidents of involuntary segregation or convictions for serious disciplinary offences.

Results of this evaluation indicate that the effectiveness of services provided by IPPM are similar to those provided by CSC's RTCs in terms of producing expected outcomes and meeting the CSC's needs (e.g., the Pinel populations and the comparison groups did not differ in terms of recidivism rates or changes over time in adjustment and functioning). However, it is important to note that small sample sizes, rendered even smaller by the limited time periods for which some

OMS data are available, precluded the possibility of conducting certain pre/post-test analyses, particularly for the sample of women. In addition, the small sample size may have diminished the statistical power of some quantitative analyses, thereby masking significant effects. To address this limitation, more in-depth and comprehensive forms of data gathering (e.g., qualitative data gathered from offender file reviews and key informant interviews) were utilized.

Given the small sample sizes and restrictions in the availability of relevant OMS data, it was not possible within the context of the current evaluation to compare outcomes for psychiatric offenders sent to IPPM or RTCs for assessment only with those sent for both assessment and treatment. For the same reasons, it was also not possible to compare outcomes for offenders who completed the purpose of their stay at IPPM or RTCs with those who did not do so. Such comparisons may have enabled more detailed conclusions regarding which types of services provided by IPPM benefit federal offenders most/least and whether there is a need to implement more stringent selection criteria for offenders sent to IPPM (e.g., based on offenders' likelihood of completing assessments/treatments). Despite this limitation, the pervasive lack of significant differences between IPPM and comparison group members in the current evaluation's findings suggest that within-group factors would likely not alter the evaluation conclusions in any meaningful way. However, should the decision be made to renew the contract between CSC and IPPM in the future, it is recommended that specific provisions be included for the collection of relevant data in order to better inform future evaluations.

## 3.0 Evaluation Findings

Findings and recommendations pertaining to each of the three offender populations are presented separately under their respective evaluation objectives, namely program relevance, design and implementation, and effectiveness. General findings for the three offender populations are presented under governance and accountability, and cost-effectiveness as there was considerable overlap.

Quantitative data from the offender satisfaction questionnaires and the key informant interviews with CSC internal stakeholders, IPPM staff, and staff at the Joliette and La Macaza Institutions who are involved in the management and delivery of programming/treatment are presented in table format in support of the qualitative data. Quantitative data were not collected during the 'group discussion' interviews with staff at the Archambault Institution, but qualitative data from Archambault Institution are presented where relevant.

### 3.1 Women Psychiatric Offenders

#### *3.1.1 Program Relevance*

***Objective 1: Relevance***

*The extent to which the contract realistically addresses and actual need.*

**<u>Occupancy Rates</u>**

***FINDING 1: The number of Canadian women offenders suffering from mental health problems is increasing, as is the complexity of offenders' behavioural problems. In the context of this trend, IPPM is operating below its capacity. Contributing factors include limited awareness about the program among CSC personnel and offenders, the voluntary nature of admission and treatment and offender reluctance to self-admit to IPPM, delays in processing referrals, and a high rate of offenders refusing service at IPPM.***

CSC administrative records indicate that, in the initial year of the contract (2004-2005), the annual occupancy rate for the minimum of 12 beds at the IPPM women offender unit was 68%. The annual occupancy rate declined to 56% in the second year of the contract and increased to 72% in the third year of the contract (see Table 5).

**Table 5: Women offender occupancy rate at IPPM**

| Year | Total Number of Bed-Days Used at IPPM | Average Number of Beds Occupied | Occupancy Rate[a] |
|---|---|---|---|
| 2004 – 2005 | 2,963 | 8.1 | 67.5% |
| 2005 – 2006 | 2,445 | 6.7 | 55.8% |
| 2006 – 2007 | 3,129 | 8.6 | 71.7% |

[a] Based on the minimum 12 beds available per day (or 5475 bed-days per year).
Source: Regional Administration/Regional Headquarters (Quebec). 2008.

Results from interviews with key sources support the findings contained in the administrative records as most of the key sources interviewed (12 of 15) confirmed that the women's unit at IPPM has never reached full capacity. Several CSC internal stakeholders reported that the largest number of beds occupied in IPPM's women's unit at any one time was 10; this occupancy rate lasted for a period of approximately three months.

Results from interviews with key sources also confirmed that IPPM has a sufficient number of beds for women offenders relative to the number of referrals from CSC. Most of the CSC internal stakeholders, IPPM staff members, and Joliette Institution staff members (18 of 22) reported that there are a sufficient number of beds available at IPPM for women psychiatric offenders (see Table 6).

**Table 6: "Is there a sufficient number of beds available at IPPM for women psychiatric offenders relative to the number of referrals from CSC?"**

| | | Yes | No | Unsure | Total |
|---|---|---|---|---|---|
| CSC Internal Stakeholders | *n* | 7 | 0 | 1 | 8 |
| | % | 87.5 | 0.0 | 12.5 | 100.0 |
| IPPM Staff | *n* | 8 | 0 | 1 | 9 |
| | % | 88.9 | 0.0 | 11.1 | 100.0 |
| Joliette Staff | *n* | 3 | 0 | 2 | 5 |
| | % | 60.0 | 0.0 | 40.0 | 100.0 |
| Total | *n* | 18 | 0 | 4 | 22 |
| | % | 81.8 | 0.0 | 18.2 | 100.0 |

Interviews with CSC internal stakeholders, IPPM staff, and Joliette Institution staff revealed a number of contributing factors that are resulting in the low occupancy rates including:

- limited promotion of the IPPM program in CSC institutions;

- inadequate preparation of women offenders for their assessment and/or treatment at IPPM;
- delays experienced by CSC in preparing and processing referrals;
- reluctance on the part of suitable candidates to admit themselves to IPPM; and,
- offenders being discharged early from IPPM as a result of their refusal to participate in the assessment and/or treatment process.

An examination of the assessment and treatment completion rates at IPPM confirms that there is a high incidence of women offenders leaving IPPM prior to the completion of their assessment and/or treatment. For example, over half of the women offenders sent to IPPM for both assessment and treatment did not complete the purpose of their stay at IPPM (53.8%; *n* = 19). The primary reason for non-completion was the offender's refusal to participate in the assessment and treatment process.

CSC internal stakeholders consider the women's unit at IPPM to be relevant in responding to the growing need for specialized mental health services for women offenders. CSC internal stakeholders also reported that the behavioural problems of offenders are becoming more complex and there are many women offenders who would benefit from the services provided by IPPM. In 2006, CSC determined that over 25% of its female offenders were in need of mental health interventions.[26]

***RECOMMENDATION 1: CSC should continue to monitor the occupancy rates of the women psychiatric offender beds at IPPM and low occupancy rates should be systematically flagged. CSC and IPPM should review the way IPPM services/programs are currently being promoted in CSC institutions and explore options for increasing awareness among CSC personnel and offenders. CSC and IPPM should review the referral process to identify options for addressing issues that are causing delays. The Joint Committee should identify the causes associated with women's reluctance to self-admit to IPPM.***

**CSC and Community-based Alternatives**

***FINDING 2: No suitable community-based alternatives to IPPM were identified based on the feedback provided by key sources. Existing CSC facilities continue to require the specialized services of IPPM for the women psychiatric offender population.***

[26] Treasury Board Submission - Institut Philippe-Pinel de Montréal. April 3, 2006.

The need for the specialized services provided by IPPM is reinforced by the lack of community-based alternatives and the limited options within CSC institutions. Most CSC internal stakeholders and Joliette Institution staff were unable to identify any community-based alternatives for women psychiatric offenders other than the services provided by IPPM. Many of the respondents reported that there are no community services available that are comparable to the services provided by IPPM, especially considering the security requirements of this population. It was further noted that community hospitals and psychiatric hospitals will rarely admit people with severe disorders as these facilities do not have the resources to manage disruptive and dangerous cases.

As reported by one CSC internal stakeholder, CSC has agreements with some certified hospitals (e.g., Grand River, Kitchener, St. Thomas) for the provision of psychiatric services on a very short term basis, but these hospitals do not have the infrastructure and security features that IPPM offers, nor do they typically offer bilingual services or services that are sensitive to the needs of Aboriginals.

With respect to alternative options for the women psychiatric offender population within CSC, CSC internal stakeholders and Joliette staff identified the Churchill Unit at the RPC in Saskatoon as CSC's primary option for the intensive care of women offenders.

CSC internal stakeholder sources stressed that a key strength of IPPM relative to the Churchill facility is the provision of intense treatment with more psychiatric services and a greater emphasis on treatment-related, rather than corrections-related, activities. It was also noted that “medication management and stabilization are much more superior at IPPM”. As well, it was reported that the Churchill facility does not offer services in French and there is sometimes a waiting list because the unit generally has its 12 beds fully occupied.

A staff member at IPPM suggested that offenders tend to respond better to treatment in a hospital setting than in a penitentiary. It was noted that offenders at IPPM appreciate having more control/input about their condition than is possible in a penitentiary.

## Viability of CSC Developing/Implementing New Services to Replace IPPM

***FINDING 3: CSC stakeholders are generally more in favour of maintaining the existing services at IPPM and exploring opportunities for expanding/enhancing services at IPPM rather than developing new services within CSC. CSC stakeholders are also interested in examining research activities with IPPM as a way to add value to the contract.***

Many of the CSC internal stakeholders believe that it would not be viable for CSC to develop and implement new services for the women psychiatric offender population to replace the services currently being provided by IPPM. It was noted that mental health is emerging as an increasingly important concern to CSC and, although CSC has extensive experience with sex offender programs, it needs IPPM's expertise with mental health to ensure that it uses appropriate assessment and treatment responses. It was suggested that it would be a very long process to develop and implement an operational plan that would provide equivalent services within CSC. It was noted that IPPM operates on a corporate model and, consequently, they are quicker in responding than CSC.

Rather than developing and implementing new services and building new facilities, some respondents suggested that CSC needs to "maximize what IPPM currently has to offer" and "determine what could be improved at IPPM for expanded CSC use". Some of the ideas presented include:

- developing and implementing a strategy at IPPM for handling the small population of disruptive offenders that fall outside the current abilities of CSC and IPPM;
- establishing a CSC-operated surveillance unit at IPPM. This type of facility would provide a similar environment to a hospital and would allow the offender to be monitored even if she does not consent to treatment;[27] and,
- examining ways to get more value from the contract through research and sharing best practices.

One CSC internal stakeholder suggested the need for a better balance between the Churchill facility and IPPM. It was noted that CSC currently has a total of 27 psychiatric beds available for women between Churchill and IPPM, but perhaps only 18 beds are needed. However, it was also noted that closing Churchill is not a real option as the facility is still needed for admitting offenders with the highest need. The issue of offenders based in western Canada preferring a facility closer to home was also raised. It was emphasized that CSC covers a large

[27] Under Canadian mental health legislation, it would not be permissible to send offenders to IPPM without their consent if they were deemed capable of providing consent.

territory as a national service and the provision of services for women offenders at Churchill and IPPM reflects this reality.

Another CSC internal stakeholder suggested that CSC services could be expanded in the correctional context for some women who do not require IPPM services, but who still need some support to deal with mental health issues. It was reported that the population of women offenders is increasing and many of the women suffer from mental illness. It was noted that "CSC may eventually have to create mental health units within all penitentiaries to deal with this issue". It was further noted that, until fairly recently, CSC had very few resources to deal with offenders suffering from mental illness and the CSC programs department still does not have all the necessary mental health-related knowledge it needs. On a positive note, it was reported that people at CSC have the will to address mental health issues and to train staff accordingly, and this will has been put in motion with the specialised training of Parole Officers that is now underway.

***RECOMMENDATION 2: The Joint Committee should examine options for expanding/enhancing services at IPPM to better respond to the needs of CSC.***

**Compliance with the Intended Purpose of the Contract between CSC and IPPM**

***FINDING 4: IPPM is generally being used for its intended purpose. However, the current service agreement with IPPM leaves CSC with no options for women offenders who will not self-admit to IPPM or those who refuse service while at IPPM. Furthermore, on some occasions CSC institutions refer "difficult cases" to IPPM in order to provide these offenders with alternative services that may prove more effective than those available within CSC institutions. IPPM is normally very strict in applying the admission criteria, but attempts to be flexible in accepting these cases.***

Just over 90% (19 of 21) of the key sources interviewed believe that IPPM is being used for its intended purpose as it relates to the women offender population (see Table 7).

**Table 7: "IPPM is being used for its intended purposes under the terms of the contract with CSC."**

| | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Total |
|---|---|---|---|---|---|---|---|
| CSC Internal Stakeholders | *n* | 0 | 0 | 0 | 6 | 1 | 7 |
| | % | 0.0 | 0.0 | 0.0 | 85.7 | 14.3 | 100.0 |
| IPPM Staff | *n* | 0 | 0 | 0 | 3 | 5 | 8 |
| | % | 0.0 | 0.0 | 0.0 | 37.5 | 62.5 | 100.0 |
| Joliette Staff | *n* | 0 | 1 | 1 | 4 | 0 | 6 |
| | % | 0.0 | 16.7 | 16.7 | 66.7 | 0.0 | 100.0 |
| Total | *n* | 0 | 1 | 1 | 13 | 6 | 21 |
| | % | 0.0 | 4.8 | 4.8 | 61.9 | 28.6 | 100.0 |

In line with the intended purpose of the contract between CSC and IPPM, internal stakeholders reported that the main purpose of the contract with IPPM is to increase CSC's capacity for women psychiatric treatment beds.

This includes beds for women offenders from across Canada who are difficult to handle in a regular correctional environment. A key distinction is made between CSC units (which are penitentiaries) and IPPM (which is a psychiatric hospital with high security features). It was emphasized that women offenders are sent to IPPM for its assessment value and ability to stabilize offenders sufficiently to function in CSC programs when they return to their parent institution. CSC internal stakeholders also noted that IPPM is better able to deal with women offenders who commit self-mutilation. It was emphasized that women "are not sent to IPPM for its correctional value."

Also in keeping with the intended purpose of the contract between CSC and IPPM, CSC internal stakeholders reported that IPPM is providing long-term treatment for indefinite periods of time based on the needs of the offender, as well as emergency services (particularly for offenders from Quebec Region with acute psychiatric needs). In addition, one CSC source noted that some CSC institutions may view IPPM as an option for women offenders who are struggling with DBT treatment in the CSC setting.

CSC internal sources indicated that they are pleased with IPPM's ability to carry out the intended purpose of the contract between CSC and IPPM. Specifically, they reported that IPPM is providing comprehensive assessments and conducting excellent work in stabilizing offenders while using the least restrictive methods.

Two CSC internal stakeholders noted that some women offenders in CSC institutions "can be very hard to handle" and questioned whether some offenders were being referred to IPPM in order to provide alternative services when those offered by CSC appear ineffective. It was suggested that there is a "real lack of understanding among senior staff and even some health professionals at CSC regarding the purpose of IPPM". It was noted that IPPM is clear about the admission criteria and is usually very strict, but has also demonstrated that it can be flexible in responding to the needs of CSC.

IPPM staff reported that psychiatric assessment and treatment services for women offenders in eastern Canada were very limited prior to the introduction of the women's unit at IPPM. It was noted that the contract between CSC and IPPM responds to the findings from the Federal Task Force on federally incarcerated women (CSC, 1990). As described by IPPM sources, the key services provided by IPPM for the women offender population include stabilizing the offender, completing a thorough and detailed assessment, and providing DBT. It was noted that IPPM admits offenders from CSC institutions who are unable to function in the CSC system.

IPPM staff sources reported that the initial psychiatric assessment lasts approximately 30 days and can include stabilizing the offender when she is first admitted. It was noted that the assessment is very comprehensive and includes a second and third opinion. IPPM sources reported that they also offer a treatment program for women offenders with personality disorders using the preferred CSC model – DBT. However, in the IPPM setting, DBT is offered in conjunction with other psychotherapeutic and pharmacological approaches where deemed appropriate. It was noted that DBT in the CSC setting has not been meeting all of the needs of some women and the IPPM program is designed to help women with their adaptation skills to better enable them to reintegrate back into CSC institutions.

As stipulated by the objectives of contract between CSC and IPPM for the women psychiatric population, IPPM sources reported that their main focus is on preparing offenders for their return to the CSC system. However, it was noted that IPPM can also help offenders "think ahead" and prepare for reintegration into society if their sentence is coming to an end.

In contrast to the opinions expressed by CSC internal stakeholders and IPPM staff members, staff sources at the Joliette Institution suggested that the contract does not adequately address the needs of CSC. Currently, the contract meets the needs of offenders who are willing to

participate in the program, but the arrangement lacks a strategy for dealing with offenders who could potentially benefit from the program but who decline to admit themselves to IPPM or who refuse service once they arrive at IPPM. As noted by one Joliette source, when offenders sign refusals for treatment at IPPM, the staff at Joliette Institution lack other recourses for working with offenders who require services other than those available within CSC. It was suggested that a strategy is needed to respond to refusals (e.g., a collaborative 'intervention' effort by CSC and IPPM staff to try to convince women to stay at IPPM).

Joliette staff sources also suggested that the criteria for emergency admissions (e.g., life must be in danger) are generally too strict. It was noted that, as soon as an offender is stabilized at IPPM, she is returned to Joliette and often the cycle begins again shortly after her return.

One Joliette staff source also noted that, according to the current admission/exclusion criteria, IPPM is not obliged to admit offenders who are under a Management Protocol (i.e., women who have been involved in a major security incident and have not commenced the reintegration phase of the Protocol), which means offenders who could potentially benefit from the program at IPPM may be denied admission.

***RECOMMENDATION 3: The Joint Committee should examine treatment options for women offenders who will not admit themselves to IPPM or those who refuse treatment at IPPM.***

## Relevance of IPPM Services to Women Psychiatric Offenders

***FINDING 5: Women offenders are generally satisfied with the services they receive at IPPM.***

As part of the women offender satisfaction questionnaire, participants were asked to indicate their level of satisfaction with the services they received at IPPM.[28] Just over 70% (12 of 17) of the women offenders interviewed reported that they were mostly or completely satisfied with the services they received at IPPM, while 12% (2) reported that they were somewhat satisfied and 18% (3) were dissatisfied. There were no significant differences between Aboriginal and non-Aboriginal offenders or French and English speaking offenders ($t(15) = 1.34$, $p = .201$ and $t(15) = .45$, $p = .661$, respectively).

[28] In accordance with the RMAF, overall satisfaction was only examined for the women psychiatric population due to the recency of the opening of the women's unit at IPPM.

### *3.1.2 Design and Implementation*

| |
|---|
| ***Objective 2: Design and Implementation*** |
| *The extent to which admissions and refusals to IPPM are appropriate.* |
| *The extent to which the services at IPPM have been implemented as intended.* |
| *The extent to which the treatment being provided by IPPM facilitates a continuum of care.* |
| *The extent to which the services being provided by IPPM are sensitive to the needs of Aboriginal offenders and offenders' preferred official language of service.* |

#### *3.1.2.1 Admissions to IPPM*

***FINDING 6: The admission and exclusion criteria for women offenders contain sufficient detail and clarity and in most cases the women psychiatric offenders who are sent to IPPM meet the appropriate offender profile. However, CSC and IPPM sources identified the need for CSC personnel to be better informed about the admission and exclusion criteria and the referral and admission process. IPPM and CSC institution staff sources identified the need for more clinicians and psychiatrists from CSC to be involved in the referral/admission process.***

Overall, most of the CSC internal stakeholders (6 of 8) and all of the Joliette Institution staff members (5) and IPPM staff members (9) interviewed reported that the admission and exclusion criteria as they relate to the women offender population have sufficient detail and clarity.

The majority of the CSC internal stakeholders (83%, 5 of 6) and all Joliette staff sources (4) reported that most of the women offenders who are sent to IPPM meet the criteria for admission. From the perspective of IPPM, close to 67% (6 of 9) of staff sources reported that all of the women psychiatric offenders who are sent to IPPM meet the appropriate offender profile, while 33% of the IPPM sources reported that most offenders meet the appropriate profile (see Table 8).

Although sources were unable to provide specific numbers, CSC internal stakeholders, IPPM staff and Joliette staff all reported that very few women have been refused admission to IPPM. Some of the more common reasons for being refused admission include lack of motivation and refusal for treatment.

**Table 8: "To what extent do the offenders who are sent to IPPM meet the appropriate offender profile?"**

| | | Never Rarely | In Some Cases | In Most Cases | In All Cases | Total |
|---|---|---|---|---|---|---|
| CSC Internal Stakeholders | *n* | 0 | 1 | 5 | 0 | 6 |
| | % | 0.0 | 16.7 | 83.3 | 0.0 | 100.0 |
| IPPM Staff | *n* | 0 | 0 | 3 | 6 | 9 |
| | % | 0.0 | 0.0 | 33.3 | 66.7 | 100.0 |
| Joliette Staff | *n* | 0 | 0 | 4 | 0 | 4 |
| | % | 0.0 | 0.0 | 100.0 | 0.0 | 100.0 |
| Total | *n* | 0 | 1 | 12 | 6 | 19 |
| | % | 0.0 | 5.3 | 63.2 | 31.6 | 100.0 |

lthough the key sources interviewed in this study identified a high degree of compliance with the offender admission criteria, some of the CSC internal stakeholders reported that staff at CSC institutions may not have a common and comprehensive understanding of the criteria, and it was suggested that staff turnover in CSC institutions could be a factor in limiting awareness of the criteria.

With respect to possible improvements to the referral/admission process, CSC internal stakeholders, IPPM staff and staff members at the Joliette Institution provided a number of suggestions. The majority of these were aimed at issues that CSC should address, including:

- enhancing the promotion of IPPM admission/exclusion criteria in CSC institutions;
- improving CSC personnel awareness of mental health issues and the mandate and services provided by IPPM;
- requiring CSC institutions to provide a detailed description of the reasons for which an offender is well suited for IPPM, why they think the offender will benefit from IPPM, and what they want to see achieved from the stay at IPPM;
- implementing a more thorough assessment of offender motivation, stage of change, etc. prior to referring to IPPM in order to reduce the likelihood of an offender dropping out of IPPM. It was suggested that perhaps the Health Services Branch could examine whether CSC institutions are appropriately applying readiness assessment standards;

- requiring that CSC institutions have all support documents (e.g., evidence of treatment plans to date, observed improvements if applicable) prepared for the internal discussion with CSC NHQ and the conference call with IPPM;
- requiring greater involvement of CSC clinicians and psychiatrists in the referral/admission process;
- requiring CSC institutions to inform IPPM if offenders are being sent to IPPM for the purpose of providing alternative services that may prove more effective than those offered by CSC;
- providing offenders with information on travel (flight) limitations to and from IPPM in advance of their trip to IPPM because there is only one flight per month traveling east and west;
- providing IPPM with more information on the staffing/service challenges faced by CSC and the need for IPPM to respond to emergency cases; and,
- consulting with CSC institutions to make the referral/admission process as efficient as possible.

***RECOMMENDATION 4: In collaboration with IPPM and CSC institutions, the admission and exclusion criteria should be more intensely promoted by CSC within CSC and IPPM to ensure that the criteria are consistently applied. CSC should also review and confirm the key CSC/IPPM stakeholders that need to be engaged in the referral and admission process.***

#### *3.1.2.2 Implementation of Interventions*

**Mental Health Plans**

***FINDING 7: All women psychiatric offenders generally have their mental health treatment plans adjusted while at IPPM. Offenders are under constant observation at IPPM and their treatment plans are adjusted on a weekly and sometimes daily basis. However, the paper copy files provided by IPPM lack sufficient clarity and detail to determine whether treatments are effective.***

The majority of CSC internal stakeholders (80%, 4 of 5) and all of the Joliette Institution staff (1) and IPPM staff sources (9) reported that, in keeping with IPPM's ongoing and dynamic assessment and treatment approach, most or all women psychiatric offenders have their mental health plans adjusted while at IPPM (see Table 9).

**Table 9: "Based on what you observe, to what extent do offenders have their mental health plans adjusted while at IPPM?"**

| | | Never Rarely | In Some Cases | In Most Cases | In All Cases | Total |
|---|---|---|---|---|---|---|
| CSC Internal Stakeholders | *n* | 0 | 1 | 1 | 3 | 5 |
| | % | 0.0 | 20.0 | 20.0 | 60.0 | 100.0 |
| IPPM Staff | *n* | 0 | 0 | 0 | 9 | 9 |
| | % | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 |
| Joliette Staff | *n* | 0 | 0 | 1 | 0 | 1 |
| | % | 0.0 | 0.0 | 100.0 | 0.0 | 100.0 |
| Total | *n* | 0 | 1 | 2 | 12 | 15 |
| | % | 0.0 | 6.7 | 13.3 | 80.0 | 100.0 |

A review of the women offender paper copy files was undertaken to determine the extent to which individualized treatment plans were developed for offenders during their stay at IPPM. During the file review process it was discovered that some files contained incomplete or missing documents and reports. In some cases the information was hand written and illegible. Although electronic copies of offender files are also available on OMS, the format of data entry is inconsistent because, over time, offender file information was made available only in paper copy, only on OMS, or both.

Most women who are admitted to IPPM are either in crisis or are being admitted for the second, third, or fourth time because they have decided that they need and are ready to seek out assistance and treatment for their disorder. The file review also revealed that many women offenders go to IPPM for assessment and are discharged before the treatment phase can start due to an incident (e.g., violence against inmates or staff). Premature discharge from IPPM also occurs because patients are unable to adapt to IPPM's environment and the regulations that are imposed at IPPM.[29] However, despite the high frequency of early discharges, it does seem that, in most cases, some form of treatment is taking place the entire time that the offender is at IPPM, even if there is no formal plan outlined. For example, their medications are being changed, general behavioural management principles are used, or suicide prevention measures are taken.

Although there are some information gaps in the file records, IPPM does complete an evaluation report at the beginning of an offender's stay and a final report at the end. These

[29] Additional details on rates of treatment completion and non-completion and reasons for non-completion are provided in section 3.4 of this report.

reports contain a substantial amount of information about the history of the offender and are very thorough in terms of the psychological testing that is done. However, they do not specifically report on the treatment plan being proposed or used or on whether any progress was made. The reports generally indicate that treatment was conducted or the offender met her objectives, but the records do not indicate what the treatment was or what the objectives were. As well, the reports do not always provide clear recommendations for future actions to be taken post-IPPM.

Many of the offender files indicate that, while in the CSC institutions, offenders undergo some form of therapy/treatment. This generally takes place after returning from IPPM. However, it is not clear whether the treatment offenders undergo in these institutions is actually recommended by IPPM or if it is initiated and sustained by the institutions' psychiatric teams.

The records indicate that DBT is often used at IPPM, but in many cases the treatment is interrupted because of a setback experienced by the offender that causes her to give up. DBT requires a certain level of concentration, as well as the ability to memorize concepts. For the majority of the women, this is very difficult. To accommodate women with low intelligence levels and/or problems concentrating, IPPM modifies DBT and conducts shorter sessions, usually on a one-on-one basis with the offender.

***RECOMMENDATION 5: IPPM reports/documents should clearly identify the treatment plan for each women offender. In addition, these reports should provide greater details regarding the objectives and any progress made toward achieving these objectives. Recommendations for post-IPPM treatment should also be clearly identified in the reports.***

## Physical Health, Cultural, Spiritual Interventions

***FINDING 8: IPPM is addressing the physical health needs of the women offender population. While women offenders are largely satisfied with the physical health services they receive at IPPM, they appear to be less satisfied with the cultural and religious/spiritual interventions that are made available at IPPM.***

### *Physical Health Needs*

All of the CSC internal stakeholder sources (7), Joliette staff sources (4), and IPPM staff sources (9) reported that the physical health needs of women psychiatric offenders are being met while at IPPM.

Results from the women offender satisfaction questionnaire support the above finding as 40% (8 of 17) of the offenders indicated that their physical health needs were met most of time or all of the time, while a further 23% (4) reported that their needs were met half of the time. Four of the offenders (23%) noted that their physical health needs were met some of the time and only one offender (6%) indicated that her needs were never met.

Most of the offenders (16 of 17) reported that they discussed their physical health needs with IPPM staff on more than one occasion. Of the 15 offenders who asked IPPM staff questions about their physical health, 40% indicated that they received answers that they could understand most of the time or always, while a further 33% reported that they received answers they could understand half of the time. Two offenders indicated that they could understand the answers provided by IPPM staff some of the time (13%) and two offenders reported that they could never understand the answers provided by IPPM staff in relation to their physical health questions (13%).

***Cultural and Spiritual Needs***

Women offenders were asked to indicate the extent to which their cultural needs were met while at IPPM. Seven offenders reported that this question was not applicable to them. Of the 10 offenders who indicated that this was applicable, 30% indicated that their cultural needs were met most of time or all of the time, while a further 20% reported that their needs were met half of the time. Three of the offenders (30%) noted that their cultural needs were met some of the time and a further two (20%) indicated that their cultural needs were never met. There was no significant difference between Aboriginal and non-Aboriginal offenders in this sample ($t(8) = 1.21$, $p = .260$).

Women offenders were also asked to indicate the extent to which their religious/spiritual needs were met while at IPPM. Seven offenders reported that this question was not applicable to them. Of the 10 offenders who indicated that this was applicable, 20% indicated that their religious/spiritual needs were met most of time or all of the time, while a further 10% reported that their needs were met half of the time. Two of the offenders (20%) noted that their religious needs were met some of the time, while 5 offenders (50%) reported that their religious needs were never met. There was no significant difference between Aboriginal and non-Aboriginal offenders in this sample ($t(8) = -.60$, $p = .564$).

Offenders were also asked if they ever requested something that was not already at IPPM in order to meet their religious/spiritual needs. Only four of the offenders reported that they had asked for something religious. Three of these offenders indicated that their request was addressed some of the time or always, while one offender reported that her request was not addressed.

Aboriginal participants were asked to indicate the extent to which their Aboriginal cultural needs were met while at IPPM. Of the six women offenders who responded to this question, 33% indicated that their needs were met to some extent, while 50% of the offenders reported that their needs were not met at all. One respondent was undecided.

Respondents who indicated that their cultural needs had not been met at IPPM were presented with a list of specific activities and asked to indicate the activities that were lacking at IPPM (they were also allowed to identify other activities not on the list). All five of the offenders identified the need for enhancement of the following features at IPPM:

- Access to or availability of Aboriginal activities;
- Aboriginal specific programs;
- Staff sensitivity to Aboriginal culture; and,
- Access to Aboriginal elders.

As well, 80% of the offenders identified the need for more involvement with Aboriginal persons in the nearby community.

***RECOMMENDATION 6: CSC and IPPM should conduct a review of the religious/spiritual interventions and Aboriginal activities at IPPM to ensure that the interventions are adequately responding to the needs of women offenders.***

**Linguistic Sensitivity**

***FINDING 9: Women offenders at IPPM are receiving services in the official language of their choice. However, preliminary evidence suggests that English-speaking offenders may receive service in the official language of their choice less frequently than French-speaking offenders.***

As part of the offender satisfaction questionnaire, participants were asked to indicate their language of choice for service at IPPM and the extent to which they received services in the official language of their choice while at IPPM.

The women psychiatric offender sample was almost evenly split between offenders who chose French (47%) and English (53%) as their official language for service. The majority (71%) of women offenders reported that they always received services at IPPM in the official language of their choice (see Table 10). However, English-speaking offenders reported a significantly lower frequency of service in their official language of choice than did French-speaking offenders ($t(15) = 2.66$, $p = .018$).[30]

**Table 10: Extent to which women offenders receive services at IPPM in their preferred language.**

| | | Never | Some of the Time | Half of the Time | Most of the Time | Always | Total |
|---|---|---|---|---|---|---|---|
| French | *n* | 0 | 0 | 0 | 0 | 8 | 8 |
| | % | 0.0 | 0.1 | 0.1 | 0.0 | 100.0 | 100.0 |
| English | *n* | 0 | 3 | 1 | 1 | 4 | 9 |
| | % | 0.0 | 33.3 | 11.1 | 11.1 | 44.4 | 100.0 |
| Total | *n* | 0 | 3 | 1 | 1 | 12 | 17 |
| | % | 0.0 | 17.6 | 5.9 | 5.9 | 70.6 | 100.0 |

***RECOMMENDATION 7: Future evaluations should further examine the differences between French and English offenders and the frequency with which they receive service in their official language of choice.***

### *3.1.2.3 Continuity of Care*

**<u>Satisfaction with the Communication Process</u>**

***FINDING 10: CSC internal stakeholders and IPPM staff are generally satisfied with the completeness and timeliness of the women offender information exchanged. However, staff at the Joliette Institution, including psychologists, behavioural counsellors, and parole officers, identified the need for additional details about offenders' experience/progress during their stay at IPPM and greater direct engagement with IPPM personnel to enhance the continuity of care.***

Key informants were asked to comment on their level of satisfaction with the completeness and timeliness of the information that is exchanged between CSC and IPPM, as well as their overall satisfaction with the communication process. The results indicate that both CSC internal stakeholders (72%, 5 of 7) and IPPM staff members (86%, 6 of 7) are satisfied or

[30] Results should be interpreted with caution due to the small sample size.

very satisfied with the communication process, while staff members at the Joliette Institution (67%, 4 of 6) are dissatisfied with the process (see Table 11).

**Table 11: "How satisfied are you with the completeness of the information provided by CSC/IPPM?"**

| | | Very Dissatisfied | Dissatisfied | Neutral | Satisfied | Very Satisfied | Total |
|---|---|---|---|---|---|---|---|
| CSC Internal Stakeholders[a] | *n* | 0 | 0 | 2 | 3 | 2 | 7 |
| | % | 0.0 | 0.0 | 28.6 | 42.9 | 28.6 | 100.0 |
| IPPM Staff [b] | *n* | 0 | 0 | 1 | 1 | 5 | 7 |
| | % | 0.0 | 0.0 | 14.3 | 14.3 | 71.4 | 100.0 |
| Joliette Staff [a] | *n* | 0 | 4 | 1 | 1 | 0 | 6 |
| | % | 0.0 | 66.7 | 16.7 | 16.7 | 0.0 | 100.0 |
| Total | *n* | 0 | 4 | 4 | 5 | 7 | 20 |
| | % | 0.0 | 20.0 | 20.0 | 25.0 | 35.0 | 100.0 |

[a] Satisfaction with information provided by IPPM
[b] Satisfaction with information provided by CSC

With respect to timeliness, most of the CSC internal stakeholder sources (88%, 7 of 8) are satisfied with the timeliness of the information provided by IPPM as it relates to the women offender population, as are most of the IPPM sources (88%, 7 of 8; see Table 12). However, only about one third of the sources from Joliette (2 of 6) reported that they are satisfied with the timeliness of the information they receive, while half of the Joliette sources are neutral and one individual is dissatisfied.

**Table 12: "How satisfied are you with the timeliness of the information provided by CSC/IPPM?"**

| | | Very Dissatisfied | Dissatisfied | Neutral | Satisfied | Very Satisfied | Total |
|---|---|---|---|---|---|---|---|
| CSC Internal Stakeholders [a] | *n* | 0 | 0 | 1 | 4 | 3 | 8 |
| | % | 0.0 | 0.0 | 12.5 | 50.0 | 37.5 | 100.0 |
| IPPM Staff [b] | *n* | 0 | 0 | 1 | 1 | 6 | 8 |
| | % | 0.0 | 0.0 | 12.5 | 12.5 | 75.0 | 100.0 |
| Joliette Staff [a] | *n* | 0 | 1 | 3 | 2 | 0 | 6 |
| | % | 0.0 | 16.7 | 50.0 | 33.3 | 0.0 | 100.0 |
| Total | *n* | 0 | 1 | 5 | 7 | 9 | 22 |
| | % | 0.0 | 4.5 | 22.7 | 31.8 | 40.9 | 100.0 |

[a] Satisfaction with information provided by IPPM
[b] Satisfaction with information provided by CSC

All of the IPPM sources (8) are satisfied with the structure and process used for exchanging information between CSC and IPPM as it relates to the women offender population, as are most of the CSC internal stakeholders (75%, 6 of 8; see Table 13). However, half of the sources from Joliette (3 of 6) reported that they are dissatisfied with the communication structure and process, while the other half are neutral.

**Table 13: "Overall, how satisfied are you with the structure and process that is used for exchanging information between CSC and IPPM?"**

| | | Very Dissatisfied | Dissatisfied | Neutral | Satisfied | Very Satisfied | Total |
|---|---|---|---|---|---|---|---|
| CSC Internal Stakeholders | *n* | 0 | 0 | 2 | 4 | 2 | 8 |
| | % | 0.0 | 0.0 | 25.0 | 50.0 | 25.0 | 100.0 |
| IPPM Staff | *n* | 0 | 0 | 0 | 2 | 6 | 8 |
| | % | 0.0 | 0.0 | 0.0 | 25.0 | 75.0 | 100.0 |
| Joliette Staff | *n* | 0 | 3 | 3 | 0 | 0 | 6 |
| | % | 0.0 | 50.0 | 50.0 | 0.0 | 0.0 | 100.0 |
| Total | *n* | 0 | 3 | 5 | 6 | 8 | 22 |
| | % | 0.0 | 13.6 | 22.7 | 27.3 | 36.4 | 100.0 |

Approximately 62% of the CSC internal stakeholder sources (5 of 8) reported that they are satisfied or very satisfied with the IPPM information on women offenders as it relates to meeting the needs of CSC. In contrast, only 20% of Joliette staff sources (1 of 5) reported that they are satisfied with the information provided by IPPM while the remaining 80% are dissatisfied (2 of 5) or undecided (2 of 5; see Table 14).

**Table 14: "How satisfied are you with the information provided by IPPM as it relates to meeting the needs of CSC?"**

| | | Very Dissatisfied | Dissatisfied | Neutral | Satisfied | Very Satisfied | Total |
|---|---|---|---|---|---|---|---|
| CSC Internal Stakeholders | *n* | 0 | 1 | 2 | 2 | 3 | 8 |
| | % | 0.0 | 12.5 | 25.0 | 25.0 | 37.5 | 100.0 |
| Joliette Staff | *n* | 0 | 2 | 2 | 1 | 0 | 5 |
| | % | 0.0 | 40.0 | 40.0 | 20.0 | 0.0 | 100.0 |
| Total | *n* | 0 | 3 | 4 | 3 | 3 | 13 |
| | % | 0.0 | 23.1 | 30.8 | 23.1 | 23.1 | 100.0 |

CSC internal stakeholders reported that communications have improved in recent years. It was noted that the referral and discharge processes were enhanced by having the CSC unit psychiatrist and IPPM psychiatrist communicate directly on matters related to medication. It was also noted that there was once a gap at the time of discharge from IPPM with respect to continuity of health care, but this has since been addressed with the addition of a Health Liaison Officer position about one year ago.

CSC internal stakeholders also identified a number of areas where communications could be improved. CSC sources reported the need for additional communication about offender status/progress from IPPM while the offender is at IPPM. It was noted that the discharge summaries are thorough, but there is very limited communication between the time of admission and the discharge report. It was suggested that a monthly assessment/treatment update call between the CSC unit psychiatrist and IPPM psychiatrist would help to fill information gaps.

One CSC source suggested that the psychologist from the CSC referral team should be part of the IPPM treatment team, although it was recognized that this would add more work to CSC staff who already have a heavy workload. Another CSC internal stakeholder suggested that the CSC referral team and the IPPM assessment/treatment team should be on the same admission and discharge conference calls with CSC NHQ.

CSC sources suggested that communications related to transportation services to and from IPPM could be enhanced to promote greater consultation, which could result in greater efficiencies.

The CSC Parole Liaison Officer responsible for offenders sent to IPPM reported that she meets individually with offenders two weeks after they arrive at IPPM and then at least once a month after that. The CSC Parole Liaison Officer also reported that she attends clinical meetings at IPPM in order to be better informed about the progress made by offenders. The CSC Parole Liaison Officer stressed that she is not required to attend the clinical meetings, but emphasized that this is the only way she can gain more detailed background information on the activities of offenders at IPPM. It was noted that although the reports from IPPM provide exact figures on the types of actives taking place (e.g., the offender acted out 12 times, attempted suicide once, and was put in restraints once) the context around these incidents is also important for parole officers to be aware of; however, this information is currently not made available to parole officers because it is contained in the confidential medical files. It was further suggested that the reports

prepared by the IPPM criminologist need to be much more detailed in terms of providing context around offenders' incidents and progress at IPPM.

As noted above, IPPM sources are generally satisfied with the communication process. However, one IPPM source noted that some CSC institutions are better than others at ensuring that they provide all the information required by IPPM. It was noted that CSC needs to make sure that the materials they fax to IPPM are complete. It was also noted that the confidentiality of certain documents/reports remains an issue in terms of what IPPM can access/share. It was suggested that responses to ethical issues need to be clearly defined by CSC/IPPM.

Staff sources at Joliette Institution provided a number of suggestions for improving communications. It was noted that more of the communication that takes place between CSC and IPPM needs to be documented in writing to help track the decision-making process.

Behavioural counsellors at the Joliette Institution stressed that they need to know more about the offender's progress in the programs at IPPM so that if/when the offender returns to Joliette they can be more focused in addressing issues. The counsellors noted that they need to know more about the context of incidents that occur and not just the number of incidents. It was suggested that frontline workers at Joliette, including behavioural counsellors, should be able to discuss cases with the frontline workers at IPPM in order to get background information on incidents. It was also suggested that it would helpful for behavioural counsellors to periodically visit offenders who have long stays at IPPM. It was suggested that maintaining this form of ongoing contact would help counsellors stay informed of the offenders' progress and facilitate a smoother return to the parent institution.

Psychologists at Joliette Institution noted that communication with IPPM is irregular. It was noted that CSC periodically, but not regularly, receives admission reports and summaries of treatment from IPPM. Psychologists at Joliette stressed that too much of the communication that occurs is focused on administrative aspects and not enough discussion is directed at the clinical aspects of each case. It was noted that both clinical teams - at Joliette and at IPPM - need to discuss the importance and the purpose of treatment plans. Another Joliette source noted that staff need more information regarding the offenders' dynamics and changes in behaviour, which is essential information at the end of a sentence when Joliette has to complete an offender risk analysis.

***RECOMMENDATION 8: CSC and IPPM should review communication and access to information guidelines/policies as well as privacy laws, consult with CSC institutions to confirm what types of information can be shared with personnel at CSC institutions, and examine options for providing CSC personnel with the information they need to enhance the continuity of care.***

***CSC and IPPM should review the reporting benchmarks for offenders and ensure that the relevant reports, particularly those referred to in the contract, are produced in a timely manner. It would be helpful if such reports followed a prescribed template, including a standard title (e.g., "Report: Assessment on Admission and Administration of Key Tests"), and identifying in a consistent manner the date, number of previous admissions, date of previous report if applicable, etc.***

## Consistency of IPPM Treatment with CSC Principles/Treatment Models

***FINDING 11: CSC internal stakeholders are generally satisfied that IPPM's treatment models are consistent with CSC principles and that they complement CSC treatment models. However, it appears that staff turnover issues could be impacting the consistency of treatment in both the CSC and IPPM settings.***

All of the CSC internal stakeholder sources (5) reported that the treatment models being provided by IPPM for women psychiatric offenders are consistent with CSC models to a moderate or great extent. Joliette staff sources (2) acknowledged that they are unclear about the DBT provided at IPPM, but perceived it as only somewhat consistent with CSC models.

One CSC internal stakeholder expressed concern about the intensity of DBT being provided at IPPM because offenders appear to make little progress in DBT modules. It was noted that IPPM staff are doing DBT on more of an individual basis with offenders because of their cognitive difficulties and it is common for IPPM to choose only a few activities and focus on those. One CSC source suggested that DBT is adaptable, there are different options of how to teach it, and it can be adapted to different settings. Another CSC source suggested that DBT is more optimal in a group setting – similar to a classroom setting. However, it was noted that matching treatment to intensity is essential. It was stressed that if the offender is low risk and is put into a high intensity treatment program she could deteriorate. It was also noted that if low risk, medium risk, and high risk offenders are all in the same program, it is unlikely to produce favourable results.

Several CSC sources noted that staff turnover is an impediment to providing DBT in a consistent manner. It was noted that this is a problem for both CSC and IPPM. Another CSC

source reported that there are usually so many people being targeted for this kind of treatment within CSC that it makes it difficult to deliver DBT on a consistent basis. It was further noted that, in CSC institutions, women might not always have immediate access to DBT.

One CSC internal stakeholder suggested that a full assessment of practice versus policy is required to determine how well the treatment models being used at IPPM complement the CSC models.

IPPM staff sources indicated that approximately 50% of the women offenders who are admitted to IPPM are referred to either group or individually administered DBT. It was stressed that a good candidate for DBT is someone who has memory skills for learning acronyms and retaining new skills. It was noted that many offenders have cognitive impairments due to the amount drugs they have consumed. Other types of therapy offered to women psychiatric offenders at IPPM include horticulture, sculpting, sewing, and sports. It was noted that most of the therapy is cognitive-behavioural in nature.

***RECOMMENDATION 9: CSC should review the treatment models being used with the women offender population at IPPM and confirm the extent to which the programs complement CSC programs. CSC should ensure that relevant staff at CSC institutions are better informed about the treatment models being used at IPPM to enhance the continuity of care. CSC should identify and implement methods for ensuring a smooth transition between treatments received at IPPM and at CSC.***

### *3.1.3 Success*

***Objective 3: Success***

*The extent to which the services provided by IPPM are resulting in expected outcomes.*

*The extent to which the information provided by IPPM to CSC meets the Service's needs.*

***FINDING 12: The services provided by IPPM are helping women offenders to function in a healthier and safer manner. The majority of women offenders reported an improvement in their self-confidence, their ability to overcome their difficulties, and their quality of life as a result of their experience at IPPM, while over 40% of women offenders reported an improvement in their ability to concentrate as a result of their experience at IPPM. As well, close to 40% of women offenders reported an improvement in their level of comfort with participating in correctional programs following their experience at IPPM. However, it appears that the positive results are not long-lasting once the offender returns to their CSC institution.***

As previously described, all of the CSC internal stakeholder sources (5) reported that IPPM has been successful in helping women psychiatric offenders function in a healthier and safer manner.

Results from the women offender satisfaction questionnaire support this view and indicate that the majority of women offenders often experienced a number of positive outcomes as a result of their experience at IPPM. Fifty-nine percent (10 of 17) of the women offenders reported that their quality of life, their ability to overcome difficulties, and their self-confidence improved to some extent as a result of their experience at IPPM. As well, just over 41% (7 of 17) of the women offenders reported that their ability to concentrate improved as a result of their stay at IPPM.

Further evidence of positive outcomes was identified in the paper copy offender files. Overall, the files indicate that offenders tend to benefit from their stay at IPPM. Often a diagnosis is confirmed or identified. Sometimes medications are altered to ensure the offender's stabilization. Though offenders tend to stabilize for a short period of time, they also tend to eventually become unstable again. In some cases, the environment in which the offender finds herself and the other offenders/patients surrounding her might trigger an outburst and jeopardize her stability.

The offender files indicate that approximately 37% (13 of 35) of offenders experience reduced symptoms, increased skills or improved functioning at IPPM or when they return to their parent institution. However, without relevant comparison group data, it is difficult to determine the extent to which these changes can be attributed to IPPM.

As noted above, offender files indicate that the positive outcomes experienced by the women offenders are not long-lasting. This finding was also supported by the observations of staff members at Joliette Institution. Based on post-IPPM observations, the majority of the Joliette sources (3 of 4) reported that IPPM has not been successful in helping women offenders function in a healthier and safer manner beyond the short-term.

***RECOMMENDATION 10: CSC should collaborate with IPPM and CSC institutions to ensure a smooth transition process from IPPM back to the CSC institution and establish effective continuity of care mechanisms. In this way, CSC could determine if offenders need additional supports to facilitate their reintegration and to maintain the gains made at IPPM.***

***FINDING 13: The services provided by IPPM are helping to increase CSC's clinical understanding of women psychiatric offenders. IPPM services are also helping women offenders participate in treatment/programming upon returning to their parent institution.***

All of the CSC internal stakeholders (4) and half of the Joliette staff sources (2 of 4) reported that the services provided by IPPM are serving to increase CSC's clinical understanding of women psychiatric offenders.

CSC internal stakeholders also reported that IPPM has been successful in helping women offenders access reintegration programs in CSC institutions in a more timely manner and helping offenders participate in treatment/programming upon returning to their parent institution. IPPM staff sources were less certain about this aspect of the program as there is limited follow-up communication with CSC institutions and staff members at Joliette Institution also provided very limited feedback on this aspect of the program. However, the results from the women offender satisfaction questionnaire indicate that IPPM is having a positive effect on some women offenders, as close to 40% of the offenders (5 of 13) experienced an improvement in their comfort level with participating in correctional programs following their experience at IPPM.[31]

***FINDING 14: Relative to women psychiatric offenders sent to CSC's RTC, those sent to IPPM tend to have lower levels of functioning both prior to and following intervention. Anecdotal evidence suggests that women psychiatric offenders tend to stabilize following IPPM intervention, but this stabilization is often short-lived.***

Though the current evaluation was designed with the intention of using SRSW data to assess the success of the contract between CSC and IPPM as it pertains to the women psychiatric offender population, this approach was not feasible due to the lack of available data. As discussed in the profile section, there were only 35 women offenders in the IPPM sample and only 34 women offenders in the RTC sample. In addition, because the SRSW was only implemented for women in 2005, there were no pre-test SRSW data for women. Furthermore, only 12 women from the IPPM sample and 10 women from the RTC sample had post-test data related to the SRSW. Therefore, these sample sizes also precluded the possibility of conducting

[31] This question was specifically aimed at those women who had already been released back to their parent institutions.

quantitative analyses in order to examine between-group pre-intervention[32] comparisons and within-group pre/post-intervention comparisons.

Despite these limitations, a visual examination of static and dynamic factors suggests similar levels of risk and need for women in the IPPM sample and women in the RTC comparison group sample, as well as lower levels of motivation and reintegration potential for the IPPM sample at both pre- and post-intervention (see Table 15).

Data gathered from both key informant interviews and offender satisfaction questionnaires (described in detail above) offer further insight into IPPM's ability to meet expected outcomes for women psychiatric offenders. Of note, IPPM staff reported that they admit women psychiatric offenders who are typically unable to function within the CSC system. Despite this lower level of functioning, CSC internal stakeholders indicated that IPPM has been successful in helping women psychiatric offenders meet their assessment and treatment objectives, access reintegration programs in CSC institutions in a timely manner, and participate in treatment/programming upon return to parent institutions. Furthermore, the majority of women psychiatric offenders sent to IPPM reported improved self-confidence, ability to overcome difficulties, and quality of life as a result of their stays at IPPM, and over one third of women also reported improved levels of comfort for participating in correctional programs. However, CSC internal stakeholders also cautioned that, although women psychiatric offenders returning from IPPM tend to stabilize, the effects are often short-lived; women psychiatric offenders eventually tend to destabilize and require further treatment.

[32] The term "intervention" is employed here to denote services rendered at IPPM and the comparison RTCs, including both assessment and treatment services. The intervention timeframe represents the admission date of offenders' first stay at either IPPM or an RTC through to, and including, the end-date of offenders' most recent stay at either IPPM or an RTC.

**Table 15: Levels of risk, need, motivation, and reintegration potential for women psychiatric offenders following intervention.**

| | IPPM Psychiatric Offenders | | RTC Psychiatric Offenders | |
|---|---|---|---|---|
| | *n* | % | *n* | % |
| Risk | | | | |
| Pre-intervention | *n* = 31 | | *n* = 30 | |
| Low | 2 | 6.5% | 4 | 13.3% |
| Moderate | 7 | 22.6% | 7 | 23.3% |
| High | 22 | 71.0% | 19 | 63.3% |
| Post-intervention | *n* = 26 | | *n* = 23 | |
| Low | 2 | 7.7% | 2 | 8.7% |
| Moderate | 4 | 15.4% | 6 | 26.1% |
| High | 20 | 76.9% | 15 | 65.2% |
| Need | | | | |
| Pre-intervention | *n* = 31 | | *n* = 30 | |
| Low | 0 | 0% | 0 | 0% |
| Moderate | *4* | *12.9%* | *5* | *16.7%* |
| High | *27* | *87.1%* | *25* | *83.3%* |
| Post-intervention | *n* = 26 | | *n* = 23 | |
| Low | 0 | 0% | 0 | 0% |
| Moderate | 2 | 7.7% | 5 | 21.7% |
| High | 24 | 92.3% | 18 | 78.6% |
| Motivation | | | | |
| Pre-intervention | *n* = 31 | | *n* = 30 | |
| Low | 10 | 32.3% | 4 | 13.3% |
| Moderate | 16 | 51.6% | 12 | 40.0% |
| High | 5 | 16.1% | 14 | 46.7% |
| Post-intervention | *n* = 26 | | *n* = 23 | |
| Low | 8 | 30.7% | 3 | 13.0% |
| Moderate | 17 | 65.4% | 12 | 52.2% |
| High | 1 | 3.8% | 8 | 34.8% |
| Reintegration Potential | | | | |
| Pre-intervention | *n* = 31 | | *n* = 30 | |
| Low | *22* | *71.0%* | *16* | *26.2%* |
| Moderate | *8* | *25.8%* | *10* | *33.3%* |
| High | *1* | *3.2%* | *4* | *13.3%* |
| Post-intervention | *n* = 26 | | *n* = 23 | |
| Low | 20 | 76.9% | 11 | 47.8% |
| Moderate | 6 | 23.1% | 10 | 43.5% |
| High | 0 | 0% | 2 | 8.7% |

***RECOMMENDATION 11: CSC should collaborate with IPPM in conducting a comprehensive evaluation of the IPPM women psychiatric offender program, including the collection of relevant data. A realistic and complete reporting strategy, including relevant performance measures, should be prepared and implemented on an ongoing basis.***

## 3.2 Male Psychiatric Offenders

### *3.2.1 Program Relevance*

***Objective 1: Relevance***

**Occupancy Rates**

***FINDING 1: The number of male offenders suffering from mental health problems is increasing, as is the complexity of offenders' behavioural problems. Although CSC has expanded its internal capacity through CRSM to provide specialized mental health services for male psychiatric offenders, it still lacks the resources for providing services to offenders requiring incarceration in a maximum security facility that IPPM can provide in conjunction with the necessary intervention services.***

A review of CSC administrative records for the male psychiatric and male sex offender populations revealed inconsistencies[33] in the total number of bed-days and average occupancy rates.[34] For example, during the period 2001-2007 there were two years where the occupancy rates appeared lower than would be expected based on the total number of bed-days reported. A further limitation of the CSC data is that they were in the form of aggregated data for the two male offender populations. As a result, it was decided to review the disaggregated month-to-month occupancy data for the two male offender populations as reported by IPPM. The IPPM records indicate that, in the 2002-2003 year, the annual occupancy rate for the 3 male psychiatric and 12 sex offender beds at IPPM was 81% (see Table 16). More recently in 2004-2005, the occupancy rate was 89%. Data for 2005-2007 were not available at the time of this study.

[33] These inconsistencies are likely a function of differences in the way bed-days were coded.
[34] Source: Regional Administration/Regional Headquarters (Quebec). 2008.

**Table 16: Male psychiatric and sex offender occupancy rate at IPPM**

| | Total Number of Bed-Days Used at IPPM by Sex Offenders | Total Number of Bed-Days Used at IPPM by Psychiatric Offenders | Total Bed-Days | Occupancy Rate [a] |
|---|---|---|---|---|
| 2002-2003 | 4,012 | 429 | 4,441 | 81.1% |
| 2003-2004 | 3,954 | 839 | 4,793 | 87.5% |
| 2004-2005 | 3,748 | 1,095 | 4,843 | 88.5% |

[a] Based on a total of 15 beds available (12 sex offender and 3 psychiatric beds) per day (or 5475 bed-days per year).
Source: Memorandum from Jacques Jodoin, Director General Assistant, IPPM, to Esther Paquin, Contract Negotiator, Service Canada, August 9, 2005.

Results from interviews with CSC internal stakeholders (2), IPPM staff (5), as well as staff sources at the Archambault Institution who were interviewed in a group setting, indicate that there are a sufficient number of beds available at IPPM for male psychiatric offenders. While these same sources were able to confirm that the male psychiatric beds at IPPM have been at full occupancy during some periods, they were unable to identify the specific length of time that the beds were fully occupied.

IPPM staff sources reported that the number of male psychiatric offender referrals is declining. It was noted that, since CSC opened its psychiatric facility (Centre Régionale de Santé Mentale [CRSM]) at Archambault, there has been much less reliance on IPPM for the male psychiatric offender population. One IPPM source acknowledged that Archambault is “doing a good job” working with this population, but that CSC still relies on IPPM to assist with male psychiatric offenders if they are particularly violent.

CSC internal stakeholders and staff sources at Archambault reported that the reduction in male psychiatric referrals to IPPM is the result of CSC’s expanded capacity at CRSM to assess/treat this population of offenders.[35] As described by one staff member at Archambault, CRSM can now handle 95% of the cases that are sent to them, but the remaining 5% of offenders have severe and complex behavioural problems which IPPM is better suited for handling. CSC internal stakeholders and staff at Archambault also noted that CSC will continue to need the

[35] CSC’s focus on building internal capacity in recent years is linked to the growing need for specialized mental health interventions which have risen from 7% of incoming male offenders to over 11%. Treasury Board Submission - Institut Philippe-Pinel de Montréal, April 3, 2006.

three beds at IPPM for this population until CRSM has the resources/infrastructure to admit offenders requiring incarceration in a maximum security facility.

## CSC and Community-based Alternatives

***FINDING 2: There are no suitable community-based alternatives to IPPM and existing CSC facilities continue to require the specialized services of IPPM for the male psychiatric population.***

CSC internal stakeholders and staff members at the Archambault Institution were unable to identify any community-based alternatives to IPPM. One CSC internal stakeholder emphasized that community-based hospitals with mental health units offer "very basic care, but nothing compared to the intervention services IPPM provides". As noted above, CSC is using CRSM to assess/treat the majority of male psychiatric offenders, but it still relies on the services of IPPM to respond to the needs of offenders with severe and complex behavioural problems.

Archambault staff members noted that CRSM programs, although not national, are able to admit Anglophones and offenders who are under a Management Protocol (i.e., offenders who have been involved in a major security incident and have not commenced the reintegration phase of the Protocol). Several staff members at Archambault also suggested that CRSM should become the headquarters for all care provided to offenders by establishing three beds for male psychiatric emergencies and a special unit for male sex offenders to participate in sex offender programs. However, CSC internal stakeholders and staff members at Archambault were generally uncertain about the viability of CSC developing new services to replace IPPM. One CSC stakeholder suggested that creating a unit similar to IPPM may reduce fees in the long run, but may not be as efficient and may be difficult to operate in terms of regulations/laws (hospital context versus correctional context).

## Compliance with the Intended Purpose of the Contract between CSC and IPPM

***FINDING 3: IPPM is being used for its intended purpose in relation to the male psychiatric offender population. On some occasions CSC institutions refer "difficult cases" to IPPM in order to provide these offenders with alternative services that may prove more effective than those available within CSC institutions. IPPM is normally very strict in applying the admission criteria, but attempts to be flexible in accepting these cases.***

CSC internal stakeholders (2) and IPPM staff (3) familiar with the male psychiatric program generally reported that IPPM is being used for its intended purpose.

As reported by CSC internal stakeholders, IPPM handles male psychiatric offender cases that are problematic for CSC. This includes male psychiatric offenders with severe mental health problems. It was noted that IPPM is able to admit offenders who are classified at any security level. It was also noted that IPPM provides specialized services to Aboriginals (e.g., access to elders, sweat lodge). CSC internal stakeholders reported that a key objective for male psychiatric offenders at IPPM is to improve the offenders' mental health and reduce the risk of violence within CSC institutions.

IPPM sources noted that IPPM admits male psychiatric offenders from CSC who have difficulty functioning in the CSC system. IPPM evaluates the capacity of the offender to change and helps the offender begin a reflection process and initiate therapy. In terms of objectives, IPPM seeks to reduce symptomatology and ensure that the offender can function more effectively when he returns to the CSC institution. IPPM sources noted that, in some cases, they work to prepare the offender for release back into society if the offender's sentence is coming to an end.

Staff sources at the Archambault Institution generally reported that their knowledge of the contract was limited, but they recognize that IPPM provides extra psychiatric help to support CSC. Archambault staff sources also noted the importance of retaining the three male psychiatric beds at IPPM to provide alternative services when those offered at CRSM are proving ineffective. It was noted that IPPM is generally used (and is needed) as a last option or in the case of an emergency and that IPPM can take cases from CSC, such as offenders who cannot be admitted to La Macaza Institution.

***RECOMMENDATION 1: CSC should continue to monitor the occupancy rates of the male psychiatric beds at IPPM as CSC continues to develop its specialized mental health interventions. Low occupancy rates should be systematically flagged.***

### *3.2.2 Design and Implementation*

***Objective 2: Design and Implementation***

#### *3.2.2.1 Admissions to IPPM*

***FINDING 4: As reported by CSC internal stakeholders and IPPM staff, the admission and exclusion criteria contain sufficient detail and clarity and, in most cases, the male psychiatric offenders that are sent to IPPM meet the appropriate offender profile. Staff at Archambault Institution have limited awareness of the admission and exclusion criteria. IPPM and Archambault staff sources identified the need for more psychiatrists from CSC institutions to be involved in the referral/admission process as a way to help reinforce awareness of the admission and exclusion criteria and to enable CSC institutions to make more effective/appropriate referrals to IPPM.***

CSC internal stakeholders (2) and IPPM staff sources (3) reported that they are very familiar with the admission and exclusion criteria for male psychiatric offenders at IPPM and that the criteria have sufficient detail and clarity.

All of the CSC internal stakeholder sources (2) and IPPM staff sources (3) reported that most or all of the male psychiatric offenders who are sent to IPPM meet the criteria for admission. Archambault staff sources are generally unsure about the extent to which male psychiatric offender referrals to IPPM are meeting the appropriate profile because of limited awareness of the criteria among staff at the facility. Some of the staff sources at Archambault also suggested that the criteria lack sufficient detail and clarity.

Although sources were unable to provide specific numbers, CSC internal stakeholders and Archambault staff reported that male psychiatric offenders have been refused admission to IPPM. CSC internal stakeholder sources reported that men from the SHU are refused admission to IPPM because of their violent behaviour. Archambault sources reported that they were unsure why some offenders have been refused admission to IPPM.

With respect to possible improvements to the referral/admission process, CSC internal stakeholders and staff sources at Archambault suggested that CSC institution staff need to be better informed about the admission/exclusion criteria. IPPM staff sources also noted the need for some of their staff to gain a better understanding of how the admission/selection process works. One IPPM source also suggested that more input is needed from CSC psychiatrists during the referral/admission process.

Archambault staff sources also noted that the admission process needs to be simplified and made less work intensive. Archambault staff sources suggested the IPPM should provide CSC institutions with a written letter of refusal that includes an explanation for the decision to refuse admission. This would help Archambault staff to better understand the exclusion criteria and enable staff to make more effective referrals. It was also suggested that the time gap needs to be reduced between the moment the offender is accepted by IPPM and the time he is physically admitted to IPPM.

One Archambault staff source suggested that CSC establish a "minimum length of stay" policy for IPPM; CSC could pilot a minimum stay period of two to three months and assess its effectiveness. Another Archambault staff source expressed concern about IPPM's practice of mixing CSC psychiatric offenders with the other patients from the community who are at IPPM. It was noted that the SHU in Ste-Anne-des-Plaines is a nearby penitentiary that often needs to refer offenders to IPPM for psychiatric support. It was questioned whether this dangerous population of offenders should be placed in the same unit as patients from the community population.

***RECOMMENDATION 2: CSC should consult with all relevant Quebec Region CSC institutions in developing and implementing strategies to better promote the IPPM admission and exclusion criteria for male psychiatric offenders among CSC personnel. CSC should also review and confirm the key CSC/IPPM stakeholders that need to be engaged in the referral and admission process.***

#### *3.2.2.2 Implementation of Interventions*

***FINDING 5: Male psychiatric offenders at IPPM are receiving services in the official language of their choice.***

As part of the offender satisfaction questionnaire, participants were asked to indicate their official language of choice for service at IPPM and the extent to which they received services in their language of their choice while at IPPM.

The majority of the male psychiatric offenders (82%, 9 of 11) indicated that French was their official language of choice for receiving services at IPPM. Eighty-two percent of the French- and English-speaking male psychiatric offenders indicated that they always received

services at IPPM in the official language of their choice, while 18% of offenders reported that they received services in their official language of choice most of the time.[36]

***Finding 6: In all or most cases, male psychiatric offenders have their mental health treatment plans adjusted while at IPPM. IPPM is also addressing the physical health needs of the male psychiatric population.***

In keeping with IPPM's ongoing and dynamic assessment and treatment approach, all of the CSC internal stakeholder sources and IPPM sources reported that most or all male psychiatric offenders have their mental health plans adjusted while at IPPM. In addition, all of the CSC internal stakeholder sources (2) and IPPM staff sources (3) reported that the physical health needs of male psychiatric offenders are being met while at IPPM. CSC stakeholders noted that IPPM provides much more extensive physical health care services to male psychiatric offenders than CSC provides. IPPM staff sources reported that offenders always have the opportunity to see doctors and specialists, including a dentist, and there are nurses always on staff.

#### *3.2.2.3 Continuity of Care*

***FINDING 7: CSC internal stakeholders and IPPM staff are generally satisfied with the completeness and timeliness of the male psychiatric offender information exchanged. However, staff at the Archambault Institution, including psychologists, behavioural counsellors, and parole officers, identified the need for additional details about offenders' experience/progress during their stay at IPPM and greater direct engagement with IPPM personnel to enhance the continuity of care.***

Key informants were asked to comment on their level of satisfaction with the completeness and timeliness of the information that is exchanged between CSC and IPPM, as well as their overall satisfaction with the communication process. The results indicate that CSC internal stakeholder sources and IPPM sources are generally satisfied with the communication process, while staff at CSC institutions are generally dissatisfied with the process. Representatives from all stakeholder groups identified communication issues and provided suggestions for improving communications.

[36] A comparison of the extent to which English- speaking and French-speaking male psychiatric offenders received service in their official language of choice was prohibited due to the small number of male psychiatric offenders ($n$ = 2) who chose English as their official language of choice.

CSC internal stakeholder (1) and IPPM staff (2) sources reported that they are satisfied with the timeliness and completeness of the information that each organization provides, as well as the structure and process used for exchanging information between CSC and IPPM as it relates to the male psychiatric offender population.

However, staff sources at the Archambault Institution are generally dissatisfied with the communication process. Archambault staff noted that too much information is being communicated verbally between CSC stakeholders and IPPM and it was suggested that more information needs to be documented, particularly as it relates to the decision making process when referrals are being reviewed. With respect to the reports that are provided by IPPM, Archambault staff noted that they lack sufficient detail on the type of programming/activities in which an offender is involved and staff would like to know more about the level of progress/achievement in IPPM activities. It was also noted that the reporting is rarely in chronological order and sometimes the reports fail to identify areas for improvement which exist after treatment at IPPM.

Archambault sources noted that confidentiality requirements limit the amount of information that they can access from IPPM. One Archambault source suggested that a clinical evaluation of the offender should be conducted by CSC personnel every four months, particularly for those offenders with lengthy stays at IPPM.

Archambault sources noted that, in some cases, accessing required information takes too long. It was noted that, even in cases in which the offender provides his consent to share information with CRSM, the transfer of the information can take months.

Archambault sources reported that the information that the La Macaza Institution provides to CRSM after an offender completes the sex offender program is very complete and timely, and it was suggested that IPPM should be providing the same type of information.

***RECOMMENDATION 3: CSC and IPPM should review communication and access to information guidelines/policies as well as privacy laws, consult with CSC institutions to confirm what types of information can be shared with personnel at CSC institutions, and examine options for providing CSC personnel with the information they need to enhance the continuity of care.***

***CSC and IPPM should review the reporting bench marks for offenders and ensure that the relevant reports, particularly those referred to in the contract, are produced in a timely manner.***

### *3.2.3 Success*

***Objective 3: Success***

***FINDING 8: The services provided by IPPM are helping male psychiatric offenders to function in a healthier and safer manner. The majority of male offenders reported an improvement in their self-confidence, their ability to concentrate, their ability to overcome their difficulties, and their quality of life as a result of their experience at IPPM.***

Results from the male psychiatric offender satisfaction questionnaire indicate that the majority of offenders often experienced a number of positive outcomes as a result of their experience at IPPM. Just over 50% (6 of 11) of the offenders reported that their quality of life, their ability to concentrate, and their self-confidence improved to some extent as a result of their experience at IPPM. As well, just over 70% (8 of 11) of the offenders reported that their ability to overcome difficulties improved as a result of their stay at IPPM.

***FINDING 9: Pre-post institutional adjustment and functioning outcomes did not change for either the IPPM male psychiatric offender population or their comparison group. Analyses suggest that, relative to RTC offenders, IPPM offenders tend to be lower in adjustment, functioning, and reintegration potential, as well as higher in need, when they are sent for assessment/treatment and these between-group differences persist following intervention.***

**Adjustment and Functioning Outcomes**

It does not appear that assessment/treatment at either IPPM or RTCs reduced male psychiatric offenders' SRS levels from pre- to post-intervention. Repeated measures analysis of variance revealed no significant within-group differences across time for either the IPPM group or the comparison group ($F(1, 13) = 0.35$, *ns*.). Groups also did not differ from one another on average SRS scores at either pre- or post-intervention. Thus, it appears for this matched sample of male psychiatric offenders that neither IPPM nor the RTCs had an effect on SRS scores from before to after intervention. However, this could be a function of the small sample size for which data were available (i.e., pre- and post-intervention SRS scores were available for only 15 matched pairs of male psychiatric offenders).

Relative to a matched comparison group of RTC male psychiatric offenders, the available data suggest that IPPM offenders showed relatively lower levels of adjustment and functioning at

post-intervention. Whereas IPPM offenders were more likely to have been convicted of more than one serious disciplinary offence after intervention ($\chi^2(6) = 15.1$, $p < .05$), the comparison group of RTC offenders was more likely to have three or more convictions for minor disciplinary offences ($\chi^2(2) = 17.0$, $p < .0005$). Offenders at IPPM were more likely to score lower on Correctional Plan Progress ($\chi^2(4) = 12.6$, $p < .05$) and RTC offenders appeared to be slightly more motivated than the IPPM group at the end of intervention ($\chi^2(5) = 12.4$, $p < .05$). IPPM offenders were more likely to have one or more period of segregation ($\chi^2(3) = 11.4$, $p < .01$). There were no significant differences between groups with regard to pay level. Sufficient data were not available for comparing groups on recorded incidents or successful UTAs/work releases between groups. Furthermore, quantitative data were not available to determine whether the IPPM group differed from the comparison group in terms of levels of adjustment and function prior to intervention.

As described above, findings based upon offender satisfaction questionnaires indicated that male psychiatric offenders perceived improvements in their self-confidence, ability to overcome difficulties, ability to concentrate, and quality of life as a result of their experiences at IPPM. Furthermore, findings stemming from the key informant interviews indicated that IPPM is believed by CSC internal stakeholders to help male psychiatric offenders access reintegration programs and participate in treatment/programming upon their return to parent institutions. Despite these perceived benefits, post-intervention between-group comparisons indicated that, following intervention, IPPM male psychiatric offenders exhibit significantly lower levels of reintegration potential and higher levels of need than do RTC offenders, though no between-group differences were evidenced for levels of risk and motivation (see Table 17).

A statistical assessment of pre-intervention between-group differences, as well as of pre/post-intervention differences, was not possible due to small sample sizes of offenders with available pre-intervention data. However, visual examination indicated that, like at post-intervention, IPPM male psychiatric offenders at pre-intervention have lower levels of reintegration potential and higher levels of need than do RTC offenders; no between-group differences were evidenced for levels of risk and motivation. Thus, even though IPPM group members were matched with comparison group members on pre-intervention overall static and dynamic risk levels, Aboriginal status, aggregate sentence length, and age at admission, preliminary quantitative analyses suggest that there may be between-group differences in levels

of reintegration potential and need (and possibly other static and dynamic factors) at pre-intervention that account for post-intervention group differences. Of note, no pre/post-intervention within-group differences were evidenced.

The potential for pre-intervention differences between the IPPM group and the RTC group that persist at post-intervention was also alluded to by key informants, who indicated that male psychiatric offenders sent to IPPM typically suffer from more severe mental illnesses and cannot function within the CSC system (as described above).[37] Similarly, according to Archambault staff, IPPM is generally used as a last option or in the case of an emergency. Corroboration between quantitative and qualitative findings suggests that, relative to RTC male psychiatric offenders, IPPM offenders may be lower in adjustment, functioning, and reintegration potential, as well as higher in need, at post-intervention because they presented themselves with more severe mental illnesses at pre-intervention. If the contract between CSC and IPPM is renewed, an emphasis should be placed on ensuring comparison group equivalence for male psychiatric offenders in future evaluations.

[37]Unlike other Canadian regions that each have just one RTC for male psychiatric offenders, the Quebec region has both IPPM and CRSM. The RTCs in other regions are sent male psychiatric offenders with a wide range of mental health problems, whereas, in the Quebec region, most male psychiatric offenders are sent to CRSM and only the most severe cases are sent to IPPM.

**Table 17: Levels of risk, need, motivation, and reintegration potential for male psychiatric offenders following intervention.**

| | IPPM Psychiatric Offenders | | RTC Psychiatric Offenders | |
|---|---|---|---|---|
| | *n* | % | *n* | % |
| Risk | | | | |
| Pre-intervention | *n* = 17 | | *n* = 43 | |
| Low | 1 | 5.9% | 3 | 7.0% |
| Moderate | 2 | 11.8% | 7 | 16.3% |
| High | 14 | 82.4% | 33 | 76.7% |
| Post-intervention | *n* = 51 | | *n* = 50 | |
| Low | 2 | 3.9% | 3 | 6.0% |
| Moderate | 7 | 13.7% | 11 | 22.0% |
| High | 42 | 82.4% | 36 | 72.0% |
| Need | | | | |
| Pre-intervention | *n* = 17 | | *n* = 43 | |
| Low | 0 | 0% | 0 | 0% |
| Moderate | 2 | 11.8% | 8 | 18.2% |
| High | 15 | 88.2% | 35 | 81.4% |
| Post-intervention** | *n* = 51 | | *n* = 50 | |
| Low | 0 | 0% | 0 | 0% |
| Moderate | 3 | 5.9% | 12 | 24.0% |
| High | 48 | 94.1% | 38 | 76.0% |
| Motivation | | | | |
| Pre-intervention | *n* = 14 | | *n* = 41 | |
| Low | 5 | 35.7% | 11 | 26.8% |
| Moderate | 7 | 50.0% | 27 | 65.9% |
| High | 2 | 14.3% | 3 | 7.3% |
| Post-intervention | *n* = 35 | | *n* = 50 | |
| Low | 13 | 37.1% | 18 | 36.0% |
| Moderate | 19 | 54.3% | 27 | 54.0% |
| High | 3 | 8.6% | 5 | 10.0% |
| Reintegration Potential | | | | |
| Pre-intervention | *n* = 14 | | *n* = 41 | |
| Low | 12 | 85.7% | 26 | 63.4% |
| Moderate | 1 | 7.1% | 8 | 19.5% |
| High | 1 | 7.1% | 7 | 17.1% |
| Post-intervention* | *n* = 35 | | *n* = 50 | |
| Low | 28 | 80.0% | 29 | 58.0% |
| Moderate | 7 | 20.0% | 11 | 22.0% |
| High | 0 | 0% | 10 | 20.0% |

Note. * $p < .05$, ** $p < .01$.
It was not possible to compare IPPM offenders with RTC offenders due to the small sample size o f offenders for whom pre-intervention data was available.

## Recidivism Outcomes

***FINDING 10: Male psychiatric offenders who received treatment services at IPPM exhibit similar recidivism rates compared to male psychiatric offenders treated at Regional Treatment Centres.***

Male psychiatric offenders treated at IPPM had an average rate of recidivism that was similar to that of male psychiatric offenders treated at RTCs. Using available follow-up data, an examination of the total return to custody rates for the IPPM and RTC groups revealed that there were no significant between-group differences over time in the probability of returning to custody ($\chi^2(1) = .17$, $p = .67$, $e^{\beta} = 1.12$).[38] This similarity across groups was also found when recidivism rates were broken down by reason for returning to custody. Specifically, the IPPM group and the RTC group were equally likely to return to custody over time both as a consequence of technical revocations ($\chi^2(1) = .02$, $p = .88$, $e^{\beta} = 1.05$) and as a consequence of having been convicted of a new offence ($\chi^2(1) = .11$, $p = .29$, $e^{\beta} = .53$). The proportions of offenders from IPPM and RTCs who returned to custody with either a new offence or a technical revocation are displayed in Table 18.

**Table 18: Proportions of male psychiatric offenders who returned to custody following release**

| | IPPM (*N* = 63) | | RTCs (*N* = 37) | |
|---|---|---|---|---|
| Reason for Return | *n* | % | *n* | % |
| New Offence | 13 | 20.6% | 5 | 13.5% |
| Technical Revocation | 30 | 47.5% | 16 | 43.2% |
| Total Returned to Custody | 43 | 68.2% | 21 | 56.8% |

***RECOMMENDATION 4: CSC should collaborate with IPPM in conducting a comprehensive evaluation of the IPPM male psychiatric offender program, including the collection of relevant data. A realistic and complete reporting strategy, including relevant performance measures, should be prepared and implemented on an ongoing basis.***

[38] $e^{\beta}$ represents the hazard ratio, which can be interpreted here as the percent difference between the IPPM group and the RTC group in the likelihood of re-offending.

## 3.3 Male Sex Offenders

### *3.3.1 Program Relevance*

***Objective 1: Relevance***

**Occupancy Rates**

***FINDING 1: IPPM is occasionally operating below its capacity for the sex offender population. Delays in transferring sex offenders from CSC to IPPM once offenders have been approved for admission appear to be impacting the occupancy rate at IPPM.***

As noted in the previous section on findings for IPPM male psychiatric offenders, the aggregated data from CSC administrative records for the male psychiatric and male sex offender populations reveal that the occupancy rate for these populations has fluctuated from 92% in 2001-2002 to 131% (above capacity) in 2005-2006 and back down to 84% in 2006-2007.[39]

Results from interviews with CSC internal stakeholders (2), IPPM staff (8), as well as staff with the La Macaza Institution (3) indicate that there is a sufficient number of beds available at IPPM for male sex offenders. CSC internal stakeholders and staff members from IPPM confirmed that the number of occupied beds for sex offenders at IPPM fluctuates over time and that the sex offender beds at IPPM are occasionally at full occupancy. However, IPPM staff sources stressed that the 12 sex offender beds are usually not fully occupied and it was noted that some offenders can experience a month-long delay or more before being sent from CSC after IPPM has already agreed to admit them. Staff sources at the La Macaza Institution confirmed that that sex offenders may experience a two-month wait time before they get to IPPM.

The results suggest that the current number of sex offender beds at IPPM is sufficient and the need for these 12 beds is likely to continue as CSC has identified a growing need for specialized mental health interventions for male offenders as the proportion of incoming offenders requiring these types of services has risen from 7% to over 11%.[40]

[39] Disaggregated data for the male psychiatric and sex offender populations was not available at the time of this report.
[40] Treasury Board Submission - Institut Philippe-Pinel de Montréal, April 3, 2006.

***RECOMMENDATION 1: CSC and IPPM should review the referral process for male sex offenders to identify options for addressing issues that are causing delays. CSC should continue to monitor the occupancy rates of the male sex offender beds at IPPM and low occupancy rates should be systematically flagged.***

**CSC and Community-based Alternatives**

***FINDING 2: There are no suitable community-based alternatives to IPPM and existing CSC facilities continue to require the specialized services of IPPM for the male sex offender population. CSC stakeholders are generally more in favour of maintaining the existing sex offender services at IPPM and exploring opportunities for expanding/enhancing the services at IPPM rather than developing new services within CSC.***

CSC internal stakeholders and staff members at the La Macaza and Archambault Institutions were unable to identify any community-based alternatives to IPPM for male sex offenders.

Key sources at the CSC institutions also identified limitations in the capacity of CSC to respond to the service needs of sex offenders. In one example provided by a staff member at the La Macaza Institution, it was noted that a psychiatrist visits La Macaza once every two or three months and sees 15 offenders, even though there are at least 30 offenders on the emergency list who need to see the psychiatrist. La Macaza staff sources also noted that there are some sex offenders who need and want to go to IPPM, but are refused access because they are on the waiting list for La Macaza's sex offender program. It was suggested that these cases should be admitted to IPPM rather than being kept on a waiting list.

Archambault staff members also suggested that CSC continues to face challenges in responding to the service needs of dual sex/psychiatric offenders who are in denial about their problem. It was noted that CSC has very limited treatment options for this part of the offender population as it was suggested that IPPM is mostly interested in working with offenders who have already accepted their problem and are ready to change.

La Macaza staff sources suggested that, rather than implementing new services to replace IPPM, CSC needs to examine opportunities for enhancing the arrangement with IPPM.

Some staff members at Archambault Institution suggested that it would not be feasible for CSC to develop and implement new services to replace what IPPM offers. It was noted that CRSM currently lacks the space to create an isolated milieu for sex offenders and it was suggested that IPPM maintain the three beds for male psychiatric offenders for use when

alternative services are required and keep the 12 bed sexual offender unit, but ensure that the criteria for admission to IPPM is better promoted in CSC institutions and applied in a consistent manner. Alternatively, some staff members at Archambault suggested that CSC should examine the potential for developing a special unit for sex offenders at the Archambault or La Macaza Institution.

***RECOMMENDATION 2: The Joint Committee should examine options for expanding/enhancing male sex offender services at IPPM to better respond to the needs of CSC including the needs of dual sex/psychiatric offenders who are in denial about their problem.***

**Compliance with the Intended Purpose of the Contract between CSC and IPPM**

***FINDING 3: IPPM is generally being used for its intended purpose in relation to the male sex offender population.***

All of the CSC internal stakeholder (2), IPPM staff (5) and La Macaza Institution staff (4) sources interviewed reported that IPPM is being used for its intended purpose as it relates to the male sex offender population.

As reported by CSC internal stakeholders, IPPM handles sex offender cases that are problematic for CSC. Though the majority of CSC sex offenders take in-house CSC programs (e.g., programs at the La Macaza Institution), it was noted that sex offenders with severe disorders are referred to IPPM because CSC is not equipped to handle severe cases. CSC internal stakeholders reported that a key objective for male sex offenders at IPPM is to help the offenders control their violent/deviant behaviour. It was noted that IPPM also provides out-patient services to male sex offenders in order to ensure that offenders who have finished their sentence or are on parole have access to IPPM. This part of the service agreement facilitates continuity of care.

As reported by IPPM staff sources, service provision at IPPM focuses on evaluating the capacity of the offender to change, helping the offender begin a reflection process and initiate therapy, and beginning the process of change. In terms of objectives, IPPM seeks to change the thought processes of the sex offender and prepare him for reintegration back into the CSC system. IPPM attempts to make the offender aware of his problems and increase the offenders' ability to identify and avoid vulnerabilities and to cope with difficult situations. IPPM sources reported that it is crucial to develop a trustworthy relationship with the offender and to work

toward both improving interpersonal skills and helping the offender learn to listen to feedback and ask for help. Consulting with other parts of the CSC system in regards to continuity of care was also viewed by IPPM sources as an important objective.

Staff sources at La Macaza Institution generally reported that their knowledge of the contract is limited, but they recognize that IPPM provides services to sex offenders whose needs go beyond what CSC can provide. Although La Macaza has a tertiary-level clinical program for sex offenders, it is a medium security institution and is not able to handle sex offenders who are classified as maximum security. Several staff sources at La Macaza suggested that the services provided by IPPM are also intended to help offenders reintegrate into society and reduce the risk of recidivism. As noted above, IPPM staff view the role of IPPM as more focused on activities that address the desired immediate and intermediate offender outcomes than the longer-term outcomes.

### *3.3.2 Design and Implementation*

***Objective 2: Design and Implementation***

#### *3.3.2.1 Admissions to IPPM*

***FINDING 4: As reported by CSC internal stakeholders and IPPM staff, the admission and exclusion criteria contain sufficient detail and clarity, and, in most cases, the male sex offenders who are sent to IPPM meet the appropriate offender profile. However, staff members at La Macaza Institution identified a need for greater detail and clarity in the male sex offender criteria, while representatives from CSC and IPPM identified a general need for CSC institution and IPPM staff to be better informed about the admission/exclusion criteria.***

All of the CSC internal stakeholders (3) and IPPM staff sources (7) and half of the staff sources at the La Macaza Institution (3 of 6) reported that they are familiar with the admission and exclusion criteria for male sex offenders at IPPM. The other half of the La Macaza sources indicated that they are not at all familiar with the criteria.

Overall, CSC internal stakeholder and IPPM staff sources are satisfied with the detail and clarity of the admission and exclusion criteria as they relate to the male sex offender population while the majority of the La Macaza staff sources indicated that they are dissatisfied with the detail and clarity of the admission and exclusion criteria (see Table 19).

**Table 19: "From your perspective is there a sufficient amount of detail and clarity in the admission and exclusion criteria?"**

| | | Yes | No | Unsure | Total |
|---|---|---|---|---|---|
| CSC Internal Stakeholders | *n* | 1 | 0 | 0 | 1 |
| | % | 100.0 | 0.0 | 0.0 | 100.0 |
| IPPM Staff | *n* | 4 | 0 | 3 | 7 |
| | % | 57.1 | 0.0 | 42.9 | 100.0 |
| La Macaza Staff | *n* | 1 | 3 | 0 | 4 |
| | % | 25.0 | 75.0 | 0.0 | 100.0 |
| Total | *n* | 6 | 3 | 3 | 12 |
| | % | 50.0 | 25.0 | 25.0 | 100.0 |

All of the CSC internal stakeholder sources (3), IPPM staff sources (5), and staff sources at the La Macaza Institution (1) reported that most or all of the male sex offenders who are sent to IPPM meet the criteria for admission.

Although sources were unable to provide specific numbers, CSC internal stakeholders, IPPM staff sources and staff sources at the La Macaza and Archambault Institutions reported that male sex offenders have been refused admission to IPPM. CSC internal stakeholder sources reported that men from the SHU are refused admission to IPPM because of their violent behaviour. A staff member from La Macaza also noted that if IPPM refuses to admit an offender to its sex offender program, then La Macaza's clinic for sex offenders generally will not admit the offender.

Archambault sources suggested that IPPM generally will not admit a sex offender who has limited cognitive abilities. Archambault sources also noted a case in which the facilities (doorways) at IPPM presented a physical barrier for one offender who required a special wheelchair. It was noted that IPPM was unable to accommodate the wheelchair and CRSM eventually found a community sex offender program for the offender, which meant that he was released on parole earlier than planned in order to participate in the program.

With respect to possible improvements to the referral/admission process, CSC internal stakeholder sources suggested that CSC institution staff need to be better informed about the admission/exclusion criteria.

From a management perspective, a CSC internal stakeholder also suggested that the contract authority should be the person identifying the specific population of sex offenders that

IPPM would treat based on gaps in existing services for the region. The rationale for the suggestion is that Quebec offers a number of accredited sex offender programs and the human and financial resources are less for them. Thus, it was suggested that the OPI should be given the opportunity to identify who they need treated with specialised sex offender programs and then negotiate with IPPM to identify whether they would be prepared to work with this target population.

IPPM sources also noted the need for some of their staff to gain a better understanding of how the admission/selection process works. One IPPM source also suggested that more input is needed from CSC psychiatrists during the referral/admission process.

Staff sources at the La Macaza Institution suggested that the admission/exclusion criteria need to be better promoted throughout CSC and consistently applied by CSC and IPPM.

Archambault sources also noted that the admission process needs to be simplified and made less work intensive. One Archambault source suggested that IPPM should provide CSC institutions with a written letter of refusal stating the reasons why an offender is refused admission. It was noted that this information would assist in making decisions about future referrals. One source suggested that the reason for refusal should be entered into OMS. Another source suggested that the male sex offender admission criteria need to be refined to better identify those offenders who have more potential to realize the benefits of the services at IPPM.

***RECOMMENDATION 3: In collaboration with IPPM and CSC institutions, CSC should conduct a full review of the male sex offender admission and exclusion criteria, as well as the referral and admission process. The review should identify and confirm the key CSC/IPPM stakeholders that need to be engaged in the referral and admission process, and ensure that the criteria accurately and consistently identify those offenders who are best suited for the programs at IPPM.***

#### *3.3.2.2 Implementation of Interventions*

***FINDING 5: Male sex offenders at IPPM are receiving services in their official language of choice.***

As part of the offender satisfaction questionnaire, participants were asked to indicate their official language of choice for service at IPPM and the extent to which they received services in the language of their choice while at IPPM.

The majority of the male sex offenders (93%, 25 of 27) indicated that French was their official language of choice for receiving services at IPPM. Just over 85% of the French- and English-speaking male sex offenders indicated that they always received services at IPPM in the official language of their choice, while the balance of offenders (15%) reported that they received services in their official language of choice some or most of the time. There is a significant difference between the French- and English-speaking male sex offenders; English-speaking offenders reported a significantly lower frequency of service in their preferred language ($t(25) = 6.32$, $p = .001$) than did French-speaking offenders.[41]

***FINDING 6. In all or most cases the male sex offenders have their mental health treatment plans adjusted while at IPPM. IPPM is also addressing the physical health needs of the male psychiatric population.***

All of the CSC internal stakeholder sources (2) and IPPM sources (8) reported that most or all male sex offenders have their mental health plans adjusted while at IPPM. In addition, all of the CSC internal stakeholder sources (3), La Macaza staff sources (5), and IPPM sources (7) reported that the physical health needs of male sex offenders are being met while at IPPM.

#### *3.3.2.3 Continuity of Care*

***FINDING 7: CSC internal stakeholders and IPPM staff are generally satisfied with the completeness and timeliness of the male sex offender information exchanged. However, staff at parent institutions, including parole officers, identified the need for additional details about offenders' experience/progress during their stay at IPPM and greater direct engagement with IPPM personnel to enhance the continuity of care.***

CSC internal stakeholders (1) and IPPM staff sources (5) reported that they are generally satisfied with the timeliness and completeness of the information that each organization provides, as well as the structure and process used for exchanging information between CSC and IPPM as it relates to the male sex offender population. However, half of the staff members interviewed at the La Macaza Institution (2 of 4) are dissatisfied with the communication process.

[41] Results should be interpreted with caution due to the small and uneven sample size.

CSC internal stakeholder sources reported that IPPM provides a considerable amount of verbal communication, but much of this information should be documented to ensure that a comprehensive written record on each offender is maintained.

IPPM staff sources noted that the exchange of information is generally fine, but there are sometimes issues with the time it takes to have a sex offender physically admitted to IPPM. It was noted that once an offender is accepted by IPPM, CSC can take a long time to provide all the paperwork which is required before IPPM can admit the offender. It was noted that the delays can sometimes last months. It was also noted that the confidentiality of certain documents/reports remains an issue in terms of what IPPM can access/share.

Staff members at the La Macaza Institution suggested that more information from the offender medical file should be made available to the case management team as some members of the team are not aware of an offender's condition.

Parole Officers at the La Macaza Institution reported that they would like to be better informed about the offenders' activities and progress while at IPPM. It was noted that this would help in identifying gaps in treatment once an offender is discharged from IPPM. It was noted that IPPM does not conduct a risk assessment before the offender is discharged. It was suggested that it would be beneficial for all Parole Officers at La Macaza to visit IPPM to meet with IPPM personnel as a way to facilitate more communication in the future.

Parole Officers at La Macaza reported that they are very satisfied with the communication structure they have with the program agents from La Macaza's sex offender unit. It was reported that the psychologist and program agents provide a report on the offender after both four and eight months of program participation. It was noted that the reports are very detailed and describe the modules/activities the offender has participated in and any progress/existing gaps. It was suggested that IPPM should also be making this type of information available to CSC Parole Officers.

***RECOMMENDATION 4: CSC and IPPM should review communication and access to information guidelines/policies as well as privacy laws, consult with CSC institutions to confirm what types of information can be shared with personnel at CSC institutions, and examine options for providing CSC personnel with the information they need to enhance the continuity of care. CSC and IPPM should also review the reporting benchmarks for male sex offenders and ensure that the relevant reports, particularly those referred to in the contract, are produced in a timely manner.***

### *3.3.3 Success*

***Objective 3: Success***

***FINDING 8: Pre-post institutional adjustment and functioning outcomes did not change for the IPPM male sex offender population or their comparison group. Analyses suggest that, relative to RTC offenders, IPPM offenders tend to be lower in adjustment and functioning when they are sent for sex offender treatment and these between-group differences persist following intervention.***

**Adjustment and Functioning Outcomes**

It does not appear that sex offender treatment at either IPPM or RTCs reduced sex offenders' SRS levels from pre- to post-intervention. Specifically, a repeated measures analysis of variance for pre- and post-intervention SRS scores for 50 matched pairs of male sex offenders revealed no significant changes ($F(1,48) = 0.04$, *ns*). However, paired samples *t*-tests indicated that IPPM sex offenders had higher security classification levels than did their matched RTC counterparts at both pre- and post-intervention. Thus, it appears that IPPM sex offenders have higher security classification levels when they begin sex offender treatment and this between-group difference persists following sex offender treatment.

As described above, key informant interviews with CSC internal stakeholders, as well as with staff from both IPPM and CSC institutions, revealed that IPPM tends to handle sex offenders with more severe disorders. Thus, like male psychiatric offenders, differences between IPPM sex offenders and their matched counterparts that were not captured through the application of matching criteria may explain between-group differences in outcomes. The available data suggest that, at post-intervention, IPPM offenders showed poorer adjustment and functioning on several indicators, relative to their matched RTC counterparts. Using individual items from the SRS as proximal indicators of post-intervention adjustment, IPPM male sex offenders were significantly more likely to have convictions for serious disciplinary offences. IPPM sex offenders were also more likely to have one or more periods of segregation ($\chi^2(3) = 11.7$, $p < .01$) and less likely to have addressed factors on their Correction Plans ($\chi^2(5) = 18.8$, $p < .005$). Between-groups comparisons of minor disciplinary offences, recorded incidents, pay level, and motivation were non-significant. Data were unavailable to compare groups on likelihood of successful UTAs/work releases. It must also be noted that, due to

unavailable data for the majority of SRS indicators for both IPPM and RTC groups, caution must be used when interpreting these results.

When IPPM sex offenders were compared with their matched counterparts before and after intervention, both groups showed similar levels of risk, need, motivation, and reintegration potential (see Table 20). Though small sample sizes precluded pre/post-test within-group comparisons, visual examination of the data suggests that pre-intervention levels of risk, need, motivation and reintegration potential are comparable to post-intervention levels for both the IPPM group and the comparison group. The majority of both groups continued to show high levels of risk and need, moderate levels of motivation, and moderate or low levels of reintegration potential following intervention.

**Table 20: Levels of risk, need, motivation, and reintegration potential for male sex offenders at pre- and post-intervention.**

| | IPPM Sex Offenders | | RTC Sex Offenders | |
|---|---|---|---|---|
| | *n* | % | *n* | % |
| Risk | | | | |
| Pre-intervention | *n* = 86 | | *n* = 66 | |
| Low | 0 | 0% | 0 | 0% |
| Moderate | 18 | 20.9% | 13 | 19.7% |
| High | 68 | 79.1% | 53 | 80.3% |
| Post-intervention | *n* = 95 | | *n* = 75 | |
| Low | 0 | 0% | 0 | 0% |
| Moderate | 17 | 17.9% | 12 | 16.0% |
| High | 78 | 82.1% | 63 | 84.0% |
| Need | | | | |
| Pre-intervention | *n* = 86 | | *n* = 66 | |
| Low | 0 | 0% | 0 | 0% |
| Moderate | 13 | 15.1% | 11 | 16.7% |
| High | 73 | 84.9% | 55 | 83.3% |
| Post-intervention | *n* = 95 | | *n* = 75 | |
| Low | 0 | 0% | 0 | 0% |
| Moderate | 14 | 14.7% | 20 | 26.7% |
| High | 81 | 85.3% | 55 | 73.3% |
| Motivation | | | | |
| Pre-intervention | *n* = 85 | | *n* = 65 | |
| Low | 19 | 22.4% | 10 | 15.4% |
| Moderate | 52 | 61.2% | 41 | 63.1% |
| High | 14 | 16.5% | 14 | 21.5% |
| Post-intervention | *n* = 88 | | *n* = 69 | |
| Low | 20 | 22.7% | 12 | 18.8% |
| Moderate | 52 | 59.1% | 39 | 56.5% |
| High | 16 | 18.2% | 17 | 24.6% |
| Reintegration Potential | | | | |
| Pre-intervention | *n* = 85 | | *n* = 65 | |
| Low | 34 | 40.0% | 33 | 50.8% |
| Moderate | 34 | 40.0% | 19 | 29.2% |
| High | 17 | 20.0% | 13 | 20.0% |
| Post-intervention | *n* = 88 | | *n* = 69 | |
| Low | 55 | 62.5% | 37 | 53.6% |
| Moderate | 30 | 34.1% | 25 | 36.2% |
| High | 3 | 3.4% | 7 | 10.1% |

*Note:* No between-group differences were statistically significant at either pre-intervention or post-intervention.

***RECOMMENDATION 5: CSC should collaborate with IPPM in conducting a comprehensive evaluation of the program, including the collection of relevant data. A realistic and complete reporting strategy, including relevant performance measures, should be prepared and implemented on an ongoing basis.***

### *Recidivism Outcomes*

***FINDING 9: Men who received treatment services at IPPM exhibit similar recidivism rates compared to those treated at RTCs.***

Like male psychiatric offenders, male sex offenders treated at IPPM had an average rate of recidivism that was similar to male sex offenders treated at RTCs. Using available follow-up data, an examination of the total return to custody rates for the IPPM and RTC groups revealed that there were no significant between-group differences over time in the probability of returning to custody ($\chi^2(1) = 1.60$, $p = .21$, $e^{\beta} = 1.39$). This similarity across groups was also found when recidivism rates were broken down by reason for returning to custody. Specifically, the IPPM group and the RTC group were equally likely to return to custody over time both as a consequence of technical revocations ($\chi^2(1) = 2.31$, $p = .13$, $e^{\beta} = 1.71$) and as a consequence of having been convicted of a new offence ($\chi^2(1) = .21$, $p = 0.65$, $e^{\beta} = .84$). The proportions of offenders from IPPM and RTCs who returned to custody with either a new offence or a technical revocation are displayed in Table 21.

**Table 21: Proportions of male sex offenders who returned to custody following release**

| | IPPM (*N* = 72) | | RTCs (*N* = 86) | |
|---|---|---|---|---|
| Reason for Return | *n* | % | *n* | % |
| New Offence | 12 | 16.7% | 15 | 17.4% |
| Technical Revocation | 19 | 26.4% | 15 | 17.4% |
| Total Returned to Custody | 31 | 43.1% | 30 | 34.8% |

Between-group differences in sexual re-offending were also examined. Results indicated that there no were significant difference between IPPM sex offenders and RTC sex offenders in terms of their propensity for sexual re-offending over time ($\chi^2(1) = .04$, $p = .85$, $e^{\beta} = 1.11$).

## 3.4 Governance and Accountability

***Objective 4: Governance and Accountability***

*The extent to which the governance structure is operational.*

*The extent to which accountabilities and the appropriation of funds related to the contract are understood.*

This section of the report examines all three offender populations together as there is considerable overlap in the findings and recommendations.

***FINDING 1: The Joint Committee is not meeting its basic requirements in terms of meeting at least once on an annual basis, providing oversight through a collective group, and developing and guiding a research agenda.***

**Governance by the Joint Committee**

When asked to comment on the role and objectives of the Joint Committee, half of the CSC internal stakeholders interviewed (5 of 10) acknowledged that they were not very familiar with the Joint Committee. The remaining CSC internal stakeholders reported that they understood the role/objectives of the Joint Committee to a moderate (3) or great extent (2).

As described by one CSC internal stakeholder, the Joint Committee was established to be a higher level of authority to monitor the results of the program in relation to the requirements of the contract for all three offender populations. It was noted that the responsibilities of the Committee include establishing coordination and reporting mechanisms, as well as formulating appropriate recommendations to ensure that the program meets the needs of the three offender populations. It was also noted that the Joint Committee is responsible for resolving administrative and clinical issues/challenges, and for providing recommendations for research projects to a regional research committee. Membership on the Committee consists of representatives from both CSC (NHQ and the Quebec Region) and IPPM.

When asked to comment on the extent to which the Joint Committee is fulfilling its role, all of the CSC sources who are familiar with the role of the Joint Committee generally agreed that the Committee is not fulfilling its role.

CSC internal stakeholder sources reported that the Joint Committee has met infrequently and has been hampered by turnover in staff and scheduling problems for its members. As a

result, the Joint Committee "has yet to come together to work collectively". It was further noted that the Terms of Reference for the Committee have been drafted, but have yet to be approved by the Committee. It was acknowledged by one respondent that CSC has not fulfilled its responsibility to call the Joint Committee meetings as it should.

A Coordinating Committee was established by the Joint Committee to ensure that members of the Joint Committee are briefed on operations. The Coordinating Committee consists of a representative from IPPM and two representatives from CSC (a representative for the women's population and a representative for the men's population). CSC sources noted that the Coordinating Committee engages with the individual members of the Joint Committee to gain their input/feedback/endorsement on operations as needed. It was stressed that "ideally, the Joint Committee should be meeting as a whole to discuss operations and provide input".

Several CSC internal stakeholders expressed their disappointment with the lack of leadership and oversight provided by the Joint Committee. One respondent noted the contract requires the Joint Committee to establish a subcommittee to identify and implement evaluation/research projects in relation to the program, but the subcommittee has not been established. Given IPPM's status as a "leader in research in the mental health field", it was suggested that CSC is missing an opportunity to conduct focused research with the three offender populations. For example, one respondent identified the need to examine why some offenders are not completing their stay and/or are not benefiting from the program at IPPM and identify options for enhancing success rates.

Although largely inactive at the moment, CSC internal stakeholders emphasized that the Joint Committee can still serve a very important function. There is a desire to see the Joint Committee operationalized as originally intended. It was noted that considerable effort went into preparing the Terms of Reference for the Joint Committee and that, if the Terms of Reference require further revisions, it would result in further delays and inactivity.

IPPM sources also expressed disappointment with the Joint Committee. It was noted that the mandate for a Joint Committee has been in the contract "for at least 20 years," yet is still only functioning "informally" (i.e., not as it should). IPPM sources attributed this poor functioning to staff turnover at CSC and the requirement that the Joint Committee meet only once a year.

IPPM sources suggested that the Coordinating Committee is a much more important body in terms of carrying out the practical work of the contract. As described by one respondent, the

Coordinating Committee is currently taking responsibility for managing the contract. It was noted that members of the Coordinating Committee were selected by the Joint Committee to keep Joint Committee members briefed. It was further noted that there are no formal records of the meetings/discussions between Coordinating Committee members and Joint Committee members. Several IPPM sources expressed interest in having the Joint Committee commit to at least two meetings per year and establishing subcommittees, such as a research committee. It was emphasized that the Joint Committee needs to review the roles of CSC and IPPM stakeholders.

***RECOMMENDATION 1: CSC must act immediately to ensure that the Joint Committee is operationalized as intended. Immediate priorities include confirming/identifying the committee members, establishing a formal meeting schedule, approving the Terms of Reference, and establishing a research subcommittee.***

***FINDING 2: Many CSC internal stakeholders are unfamiliar with the accountability structure of the contract. It was generally recognized that the reporting structure needs to be enhanced to ensure that CSC and IPPM stakeholders alike are fully aware of, and accountable for, the information/reporting requirements outlined in the contract and operational plans. Many CSC stakeholders are also unfamiliar with IPPM's programs and physical setting.***

**Accountability**

When asked to describe the accountability structure of the contract between CSC and IPPM, half of the CSC internal stakeholders interviewed (5 of 10) acknowledged that they were not very familiar with the accountability structure. The remaining CSC internal stakeholders reported that they understood the accountability structure either to a great extent (2) or completely (3).

CSC internal stakeholders reported that the reporting structure needs to be enhanced to ensure that all CSC and Pinel stakeholders are aware of the type of reports that need to be completed both during offenders' stays at IPPM and at follow-up, after offenders leave IPPM. Currently there is no requirement in the contract for tracking the outcomes of offenders post-IPPM, but CSC internal stakeholders expressed interest in adding this element.

IPPM sources reported that CSC is responsible for ensuring that offenders arrive safely at IPPM. Though IPPM is responsible for offenders' well-being while at IPPM, offenders remain under the jurisdiction of CSC. IPPM has several departments that oversee the handling of offenders, including delivery of care services, finances, and logistics.

***RECOMMENDATION 2: CSC should prepare a briefing note/document on the accountability structure as it relates to all three offender populations and circulate this document to all relevant CSC and IPPM personnel. Because many CSC stakeholders are also unfamiliar with IPPM's programs and physical setting, CSC should consider conducting a briefing day for CSC personnel on-site at IPPM. This briefing day could be open to CSC personnel from some of the local referral institutions.***

***Appropriation of Funds***

***FINDING 3: In 2006/2007 IPPM made an annual financial adjustment to account for unoccupied beds, resulting in a $93,150 cost saving for CSC. Relatively few CSC internal stakeholders, including some members of the Joint Committee, are familiar with how the funding formula with IPPM works, but there is a desire to be better informed. One area that continues to lack clarity in the contract relates to responsibility for certain costs, such as medical fees and health insurance costs.***

The CSC 2006-2012 contract with IPPM has a total expenditure value of $28,153,479. As detailed in the contract, the expenditure is to be allocated as follows over the six-year period:

- 2006/2007: $4,500,000
- 2007/2008: $4,500,000
- 2008/2009: $4,612,500
- 2009/2010: $4,727,813
- 2010/2011: $4,846,008
- 2011/2012: $4,967,158

The cost of the contract is based on a daily requirement for a total of 25 beds (men and women) at a rate of $479.00 per bed.[42]

IPPM provides CSC with a monthly invoice detailing the number of beds occupied for each of the three offender populations. The invoice also indicates the length of stay (days) at IPPM by offenders during each month. IPPM is paid a flat rate each month for the beds that are kept on standby (a minimum of 12 and a maximum of 15 women psychiatric beds, 3 male

[42] Results Based Management and Accountability Framework - Contract with the Institut Philippe-Pinel de Montréal. 2007. p.15.

psychiatric beds, and 12 sex offender beds), regardless of whether the beds are occupied or not. This amounts to $346,153.85/pay period.[43]

As part of the 2006-2012 contract between CSC and IPPM, a provision for an annual financial adjustment was included to address situations in which more or fewer beds are utilized than expected. If the average occupancy during one year is less than 23 beds in total (i.e., 8,395 days), IPPM is required to reimburse CSC $50 per day per bed based on the variable cost only. Conversely, if the average occupancy during one year is more than 27 beds in total (i.e., 9,855 days), CSC is required to pay IPPM an additional $50 per day per bed. No adjustment is made if the average occupancy is between 23 and 27 days. Between July 24, 2006 and July 21, 2007 IPPM reported a total of 1,863 days in which beds were unoccupied, which translated into a year-end adjustment of $93,150. An example of how the financial adjustment is applied is presented in Table 22.

[43] Calculated by using the 2006/2007 base value of $4.5 million and applying a factor of 1/13 (for the 13 pay periods during the year) to determine the amount per pay period.

**Table 22: Average occupancy at IPPM July 2006 – July 2007 (all offender populations combined)**

| Time Period | Dates | # of days invoiced | # of days within time period | Average # of offenders |
|---|---|---|---|---|
| 1 | July 24 - Aug 19, 2006 | 515 | 27 | 19.07 |
| 2 | Aug 20 - Sept 16, 2006 | 464 | 28 | 16.57 |
| 3 | Sept 17 - Oct 14, 2006 | 465 | 28 | 16.61 |
| 4 | Oct 15 - Nov 11, 2006 | 482 | 28 | 17.21 |
| 5 | Nov 12 – Dec 9, 2006 | 507 | 28 | 18.11 |
| 6 | Dec 10, 2006 - Jan 6, 2007 | 532 | 28 | 19.00 |
| 7 | Jan 7 - Feb 3 2007 | 534 | 28 | 19.07 |
| 8 | Feb 4 - March 3, 2007 | 572 | 28 | 20.43 |
| 9 | March 4 - March 31, 2007 | 560 | 28 | 20.00 |
| 10 | April 1 - April 28, 2007 | 475 | 28 | 16.96 |
| 11 | April 29 - May 26, 2007 | 430 | 28 | 15.36 |
| 12 | May 27 - June 23, 2007 | 440 | 28 | 15.71 |
| 13 | June 24-July 21, 2007 | 510 | 28 | 18.21 |
| Totals and annual average | | 6,486 | 363 | 17.87 |
| Required Adjustment | | | | |
| Base number of days where 23 beds are paid for (23*363 days) | | | 8,349 | |
| Number of days- beds are used | | | 6,486 | |
| Number of days- beds are unused | | | 1,863 | |
| Adjustment rate ($50 per day per bed) | | | $50 | |
| Required adjustment (difference which doesn't need to be paid) | | | $93,150 | |

Source: Correctional Service Canada, Quebec Region.

When asked to describe how the funds for the contract are appropriated between CSC and IPPM, half of the CSC internal stakeholders interviewed (5 of 10) acknowledged that they were not very familiar with this aspect of the contract. The remaining CSC internal stakeholders reported that they understood this aspect of the contract to a moderate (4) or great (1) extent. One of these sources noted that there is a need for greater clarity in the contract in relation to responsibilities for some costs. It was suggested that the contract needs more details about who is responsible for covering medical fees and health insurance costs.

***RECOMMENDATION 3: CSC should prepare a briefing note/document on the funding arrangements with IPPM for dissemination among internal stakeholders. In accordance with privacy laws, the contract should be updated to specify how the medical fees and health insurance costs associated with offenders at IPPM are to be handled.***

***FINDING 4: Staff turnover is a hindrance for both CSC and IPPM in ensuring that all personnel are up-to-date with DBT and other treatment models. CSC provided DBT training, Women Centered Training, and Aboriginal Awareness training to IPPM staff in 2004, but there has been no follow-up training provided by CSC since this period. IPPM has continued to provide DBT training to its own personnel, facilitated by experienced IPPM staff. However, IPPM staff acknowledge the need for further training.***

**Staff Training**

The Operational Plan for the women offenders' unit at IPPM includes a brief description of the training requirements for IPPM staff with respect to CSC's treatment models (CSC, 2006, p. 17). As part of the agreement between CSC and IPPM, CSC is required to provide training to IPPM staff in CSC's DBT, the Women Centered Training Program, and Aboriginal Awareness training. The Operational Plan also notes that CSC staff are to receive training on IPPM issues and policies, facilitated by IPPM staff. However, there are no details in the Operational Plan as to the frequency of training.

Several CSC sources confirmed that CSC provided an initial DBT training session to IPPM staff in 2004, when the women offenders' unit was established. With respect to follow-up training, CSC sources noted that any ongoing DBT training at IPPM is being conducted by some of IPPM's own personnel. CSC sources are unaware of the frequency of training or the number of staff that have been trained at IPPM. A CSC source reported that, as recently as 2007, IPPM was interested in receiving additional training in DBT.

Several CSC sources stressed that staff turnover was a complicating factor for both CSC and IPPM in ensuring that all personnel were up to date with DBT and other treatment models. Language was identified as another possible hindrance. One CSC source questioned whether CSC has the capacity to adequately provide DBT training in French. Another source stressed the importance of ensuring that offenders are able to effectively receive services in their official language of choice.

One CSC source suggested that a full assessment of "practice versus policy" is needed to determine the extent to which the treatment models being used at IPPM are consistent with/complement CSC's treatment models.

IPPM sources confirmed that IPPM staff received training from CSC in DBT, Women Centered Training, and Aboriginal Awareness training in 2004. It was reported that, at the time the unit was opened in 2004, a total of 17 IPPM employees received training. It was noted that

seven of these original employees continue to work at the unit. It was further reported by IPPM sources that, since the initial training in 2004, the Assistant Coordinator and a psychologist in the women's unit at IPPM have conducted DBT reviews and training sessions with staff members. It was noted that staff at IPPM are provided with training allowances. IPPM sources were unable to provide exact details on the frequency of training or the number of participants. One IPPM source acknowledged that some staff at IPPM who were hired after 2004 may not have received all of the training and it was suggested that more training is needed.

***RECOMMENDATION 4: CSC should collaborate with IPPM in identifying training needs and opportunities to ensure that all appropriate IPPM staff are up to date on CSC treatment models. Training sessions should be led by CSC officials and conducted on site at IPPM to facilitate higher participation rates.***

### 3.5 Cost-Effectiveness

***Objective 5: Cost-Effectiveness and Efficiency***

*The extent to which the most appropriate and efficient means have been used to achieve objectives, relative to alternative delivery approaches.*

***FINDING 1: The 2006/2007 IPPM per diem cost of $595 per bed is comparable to that of CSC RTCs, which range between $391 and $584. Funding appears to have been allocated to IPPM as planned and financial adjustments have been made in response to changes in occupancy rates. However, differences in the way IPPM and CSC tabulate/report occupancy rates make it difficult to determine actual occupancy rates. Research conducted by IPPM is providing additional value that is difficult to quantify monetarily.***

A fixed per diem rate was established by CSC and IPPM at the time the contract was renewed in 2006.[44] The fixed rate was established by using 2005 as the base year and applying an annual index of 2.5% through to 2011. In 2005, the estimated per diem was $467.11 and increased to $478.79 for the 2006/07 period based on the 2.5% annual index.[45]

The daily rate reflects operational costs only and is based on the cost to operate separate units for male sex offenders and female psychiatric offenders, whether one or all beds in each unit are occupied (a minimum of 12 and maximum of 13 beds for women offenders, 12 beds for

[44] CSC Contract with the Institut Philippe-Pinel de Montréal, 2006-2012. 2005. Appendix B.
[45] Memorandum from Jacques Jodoin, Director General Assistant, IPPM, to Esther Paquin, Contract Negotiator, Service Canada, August 9, 2005.

male sex offenders, and 3 beds for male psychiatric offenders). However, an annual financial adjustment is made in situations in which more or fewer beds are utilized than expected. If the average occupancy during one year is less than 23 beds in total (i.e., 8,395 days), IPPM is required to reimburse CSC $50 per day per bed based on the variable cost only. Conversely, if the average occupancy during one year is more than 27 beds in total (i.e.9,855 days), CSC is required to pay IPPM an additional $50 per day per bed.[46] In 2006/07 the average occupancy at IPPM was 17.87 beds, which amounts to a total of 6,486 days during the year.[47] This translates into a total of 1,863 days in which beds were unoccupied and resulted in a financial adjustment of $93,150 (i.e. CSC was not required to pay this amount to IPPM in 2006/07).

Funding appears to have been allocated to IPPM as planned. For example, in 2006/07 the total contract amount of $4.5 million (for all three offender populations and the provision of emergency services) was allocated to IPPM through 13 equal instalments of $364,153.85. In the 13th pay period a financial adjustment of $93,150 was applied (as outlined above) as a result of fewer beds being utilized than expected.[48] However, in reviewing the occupancy and cost data provided by CSC and IPPM for the 2001-2007 period, several discrepancies (possibly due to differences in the way bed-days were coded) were identified. For example, as described earlier in this report, during the period 2001-2007 there were two years where the occupancy rates for male offenders sent to IPPM appeared lower than would be expected based on the total number of bed-days reported. A further review is required to determine why some figures are inconsistent.[49]

Currently, the funding for the male psychiatric and male sex offenders sent to IPPM is obtained from the Quebec Regional budget and the finances for the women offenders is obtained

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[46] In 2005 CSC defined normal, low and high annual occupancy rates based on a review of annual occupancy rates from 2001 to 2005. The normal annual occupancy rate was established at 25 beds (11.6 beds for male sex offenders, 11.6 beds for women offenders, and 2 beds for male psychiatric offenders) and CSC and IPPM agreed to a low annual occupancy rate of 23 beds and a high annual occupancy rate of 27. (Memorandum from Jacques Jodoin, Director General Assistant, IPPM, to Esther Paquin, Contract Negotiator, Service Canada, August 9, 2005).

[47] For the 363 day period between July 24, 2006 and July 21, 2007.

[48] In the 2006/07 funding formula, approximately 0.05% of the $4.5 million in contracted services was to be dedicated to the provision of emergency services at IPPM while the balance was to be weighted across the three offender populations based on the projected normal occupancy rates: 11.6 beds (46%) for women offenders, 11.6 beds (46%) for male sex offenders, and 2 beds (7.5%) for male psychiatric offenders (Memorandum from Jacques Jodoin, Director General Assistant, IPPM, to Esther Paquin, Contract Negotiator, Service Canada, August 9, 2005). Disaggregated billing data for the three offender populations was unavailable at the time of this study to determine the actual allocation of funds across the three offender populations.

[49] For example, 2004/05 occupancy data provided by CSC Quebec Region identified a total of 6,204 bed days for male sex and male psychiatric offenders at IPPM while the data provided by IPPM identified a total of 4,843 bed days for the same group.

from a service exchange agreement for which the Women Offender Sector is the Office of Primary Interest. The amount paid out of each budget is based on an estimation of the average occupancy rates of male and female offenders at IPPM, which was determined when the contract was last renewed in 2005 (i.e., 11.6 beds for women offenders, 11.6 beds for male sex offenders, and 2 beds for male psychiatric offenders). However, as noted by a source with CSC Finance (Quebec Region), it would be preferable to base the amount paid out of each budget on the actual proportion of male and female offenders sent to IPPM, rather than on the estimated proportion. This would allow for a more equitable allocation of funding from the two sources.

**Cost Comparison with other CSC Institutions**

Results indicate that IPPM is providing services at a cost that is comparable to that of CSC Regional Treatment Centres, which handle similar offender populations.

Though the estimated daily cost per bed at IPPM for all three offender populations was $479,[50] the actual daily rate per bed at IPPM was $595/day in 2006/2007, after the year-end financial adjustment for unoccupied beds was taken into account (see Appendix 1 for more detail).

This daily rate per bed for CSC offenders at IPPM compares favourably with the daily rate that IPPM charges for its regular provincial court order clients ($701/day).

Additionally, when the average daily rate for maintaining an offender at IPPM is compared to the average costs of maintaining an offender at CSC's RTCs (which also offer treatment for psychiatric and sex offenders), results indicate that RTC daily rates are fairly equivalent to IPPM rates (NHQ Finance, Per Diem Rates 2006/2007).[51] Specifically, relative to the $595/day for offenders sent to IPPM in 2006-2007, RTC rates for approximately the same time period ranged between $391 and $584 per day:

- Pacific Regional Treatment Centre – Abbotsford BC ($391)
- Ontario Regional Treatment Centre – Kingston ON ($400)

[50] CSC Contract with the Institut Philippe-Pinel de Montréal, 2006-2012. 2005. Appendix B.

[51] 2006-07 per diem rates provided by NHQ Finance. Calculation methodology: The cost of maintaining an offender on a per day basis is obtained by dividing the overall ongoing expenses of CSC (including all security related expenses) by the annual average number of offenders and by dividing the annual cost of maintaining an offender by 365 days. The calculation of these costs is based on actual salaries and operating expenditures as reflected in the 2006-07 Public accounts, including contribution to employee benefit plan but excluding the retroactive payments of salaries pertaining to previous years for newly signed collective agreements. It also excluded capital expenses and CORCAN (SOA) disbursements.

- Prairies Regional Treatment Centre – Saskatoon SK ($471)
- Atlantic Shepody Treatment Centre – Dorchester NB ($584)

A cost comparison between the costs for services provided by IPPM and those incurred if CSC were to take on the current functions of IPPM internally was beyond the scope of this evaluation. As well, a comparison with community-based models in Canada was not feasible because, as indicated by CSC key informant interviews, no comparable community models exist. However, as described earlier in this report, CSC internal stakeholders were asked for their views on how viable it would be for CSC to develop and implement services for the three offender populations to replace the services currently being provided by IPPM. In general, CSC internal stakeholders suggested that it could be a very lengthy process for CSC to develop and implement an operational plan that would replicate all of the services currently being provided by IPPM. As one source suggested "it would not be viable for CSC to construct an entire hospital and manage it when IPPM is available and has experts with years of experience that CSC can call upon". It was further noted that, even with the establishment of the mental health centre at Archambault, CSC still requires the services of IPPM for some male psychiatric offenders.

**Value for Money**

In general, CSC internal stakeholders perceive that IPPM is providing value for the money allocated for the provision of services. Although some CSC internal stakeholders and CSC staff members perceive that the services provided by IPPM are "expensive", it is important to note that many of the CSC internal stakeholders and CSC institution staff members interviewed assumed that IPPM was being paid the full amount of the contract regardless of the occupancy rate, and were unaware that a financial adjustment was being made to reimburse CSC for any unoccupied beds.

As indicated elsewhere in this report, there remains a continued need for the services provided by IPPM across all three offender populations. Although IPPM is occasionally operating below its capacity for the women offender and male sex offender populations, other findings presented in this report point to factors that are contributing to this issue and to means by which CSC can respond to these issues, such as ensuring better promotion of the program among CSC internal stakeholders and CSC institution staff.

**Value That Cannot Be Quantified**

Many of the CSC internal stakeholders and IPPM staff sources interviewed identified activities at IPPM that are providing additional value to CSC. As noted by CSC internal stakeholders, IPPM has an international reputation in psychiatric assessment and treatment, along with an established research tradition through its affiliation with the University of Montreal. CSC internal stakeholders reported that the research conducted by IPPM has been beneficial to CSC in helping to identify possible treatment solutions for the male sex offender population. For example, IPPM has examined factors underlying sexual aggression and factors associated with recidivism, and this examination has resulted in the development of important theoretical and clinical concepts (Aubut et al, 1998, p. 231). Research with sexual aggressors has also enabled IPPM to refine certain diagnostic tools. However, CSC internal stakeholders generally reported that CSC is not taking full advantage of the opportunities at IPPM to conduct more research with the offender populations and pointed to the need for the Joint Committee to fulfill its mandate in identifying and directing research activities.

CSC internal stakeholders and IPPM staff also reported that IPPM and CSC have collaborated in hosting joint research conferences and IPPM has provided opportunities for CSC staff to participate in research workshops and other conferences. As noted elsewhere in this report, staff members at CSC institutions indicated an interest in participating in IPPM research workshops, but identified accessibility concerns which in part could be addressed by IPPM conducting the workshops on site in the CSC institutions.

***RECOMMENDATION 1: In order to ensure that source funding is directed toward the intended offender population, the allocation of funds should be based on the actual proportion of beds utilized by each offender population and not the estimated proportion. CSC and IPPM should agree to a standardized approach for reporting occupancy data.***

## 4.0 Overall Conclusion

The evaluation suggests that the services provided by the IPPM are continuing to respond to the service needs of CSC in relation to the three distinct groups of federal offenders: women offenders with psychiatric needs from across Canada, male offenders with psychiatric needs incarcerated in the Quebec Region and male sex offenders incarcerated in the Quebec Region.

Results from interviews with key sources indicate that there are no suitable community-based alternatives to IPPM and existing CSC facilities continue to require the specialized services of IPPM for all three offender populations. The per diem costs for the offender populations at IPPM were found to be fairly comparable to CSC RTCs.

However, IPPM is generally operating below its capacity for all three offender populations. The women's unit in particular has encountered challenges in reaching its capacity rate. Contributing factors include limited awareness about the program among CSC personnel and offenders, offender reluctance to self-admit, delays in processing referrals and a high rate of offenders refusing service at IPPM.

Another key issue in need of attention is the Joint Committee which is not functioning as intended. CSC needs to operationalize the Joint Committee and address several immediate priorities, including confirming/identifying the committee members, establishing a formal meeting schedule, approving the Terms of Reference, and developing a research agenda. Very limited research has been conducted in relation to the three offender populations, even though such research represents one area where the IPPM could provide added value to the contract. One future research activity would be to examine treatment options for offenders who will not self-admit or who refuse treatment at IPPM.

Other activities that should be initiated by the Joint Committee include a review of:

- the admission and exclusion criteria and the referral and admission process to ensure that the criteria are sufficiently clear and that all relevant CSC and IPPM personnel are fully aware of the criteria;
- training needs and opportunities to ensure that all relevant IPPM staff are up to date on CSC treatment models;

- communication and access to information guidelines/policies to ensure that all relevant CSC and IPPM personnel have the information they need to enhance the continuity of care; and,
- reporting requirements and benchmarks for offenders to ensure that the all relevant reports, particularly those referred to in the contract are produced in a standardized, consistent, and timely manner.

The Joint Committee should also examine ways to enhance the transition process from IPPM back to the CSC institution. In addition, follow-up protocols should be established to track the progress of offenders post-IPPM to determine if offenders need additional support in order to maintain the gains made earlier and facilitate their reintegration.

The evaluation indicates that IPPM is addressing the physical health needs of the three offender populations and offenders are receiving services in the official language of their choice.[52] The results also indicate that women and male psychiatric offenders self-identified improvements in their functioning as a result of their stay at IPPM. However, pre-post institutional adjustment and functioning outcomes identified from the OMS database did not change for the IPPM populations, nor were there any differences in recidivism rates when compared to their respective comparison groups. It is important to note that small sample sizes precluded the possibility of conducting certain pre/post-test analyses, particularly for the sample of women. In addition, the small sample sizes may have diminished the statistical power of some quantitative analyses, thereby masking significant effects. The indicators available from OMS are also not specifically designed to assess mental health programming outcomes.

It was also not possible to compare outcomes for offenders who completed the purpose of their stay at IPPM or RTCs with those who did not. Such comparisons may have enabled more detailed conclusions regarding which types of services provided by IPPM benefit federal offenders most/least and whether there is a need to implement more stringent selection criteria for offenders sent to IPPM (e.g., based on offenders' likelihood of completing assessments/treatments).

[52] Based on *t*-tests, this does not appear to be as likely for English-speaking women, though small sample sizes mean the finding should be interpreted with caution.

While this research provides an indication of the continued need for the services at IPPM and some areas of success, it also identifies areas for improvement and the need for a more comprehensive evaluation of the contract between CSC and IPPM, including the identification of relevant performance measures and the devotion of resources to ongoing data collection about offenders in mental health programs.

## 5.0 References


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## 6.0 Appendices

### Appendix 1: Impact of Financial Adjustments Resulting from Lower than, or Higher than, Anticipated Occupancy Rates

The costs of the contract between CSC and IPPM are based on an average daily requirement for a total of 25 beds (men and women) at an estimated rate of $479.00 per bed.[53] This rate was determined after a review of annual occupancy rates from 2001 to 2005, at which time CSC defined normal, low, and high annual occupancy rates. The normal annual occupancy rate was established at 25 beds (11.6 beds for male sex offenders, 11.6 beds for women offenders, and 2 beds for male psychiatric offenders) and CSC and IPPM agreed to a low annual occupancy rate of 23 beds and a high annual occupancy rate of 27 beds.[54]

The annual amount allocated to the contract between CSC and IPPM is paid by CSC in 13 equal instalments. At the time of the thirteenth instalment, a year-end financial adjustment is made for annual occupancy rates that average less than 23 or more than 27 beds per day. If the average occupancy rate during one year is less than 23 beds in total (i.e., less than 8,395 days), IPPM is required to reimburse CSC $50 per day per bed. Conversely, if the average occupancy during one year is more than 27 beds in total (i.e., more than 9,855 days), CSC is required to pay IPPM an additional $50 per day per bed. No adjustment is made if the average occupancy is between 23 and 27 days.

Table 23 provides examples of costs based on the above mentioned policy.

53 Results Based Management and Accountability Framework - Contract with the Institut Philippe-Pinel de Montréal. 2007. p.15.

54 Memorandum from Jacques Jodoin, Director General Assistant, IPPM, to Esther Paquin, Contract Negotiator, Service Canada, August 9, 2005

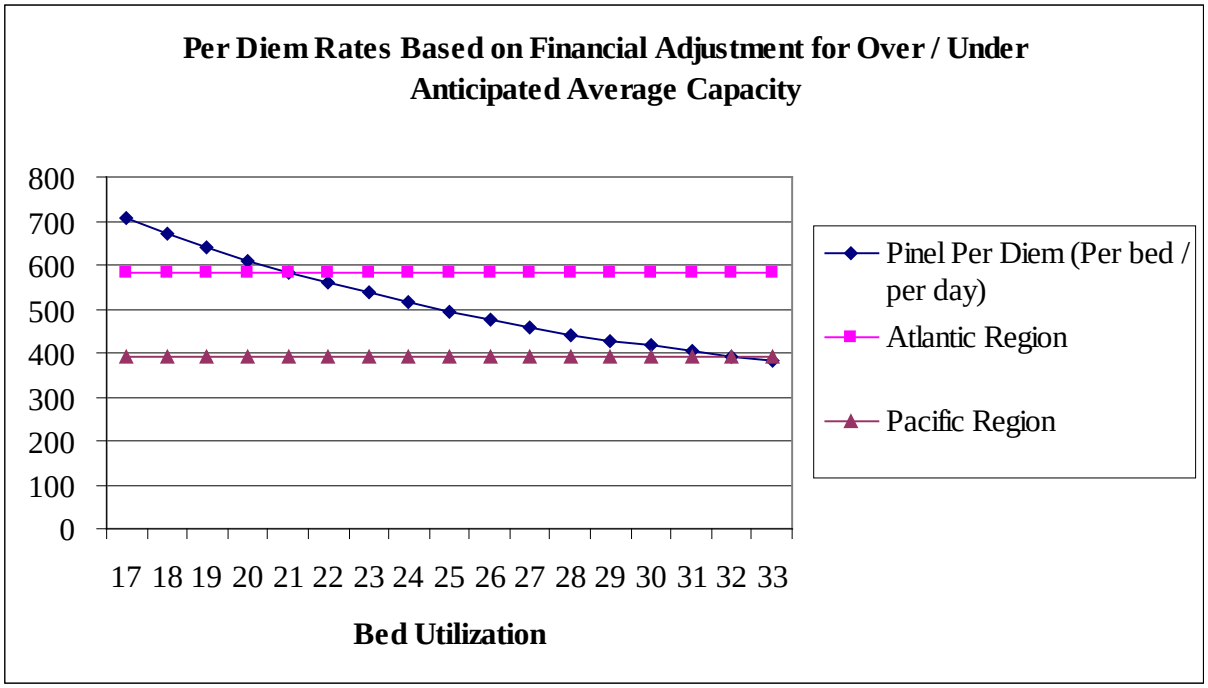
**Table 23: Costing Sample Based on Lower than, and Higher than, Anticipated Occupancy Rates for 2006/2007**

| Discrepancy in Anticipated Daily Occupancy Rates (*A*)[a] | Daily Bed Utilization (*B*) | Annual Adjustment (*C*) (*A**365*50) | Annual Expenditures (*D*) (4.5M-*C*) | Per Diem (*D*/(*B**365)) |
|---|---|---|---|---|
| -6 | 17 | -$109,500 | $4,390,500 | $707.57 |
| -5 | 18 | -$91,250 | $4,408,750 | $671.04 |
| -4 | 19 | -$73,000 | $4,427,000 | $638.36 |
| -3 | 20 | -$54,750 | $4,445,250 | $608.94 |
| -2 | 21 | -$36,500 | $4,463,500 | $582.32 |
| -1 | 22 | -$18,250 | $4,481,750 | $558.13 |
| 0 | 23 | $0 | $4,500,000 | $536.03 |
| 0 | 24 | $0 | $4,500,000 | $513.70 |
| 0 | 25 | $0 | $4,500,000 | $493.15 |
| 0 | 26 | $0 | $4,500,000 | $474.18 |
| 0 | 27 | $0 | $4,500,000 | $456.62 |
| +1 | 28 | $18,250 | $4,518,250 | $442.10 |
| +2 | 29 | $36,500 | $4,536,500 | $428.58 |
| +3 | 30 | $54,750 | $4,554,750 | $415.96 |
| +4 | 31 | $73,000 | $4,573,000 | $404.15 |
| +5 | 32 | $91,250 | $4,591,250 | $393.09 |
| +6 | 33 | $109,500 | $4,609,500 | $382.69 |

*Note:* Annual expenditure is calculated based on the $4.5M allocated in the contract between CSC and IPPM for 2006/2007.
The calculated per diem exceeds the estimated $479 per diem stipulated in the contract between CSC and IPPM because this calculated per diem represents all costs associated with the contract, including, for example, costs associated with ambulatory services.
[a] "-" denotes under anticipated capacity, "+" denotes over anticipated capacity.

In plotting the per diem costs, Figure 1 demonstrates that lower than anticipated occupancy rates result in increased per diem costs and that higher than anticipated occupancy rates result in decreased per diem costs. If occupancy rates remain between the anticipated 23 to 27 beds per year then the anticipated per diem would range between $536 (for 23 beds) and $457 (for 27 beds). Notably, the highest 2006/2007 per diem emerging from CSC RTCs is $584, in the Atlantic Region. In turn, it is not until IPPM reaches a yearly average of three unused beds per day (i.e., a utilization rate of 20 beds per day at a per diem of $609) that the costs of IPPM begin to exceed those costs of the highest range of other regional RTC per diems.

**Figure 1: 2006/2007 Per Diem Costs as a Function of Bed Utilization Rates**




In light of this information, it becomes clear that occupancy rates are critical in the accurate examination of cost-effectiveness. If occupancy rates are consistently and substantially lower than the anticipated average rates then cost-effectiveness would be unfavourably impacted. However, if occupancy rates correspond to or exceed the anticipated average rates then there would be little impact on anticipated expenditures or per diem forecasts, and cost-effectiveness would be comparable to that of CSC RTCs.

Table 24 provides the bed utilization, annual expenditure, and per diem for each fiscal year dating back to 2001-2002.[55,56] Of note, the $595 per diem for the 2006/2007 fiscal year is fairly comparable to that of regional CSC RTCs, which range between $391 (Pacific Region) and $584 (Atlantic Region).[57]

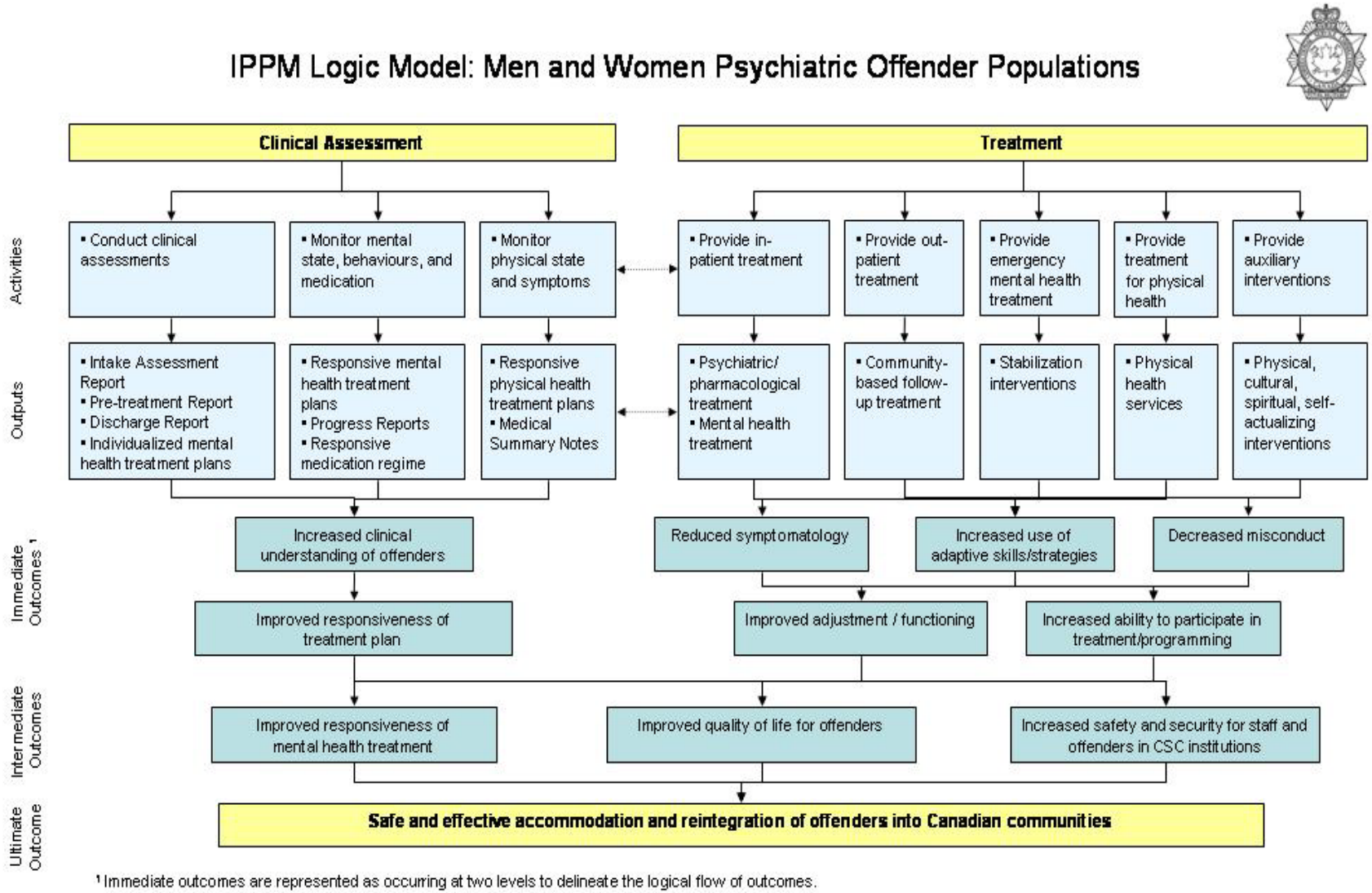
55 Data presented in Table 20 differs from the data presented in Table 18 for 2006/2007 because, in Table 20, 2006/2007 represents the fiscal year whereas, in Table 18, 2006/2007 represents the term of the contract (July 24, 2006 to July 23, 2007).
56 The per diem reported in Table 20 differs from the per diem reported in the Cost-Effectiveness" section above entitled "" due to the unavailability of certain pertinent data at the time that the main body of this report was written.
57 Annual allotments to the contract between CSC and IPPM increased with each subsequent year due to annual indexation and, therefore, annual expenditures and per diems prior to 2006/2007 cannot be meaningfully compared with the 2006/2007 RTC data presented in Figure 1.

**Table 24: Bed Utilization, Annual Expenditures, and Per Diems by Fiscal Year (All Three Populations Combined)**

| Fiscal Year | Yearly Bed/Day Utilization (*A*) | Average Daily Bed Utilization (*A*/365) | Annual Expenditures (*B*) | Per Diem (*B*/*A*) |
|---|---|---|---|---|
| 2001-2002 | 5,556 | 15.22 | $2,154,140 | 387.71 |
| 2002-2003 | 5,132 | 14.06 | $2,078,219 | 404.95 |
| 2003-2004 | 5,748 | 15.75 | $2,358,180 | 410.26 |
| 2004-2005 | 9,167 | 25.12 | $4,541,456 | 495.41 |
| 2005-2006 | 9,612 | 26.33 | $4,811,627 | 500.59 |
| 2006-2007 | 7,745 | 21.22 | $4,609,543 | 595.16 |

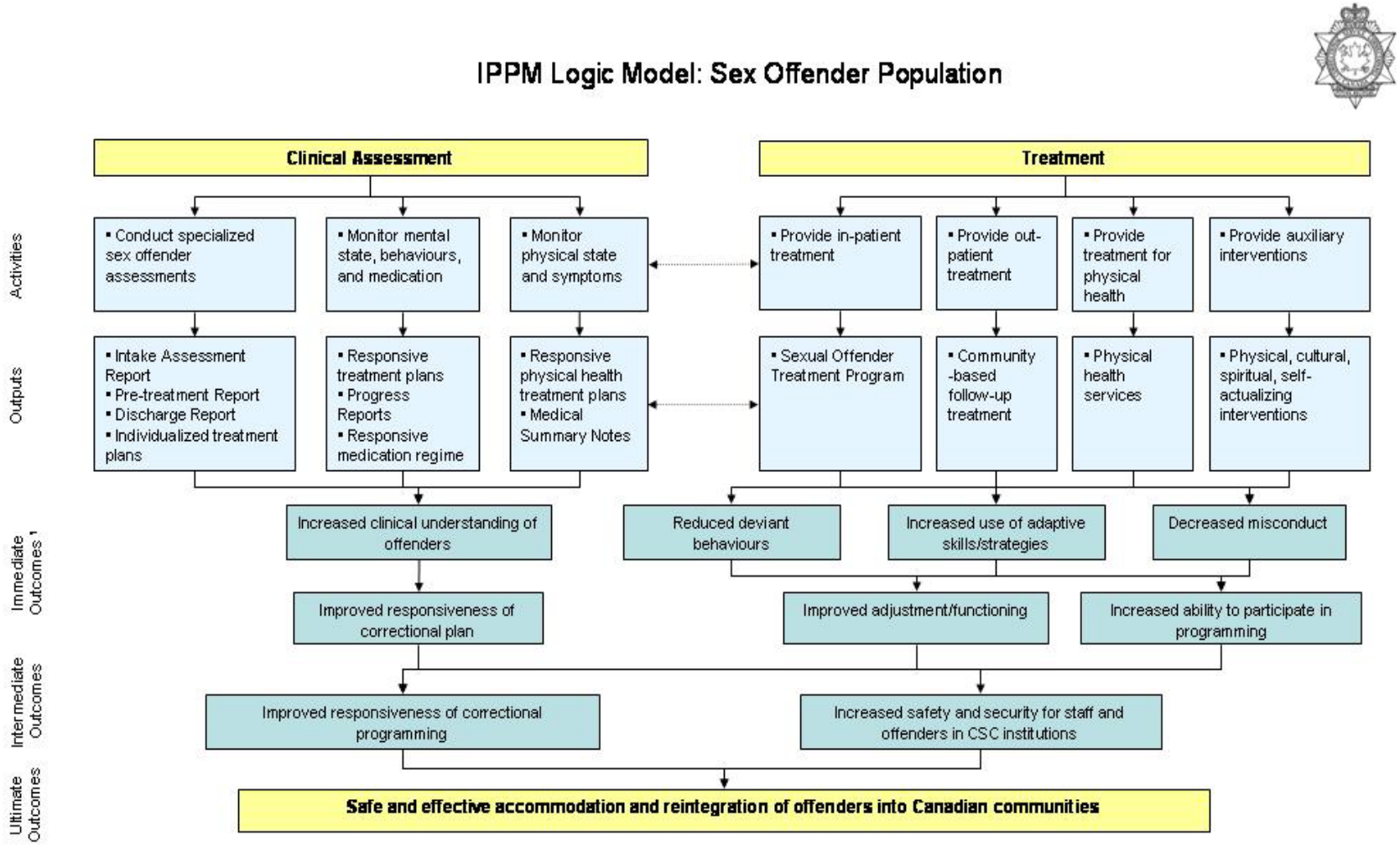
*Note:* Data regarding yearly bed/day utilization and annual expenditures were provided by Correctional Services Canada, Quebec Region, Division régionale Politiques, planification et administration.
Annual allocations to the contract between CSC and IPPM increased each year as a result of annual indexation. The most recent contract between CSC and IPPM came into effect on July 24, 2006, with $4.5M allocated for 2006/2007.

## Appendix 2: Men and Women Psychiatric Offender Populations Logic Model




[1] Immediate outcomes are represented as occurring at two levels to delineate the logical flow of outcomes.

## Appendix 3: Male Sex Offender Population Logic Model




[1] Immediate outcomes are represented as occurring at two levels to delineate the logical flow of outcomes.